

Community Food Consultation
Falkirk Council Area

Literature and Policy Review

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**Research
Report 2**

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Literature and Policy Review

1 Introduction

This study was commissioned by Forth Valley of NHS Primary Care Operating Division 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.

The policy and literature analysis was undertaken as part of the study to explore the Scottish as well as Falkirk context of such work, identify some of the key issues and approaches that have been found across Scotland and increase awareness of community food activities and projects. This will help identify current and future action.

2 Approach to the policy context

The importance of understanding the policy context is central to ensuring that those with a role in supporting implementation are aware of the potential drivers and can develop an integrated understanding of the issues and activities these might support in relation to community food initiatives. With this in mind a broad range of policies have been explored, including health, social justice and social inclusion and community learning and development.

The following questions were used to shape the policy analysis:

- What are the issues under consideration?
- How does the policy link to practice and community-based activities?
- What are the primary targets of the policy?
- Who is the policy aimed at?
- How might it impact on potential developments around community food?

3 Policy review

The Issues

'Health in Scotland' in 2004¹ identified that average life expectancy has increased for men from around 50 years in 1910 to 73.4 years in 2001 and for women to 78.7 years. Infant mortality declined from 130 in every thousand at the beginning of 20th century to about 6 in a thousand at the beginning of 21st century. However Scotland currently has the highest death rates from heart disease and lung cancer in Western Europe.

World Health Organisation statistics in the 1990s² showed that Scotland's premature death rates were twice the rate of many western European countries, with the bulk of problems relating to heart disease, strokes and cancer. The links between diet and these diseases were identified as key areas for intervention in supporting health. The James Report³ showed that the average Scottish diet was deficient in certain

¹ Scottish Executive (2004), *Health in Scotland*, Scottish Executive: Edinburgh

² Scottish Office (1996), *Scotland's Health: a challenge to us all, report of the working party to the chief medical officer for Scotland*, Stationary Office: Edinburgh

³ Scottish Office (1993), *Eating for Health: a Diet Action Plan for Scotland*, Stationary Office: Edinburgh

vitamins and fibre and had too much saturated fat, sugar and salt. Children's diets were identified as particularly bad, with many never eating fruit or vegetables and some eating almost exclusively crisps, chips, snack foods, sweets and fizzy drinks. The rate of breast-feeding was also identified as very low.

Dietary surveys across the Scottish population point to poor diet being established from an early age⁴. Scotland's eating habits are the second major cause of ill health (after smoking). The 1998 Scottish Health Survey⁵ showed that around half of Scotland's population took sugar in tea and ate chocolates, crisps or biscuits daily, although nearly half of men and over half of women ate fresh fruit daily. The findings included:

- Among adults aged 16-74, men were much more likely than women to add sugar to tea (48% of tea drinkers compared with 26%). Children (aged 2-15) who drank tea were even more likely to add sugar (63% of boys and 54% of girls).
- Just over half of men and women and most children ate chocolates, crisps or biscuits daily. For just over half of children, drinking (non-diet) soft drinks was a daily event and many boys (37%) and girls (33%) consumed soft drinks more than once a day. Over a third of men and just a quarter of women drank (non-diet) soft drinks daily.
- About a third of men and women ate a high fibre breakfast cereal, a third ate another type of cereal and a just under a third did not eat cereal. The vast majority of children ate breakfast cereal, but in most cases (59% of boys and 62% of girls) this was not usually a high fibre cereal.
- Nearly half of men and over half of women reported eating fresh fruit at least daily (46% and 59%). About three in ten men and two in ten women ate fresh fruit once a week or less often. Slightly more children had fresh fruit daily: 54% of boys and 62% of girls. Overall, 19% of boys and 12% of girls usually had fresh fruit as little as once a week, but there was a marked increase with age in these percentages.
- Cooked green vegetables were eaten more frequently than either root or raw vegetables. Even so, under half of men (39%) and women (44%) and only three children in ten (27% of boys and 31% of girls) ate green vegetables at least five times a week.
- Consumption of healthy foods was a good deal more prevalent among informants in Social Classes I and II than it was among those in Classes IV and V. Regional variations were very modest compared with social class differences

Though the overall pattern of food consumption was broadly similar in Scotland and England, men and women in Scotland were less likely to have eaten wholemeal bread and high fibre cereal, and to have been users of (semi-) skimmed milk and of

⁴ Scottish Office (1996), *Scotland's Health: a challenge to us all, report of the working party to the chief medical officer for Scotland*, Stationary Office: Edinburgh

⁵ Shaw, A; McMunn, A & Field J, (2000), *The Scottish Health Survey 1998*, Scottish Executive Department of Health: Edinburgh

butter or margarine. They were more likely to have eaten fried food and chocolates, crisps or biscuits at least once a week⁶.

Smoking, high blood pressure and high cholesterol levels and the need for a number of vitamins brought concerns about how dietary and lifestyle changes could be influenced in Scotland. 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, with concerns about foetal and child health, increased concerns about obesity in children and young people, and about the vulnerability of older people where physical activity and awareness of dietary choices and their implications are seen as a priority in supporting their 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, has been identified as a factor. Where deprivation itself seems to have an impact explains about 40% of the excess deaths. Smoking rates are another factor. These have declined more rapidly in the most affluent sections of the population. Forty three percent of women in Scotland smoked in the early 1970s which by 1998 had fallen to 28%, 10% for professional women and over 50% for unemployed or unskilled women. 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 ages⁷. Lower socio economic groups have higher chances of premature and lower birth weight babies, and heart disease, stroke and some cancers in adults. The risk factors identified include a lack of breast feeding, 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 roles in relation to health and well being also link to action taken to combat poverty. In the past components of social exclusion were identified by the Social Exclusion Unit⁸, as demographic factors, labour market factors and policy issues, such as a failure to up rate benefits in line with the growth of earnings.

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.

A recent study analysing the progress towards Government policy in relation to the ending of child poverty⁹ found that relative poverty had fallen between 1996/7 and 2001/2, largely because of improvements in employment rates and the level of some benefits. The study pointed to a fall of about one million, including half a million fewer children in poverty, largely because of improvements in employment rates.

⁶ Shaw, A; McMunn, A & Field J, (2000), *The Scottish Health Survey 1998*, Scottish Executive Department of Health: Edinburgh

⁷ Philip, W; James, T; Nelson, M; Ralph, A & Leather, S (1997), 'Socioeconomic determinants of health: The contribution of nutrition to inequalities in health', *British Medical Journal: 1545*

⁸ HMSO (1998), *Bringing Britain together: a national strategy for neighbourhood renewal*, Cmnd 4045, HMSO: London

⁹ Sutherland, H; Sefton, T & Piachaud, D (2003), *Poverty in Britain: the impact of government policy since 1997*, Joseph Rowntree Foundation: York

Pensioner poverty was predicted to be lower by 2003/4 than in 1997, but indirect taxes and duties, which have increased, have a disproportionate effect on poorer households because indirect taxes are regressive, although the overall effect would be relatively small. The introduction of policies such as the national minimum wage, working tax credit, the minimum income guarantee for pensions and winter fuel payment, appear to have had a direct impact on poverty for some people.

Although overall for the first time the number of indicators of deprivation which improved in the UK was greater than those which got worse¹⁰, there was a mixed picture of success in tackling poverty and social exclusion in Scotland¹¹. 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 life¹².

Key Messages

In Scotland we have an ageing population, the highest death rates from heart and lung disease in Western Europe and eating habits which are the second major cause of ill health.

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.

Policy aspirations – targets

In 'Towards a Healthier Scotland' in 1999¹³ specific dietary improvement aims were identified for the 'Starting Well' demonstration project. The intent was encouraging good nutrition before and during pregnancy and through breast feeding. In the Heart of Scotland demonstration project the intent was promoting eating for health. It can be seen that building on the 'Scottish Dietary Action Plan' has been a proactive and broad policy aspiration.

The 'Dietary Action Plan' recommended;

- 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

¹⁰ Rahman, M; Palmer, G & Kenway, P (2001), *Monitoring Poverty and Social Exclusion 2001* Joseph Rowntree Foundation: York

¹¹ Kenway, P; Fuller, S; Rahman, M; Street, C & Palmer, G (2002), *Monitoring poverty and social exclusion in Scotland*, Joseph Rowntree Foundation: York

¹² Both of these studies defined poverty as households with less than 60% of median income

¹³ Scottish Office (1999), *Towards a Healthier Scotland – a White Paper on Health*, Stationary Office Edinburgh

- 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

Eating for health was a key policy document for the development of initiatives to improve the Scottish diet, outlining a framework for action over 10 years by all of those who influence diet. This identified the need to influence diet 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 diet¹⁴. Towards a Healthier Scotland¹⁵ 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'¹⁶, 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 cancer¹⁷ and a strategic approach to dealing with heart disease¹⁸, both of which highlighted lifestyle and dietary change.

Research, evaluation, targets and monitoring in 'Towards a Healthier Scotland' clearly identified the targets for change and pointed to the need for:

'Effective action requires research at all levels; from policy-making to the day-to-day decisions people take and the knowledge, beliefs and attitudes behind those decisions. We especially seek research, which helps people and communities mobilise their own resources to improve health. Key research flows from the actions outlined in this Paper. Demonstration projects and interventions on diet, smoking, physical activity, dental and oral health and teenage pregnancies all demand proper evaluation using both research evidence and health monitoring data'¹⁹.

These targets link directly to other actions that will have an impact on what people will or can do and that will produce the outcomes sought. A healthy Scotland, eating a balanced diet, taking exercise, and making healthier lifestyle choices that will support longer and healthier lives is an aspiration of the Scottish Executive, which can be seen by the approach to developing policies across a range of departments. This means that there are a number of strands of activity to take into consideration; from different policy priorities that are the responsibility of a number of organisations and departments in relation to delivery.

¹⁴ Scottish Office (1996), *Eating for Health: A Diet Action Plan for Scotland*, Stationary Office: Edinburgh

¹⁵ Scottish Office (1999), *Towards a Healthier Scotland – a White Paper on Health*, Stationary Office Edinburgh

¹⁶ Scottish Executive (2000), *Our National Health: A plan for action, a plan for change*, Scottish Executive: Edinburgh

¹⁷ Scottish Executive (2001), *Cancer in Scotland: Action for Change 2001*, Scottish Executive: Edinburgh

¹⁸ Scottish Executive (2002), *Coronary Heart Disease and Stroke: Strategy for Scotland 2002*, Scottish Executive: Edinburgh

¹⁹ Scottish Office (1999), *Towards a Healthier Scotland – a White Paper on Health*, Stationary Office Edinburgh

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.

Policy aspirations – practice links and interests

Until relatively recently health policy has been dominated by health care services focused on the treatment of illness and disease rather than on health creating strategies to reduce the incidence and duration of illness²⁰. 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 has added some important dimensions of prevention or minimisation of ill health to a range of policy developments. A Health for All concept was established by WHO in 1977²¹ and the European Health for All initiative was launched in 1981. In 1998 this was revised and re-launched as Health 21. The European strategy for Health for All was based on 5 key principles:

- Equity: the reduction of inequalities in health.
- Empowerment: enabling individuals to realise their full physical and mental potential.
- Participation: by communities in decisions affecting their health.
- Co-operation: between statutory and voluntary agencies involved in health and social issues to develop common priorities and strategies.
- Local primary Health Care: preventative services at local level.

Thus identifying health and well-being as part of the social fabric rather than a narrower definition, focusing on disease management. 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. There are 29 Social Justice Milestones covering life course and community focused aspirations²². 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'²³.

²⁰ Elrick, D (2003), *Healthy Volunteering*, Volunteer Development Scotland: Stirling

²¹ Taylor, P (2002), *Understanding the Policy Maze: A Guide to Social and Health Policy in Scotland*, HEBS, CHEX, GHCP: Glasgow. This publication takes a comprehensive and informative journey through Scottish social policy

²² Scottish Executive (2000), *Social Justice ... a Scotland where everyone matters: annual report 2000*, Scottish Executive: Edinburgh

²³ Blamey, A & Murie, J (2002), 'Health Inequalities: Setting the Context', in HPPU & PHIS *Health Inequalities in New Scotland*, HPPU & PHIS: Edinburgh

As part of 'Our National Health Plan'²⁴ 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'.

Agreement that there is a need to bring about changes has been increasingly a priority in public health over the last ten years. This has helped to establish a number of issues to take into consideration when working to improve dietary choices.

Cultural Context. Scotland's eating habits are currently a top priority for policy makers. They are however only part of the policy developments that can have an impact on Scotland's health and well-being. 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.

Commissioning the Independent Inquiry into Inequalities in Health (also known as the Acheson Inquiry) was one of the first decisions of the incoming Labour Government in 1997, bringing a move from government at UK, Scottish and Local Authority levels. Tackling health inequalities created a basis for integrating policy developments, moving away from one-off initiatives and beginning to bring these together more systematically and coherently²⁵

Measuring change in the income and health developments over the period of 1997/98 and 2000/01 show a generally steady development, with only the numbers of working age people in receipt of benefits and death rates for those aged between 25 years and 65 years improved, while income inequality had worsened²⁶.

Table 1 Some Indicators performance over 5 years²⁷

Low Income	
All individuals with low income	Steady
Children and pensioners with low income	Steady
Intensity of low income	Steady
Income inequality	Worsened
Spread of low income	Steady
Working age people in receipt of benefit	Improved
On long-term benefit	Steady
Ill-health	
Death rates for those aged 25 and 65	Improved
Long-standing illness or disability	N/A
Low birth-weight babies	Steady
Standardised mortality rates for three diseases	Steady
Suicides	Steady
Problem drug use	Steady

Taking into consideration the implications of low income and the causes of low income are essential to understanding and dealing with the causes of inequalities in health.

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

²⁴ Scottish Executive (2000), *Our National Health: A plan for action, a plan for change*, Scottish Executive: Edinburgh

²⁵ Exworthy, M; Stuart, M; Marmot, M & Blane, D (2003), *Tackling health inequalities since the Acheson Inquiry*, Policy Press: Bristol

²⁶ Kenway, P; Fuller, S; Rahman, M; Street, C & Palmer, G (2002), *Monitoring poverty and social exclusion in Scotland*, Joseph Rowntree Foundation: York

²⁷ Kenway, P; Fuller, S; Rahman, M; Street, C & Palmer, G (2002), *Monitoring poverty and social exclusion in Scotland*, Joseph Rowntree Foundation: York

local level and with individuals and families, all of which need to be considered in relation to diet²⁸.

At individual level it has prompted action aimed at bringing down the number of people smoking, increasing the number of women breast feeding, 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 however need to be considered. A recent study into the needs of pregnant women and new mothers highlights one of the cultural assumptions that can create barriers to breastfeeding for some new mums:

*'See the thought of me breast-feeding – can you just imagine me with three of them sitting saying 'what are you doing mum?'*²⁹

Encouraging breast feeding in Scotland therefore is important in areas of deprivation. The Breast Feeding etc (Scotland) Act 2005 provides some of the rights that both promote breast-feeding and encourage people to think of it as a natural and normal process. Currently the proportion of mothers' breastfeeding in Scotland stands at 37%, however in the most deprived areas rates are only 22%³⁰. Approaches to supporting breastfeeding have been diverse, including providing information, through leaflets on the Internet, in hospitals and through GP surveys. Evidence indicates that providing women with information on the benefits of breastfeeding is insufficient, whereas encouraging women to participate through small group discussions or one to one advice appear to be the most effective method, in some cases tripling rates³¹.

The Scottish Executive has used advertising in support of smoking cessation and improved diet aim to begin to deal with some of the cultural norms that are thought to block improvements. In addition the Executive has moved towards a public ban on smoking in public places as a way to cut the numbers of those smoking and giving 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.

Health Inequalities. Social and economic conditions have a direct impact on the quality of diet, with poorer people generally eating less fruit and vegetables and cheaper, 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 Diet Action Plan

²⁸ McIntyre, S (2001), Social Justice Annual Report Scotland Socio-economic inequalities in health in Scotland, Scottish Executive: Edinburgh

²⁹ Elrick, D (2003), 'New Beginnings: Policies for Healthy Children in Scotland', in PHIS, *Health Inequalities in the New Scotland*, PHIS: Edinburgh

³⁰ Scottish Health Statistics www.isdscotland.org/Child_Breastfeeding

³¹ Kmietowicz Z (2000) 'Breast feeding programmes should be targeted', *British Medical Journal*; 321

recommended doubling consumption of fruit and vegetables, reducing the consumption of fat by over 5% and doubling the consumption of oily fish³².

Although changes since 1995 indicate that the percentage of the population eating fresh fruit has increased, it has increased more in the least deprived areas³³. The findings from the 2003-4 Scottish Health Survey will be available in the late spring of 2005 but there is already evidence of increased awareness of healthy eating in Scotland. 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 2003³⁴.

'The Working Group under Sir Douglas Black had concluded that, while genetic and cultural or behavioural explanations played their part, the predominant or governing explanation for inequalities in health lay in material deprivation. For statisticians perhaps the most impressive finding of the study of 678 wards in the North was that 65 per cent of the variation in ill-health, as measured not only by deaths but also permanent sickness and low-weight births, could be 'explained' (in regression analysis) by indicators of material deprivation'³⁵

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 Scotland³⁶. 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 and the ability to make informed choices for people in the most deprived areas and encouraging changes in behaviour across the population. This has prompted intervention in relation to diet in schools through the national 'Hungry for Success' initiative funded by the Scottish Executive. Intervention in schools has enabled creative practice around 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.

The recent Jamie Oliver television documentary working in primary schools in a London Borough, to provide healthy food and encourage healthy eating is probably best known but less heralded are the changes in Scotland's schools as a result of intervention through the 'Hungry for Success'

'When I arrived In Scotland the whole Jamie Oliver thing about school meals was just taking off. It was great to see the issue being given such high coverage in the media, but I was very surprised by the fact that Scottish politicians and health campaigners did not point out that Scotland was already well ahead of the curve, in tackling this issue. Through the 'Hungry for Success' reform programme, Scotland is already several years into a complete overhaul of school meals. There were a few press statements, but no real 'showcasing' of school meal success stories and no in-depth

³² Scottish Executive (2002), *Health in Scotland, 2001*, Scottish Executive: Edinburgh

³³ Bain, M (2001), 'Patterns and Trends in Health Inequalities', in PHIS, *What are Health Inequalities*, PHIS: Edinburgh

³⁴ Health Education Population Survey 1996-2003

³⁵ Introduction to *Inequalities in Health*, 1992 Edition, Peter Townsend, Margaret Whitehead and Nick Davidson

³⁶ Scottish Executive (2002), *Health in Scotland, 2001*, Scottish Executive: Edinburgh

examination of the fascinating story of how Scotland has pulled off a huge institutional change in a very short time'.

Laurie True, American public health lobbyist³⁷

Key Messages

The policy and resultant programmes have had some success in changing the eating habit and culture of Scotland's people and community food initiatives have formed an important part.

Public involvement needs assessment and increased awareness of the views and experiences of people in communities served by the NHS are seen as important indicators of success in creating responsive health care. This acknowledges an emphasis on the 'patient's whole journey' that service delivery and patient need require, and links directly to the European aspiration in Health 21 that:

*'By the year 2005, implementation of policies for Health for All should engage individuals, groups and organisations throughout the public and private sectors, and civil society, in alliances and partnerships for health*³⁸.

A whole population approach is central to the social justice agenda in Scotland. Social justice has developed from an initial interest in social exclusion. Social exclusion has been described in similar terms to the definition developed by the European Community.

*'Social exclusion refers to the multiple and changing factors resulting in people being excluded from the normal exchanges, proactives and rights of a modern society. Poverty is one of the most obvious factors, but social exclusion also refers to inadequate housing, education, health and access to services*³⁹.

The report '*Social inclusion, opening the door to a better Scotland*⁴⁰ was a significant first - a government policy specifically addressing social exclusion. It made the links between disadvantage and poor housing, lack of job opportunities, poverty, health, and education and recognised that poor skills required remedial action. Unlike the UK Parliament and most other European Governments the Scottish Parliament felt that it was important to be positive and focus not on the excluded but the process of inclusion. The key policies are described in the report '*Social inclusion, opening the door to a better Scotland*'. The Government's approach to promoting social inclusion is founded on the following principles; integration, prevention, understanding, inclusiveness and empowerment. It has four strands;

1. Promoting opportunities
2. Tackling barriers to inclusion
3. Promoting inclusion among children and young people
4. Building strong communities

³⁷ Centre for Confidence and Well-being (2005), *Confidence Matters*, Newsletter, June. P4

³⁸ Taylor, P (2002), *Understanding the Policy Maze: A Guide to Social and Health Policy in Scotland*, HEBS, CHEX, GHCP: Glasgow

³⁹ Commission of the European Communities (1993), *Background Report: Social Exclusion - Poverty and other Social Problems in the European Community*, Commission of the European Communities, EC Publications Office: Luxembourg

⁴⁰ Scottish Office (1999), *Social Inclusion opening the door to a better Scotland*, Stationary Office: Edinburgh

There is an expectation these strands will underpin specific policy and plans related to work across issues like employment, housing, education and health. This policy agenda focuses on people rather than services to encourage service providers to broaden their perspective in developing creative and responsive support that will help to improve people's quality of life. The current challenge appears to be in reshaping delivery to incorporate professional priorities in ways that will meet individual and community needs.

Social inclusion still features strongly in policy and programmes but the Scottish Executive have now adopted the term 'social justice' to describe their approach. Social justice focuses on the restoration of systems of inclusion and equality of opportunity. Current interests in relation to social justice have been established as low income, unemployment, education, ill health, housing, transport, social capital, neighbourhood, crime and fear of crime⁴¹. In *Closing the Gap*⁴² the Scottish Executive identified action to be taken to focus core public services so that services can have as much effect as possible on disadvantaged areas. Priorities were improving local outcomes in health, education, transport, crime and jobs and that the main support services are working effectively.

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 Dietary Project has supported much activity across a range of organisations. Other strands of funding have also supported local community action aimed at improving health and quality of life in local communities, for instance funding through the primary Care Volunteering Grant and funding through Social Inclusion Partnerships⁴³.

The Scottish Community Diet Project specifically works with low-income communities to improve diet. This Project was awarded the BBC Derek Cooper Award in 2000 for its contribution towards improving diet across Great Britain. 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 has been increased in line with the commitment given in 'Our National Health' to increase support to the Project to allow it to help at least 50% more projects from 2001-2.

The Scottish Healthy Choices Award Scheme aims to change dietary habits in Scotland. Support for the scheme has been extended for the next 3 years, and increased to over £100,000 per annum. This will allow the Scheme to meet increasing demand and develop as a successful mechanism within the wider national efforts to change dietary habits in Scotland. The Health Education Board for Scotland (HEBS) continues to promote the Scottish Healthy Choices Award Scheme, which has been shown to have a positive effect on the consumption of healthier food choices in a range of settings across Scotland.

The role of community-based approaches to the success has been important providing a stimulus for work with people in some of the most deprived areas in

⁴¹ Martin, C; Dudleston, A; Harkins, J; Hope, S; Littlewood, M; Murray, L & Ormston, R (2004), *Scotland's People Results from the 2003 Scottish Household Survey Annual Report*, Scottish Executive: Edinburgh

⁴² Scottish Executive (2002), *Better Communities in Scotland - Closing the Gap*, Scottish Executive Edinburgh

⁴³ Elrick, D (2003), 'New Beginnings: Policies for Healthy Children in Scotland', in PHIS, *Health Inequalities in the New Scotland*, PHIS: Edinburgh

Scotland. Therefore policies at national levels have stimulated and supported intervention that aims to work with people to improve awareness, access and choice 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 the low incomes and multiple needs that are to be found in some of the most deprived areas in the country. This is one of the challenges facing Community Planning in Scotland.

The origins of Community Planning lie in a UK wide pilot programme which was introduced in the mid early 1990's. The pathfinder programme involved 14 English councils and Clackmannanshire Council in Scotland. Following this experience it became a statutory responsibility of local authorities, with partners, to produce community plans in England and Wales. In Scotland the Government and the Convention of Scottish Local Authorities set up a joint working group to investigate and report on how it might best operate in Scotland. The group reported in July 1998 setting out the aims and benefits of community planning⁴⁴.

Aims of Community Planning

- *Improve the service provided by Councils and their public sector partners to the public through closer, more co-ordinated working;*
- *Provide a process through which Councils and their public sector partners, in consultation with the voluntary and the private sector and the community, can agree both a strategic vision for the area and the action which each of the partners will take in pursuit of that vision; and*
- *Help Councils and their public sector partners collectively to identify the needs and views of individuals and communities, and to assess how they can best be delivered and addressed.*

The Community Plan is intended to be the key strategic document. Feeding into this are the plans and strategies of the Council and its partners; health, police, enterprise and other service plans and strategies. The working group also stressed the need to recognise the contribution of voluntary organisations, businesses, community groups and others to the Community Planning process.

It is important to note that at this stage there was no statutory requirement to produce a Community Plan, only joint advice from COSLA and the Scottish Executive. With the Local Government in Scotland Act 2003 community planning became a statutory responsibility for local authorities to initiate and lead the process and for certain other agencies to participate. In subsequent guidance⁴⁵ the two main aims of Community Planning were described as;

- *'Making sure people and communities are genuinely engaged in the decisions made on public services which affect them; allied to*
- *A commitment from organisations to work together, not apart, in providing better public services'.*

This underlines the commitment and expectation that community involvement and governance should be key parts of the process. Also made explicit in the guidance are the principles national priorities which community planning partnerships should pay regard to. These included health and others which are part of and /or inform the healthy eating agenda; social justice, children's services, sustainable development,

⁴⁴ Scottish Office & Convention of Scottish Local Authorities (1998), *Report of the Community Planning Working Group*, Scottish Office: Edinburgh

⁴⁵ Scottish Executive (2004), *The Local Government in Scotland Act 2003 Community Planning Advice Notes*, Scottish Executive: Edinburgh

equalities, education including national priorities in education, joined up working and community regeneration including integrating social inclusion.

The integration of social inclusion within the Community Plan aims to support local regeneration within the wider strategic planning of the areas, to bring services and budgets together and enhance the focus and concentration on disadvantaged groups, linking physical, social and economic regeneration more effectively⁴⁶. The Scottish Executive's commitment to 'Closing the Opportunity Gap', highlights that people's health in Scotland should not depend on where they live or on their socio-economic status⁴⁷, 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 included⁴⁸:

- To reduce the vulnerability of low income families to financial exclusion and multiple debts - in order to prevent them becoming over-indebted and/or to lift them out of poverty;
- To regenerate the most disadvantaged neighbourhoods - in order that people living there can take advantage of job opportunities and improve their quality of life; and
- To increase the rate of improvement of the health status of people living in the most deprived communities - in order to improve their quality of life, including their employability prospects.

To help achieve these objectives the Community Planning process linked specific investment of Executive funding to Regeneration Outcome Agreements focused on data zones identifying areas of deprivation in each local authority.

The fundamental challenge in this development is in ensuring that those responsible for the strategic direction across services as well as for the delivery of particular services continue to be aware of the importance of beneficial and long term action that does not have an immediate impact on specific delivery targets. In this way the resources that integrated thinking and planning can bring together can be explicitly focused on longer-term aims and objectives.

Additional resources are also clearly available in communities⁴⁹, 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.

The resources available to support health improvement, dietary change and cultural developments can be found across a range of disciplines, in compulsory education,

⁴⁶ Scottish Executive & Communities Scotland (2003), *Guidance on Integrating Community Planning Partnerships and Social Inclusion Partnerships*, Scottish Executive and Communities Scotland: Edinburgh

⁴⁷ Scottish Executive (2003), *Closing the Opportunity Gap Scottish Budget 2003 – 2006*, Scottish Executive: Edinburgh

⁴⁸ <http://www.scotland.gov.uk/topics/people/social-inclusion/17415/opportunity>

⁴⁹ CHEX (2204), *Insight*, CHEX: Glasgow

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 requires 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.

Also of note in relation to Community Planning is the role of community learning and development workers, in working with people in areas of deprivation or who have particular learning and social needs and the latest guidance⁵⁰ on community learning and development which puts it at the heart of 'Community Planning'.

'We want community learning and development 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'

At practice level a focus on neighbourhood work within the policy contexts established as part of the community planning process, would enable work to be developed that was both responsive to local needs and interests and aimed at stimulating an understanding of health and well-being and stimulate action that can be taken by local people in their own terms would appear to be a priority. At strategic level a clear understanding of the importance of diet and lifestyle as upstream actions that will have long term impact on service priorities and costs, as well as on the quality of life of local people, has already been a prompt for action in Falkirk. There is however a priority in raising awareness and understanding of professionals in the health, education and social care sectors of the impact those dietary improvements might have on their own priorities and targets.

Scotland's reputation as the 'sick man of Europe' makes dietary and lifestyle choices a national and local priority where action is required to deal with the consequences of current ill health. Current action is also required in stimulating change that will have an impact on health and well being for the future.

This has been clearly recognised at all levels of government, at European, UK, Scottish and local authority, with policies and funding streams acknowledging the importance of changes. The Health Service has direct responsibility for supporting people who are ill, social care services have responsibility for ensuring that individuals have access to the services required for day to day living, community learning and development have responsibility for supporting personal development and community capacity, all three of these services have responsibilities linked to social inclusion and longer term well-being.

By integrating understanding of the issues and actions that will have an impact on lifestyle choices and long term health and well being, these services have a particular responsibility in stimulating change at individual and community levels that can support a healthier Scotland.

⁵⁰ Scottish Executive (2004), *Working and learning together to build stronger communities* Scottish Executive Guidance for Community Learning and Development, Scottish Executive: Edinburgh

Key Messages

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

With the importance of Community Planning as a process to deliver 'joined up' services on the basis of local needs and the current integration of social inclusion into Community Planning this will have further importance in future work.

4 Falkirk Council area

It is clear therefore that dietary choices are a priority concern for those responsible for planning and implementing services at local level. The issues identified demonstrate quite clearly that social deprivation is important in predicting short and longer term health issues and that people living in areas of deprivation are more at risk of ill-health. Responsibility for supporting health and well-being is a major component of the community planning process, bringing together public, voluntary and community sectors in developing strategic understanding and commitment to cross sectoral approaches to implementation at community levels. 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, therefore 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 parents⁵¹. All of the projects studied worked with people on low incomes. Research into Breakfast clubs in 2002⁵² identified 378 breakfast services across Scotland, 60% of which returned surveys. Nearly half of these (47%) 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 also part of the focus for over two thirds, with the majority (90%) involved in healthy eating initiatives.

It is clear that accessibility of initiatives focused on or incorporating healthy diet activities is increasingly recognised as central to engaging with people to raise

⁵¹ *Food projects and how they work* by Pauline McGlone, Barbara Dobson, Elizabeth Dowler and Michael Nelson is published for the Joseph Rowntree Foundation

⁵² Breakfast Service Provision for School Age Children: a mapping exercise, www.hebs.com/research/cr/

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 workers⁵³.

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, for instance Bo'ness, Hallglen and Stenhousemuir (Table 2)

Table 2 Most significant Aspects of Deprivation⁵⁴

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	XX	X			X	X	X	X
Grangemouth	1,000	XX			X				X
Hallglen	1,359	X				XX		X	
High Flats	1,668	X	XX	XX	X		X		X
Maddiston	1,389	X	X	X	X	X			X
Stenhousemuir	949	X	X			XX			
Thornhill Road	1,755							XX	X
Westquarter	1,418		XX	X	X	XX	XX	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 nutritional food, including public transport developments. High unemployment in Denny and Grangemouth in particular might make cost of good quality food a priority. The importance of locally based initiatives to target particular groups of people would appear to be central to developing action based on need.

The Regeneration objectives identified by the Community Planning Partnership also link local policies directly to the targets to be met. Thus the joint health improvement plan 2005-2008, the Forth Valley Health Plan 2002-2005 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.

⁵³ Duffy, M & McNeish, D (2002), *Child Health: what works and what counts*, Barnardos UK: Essex

⁵⁴ Adapted from Tables 1 and 2 in Falkirk Community Planning Partnership (2004), *Regeneration Outcome Agreement, Priority Areas*, Falkirk Council: Falkirk. pp 67 and 68

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. This is not to say that responsibility lies 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 in Falkirk to encourage interest in nutritional choices as well as the need to support action that will enhance their ability to make such choices.

Key Messages

The Falkirk area Community Plan has both health as a theme in its own right and other themes which impact on healthy lifestyles.

The drivers of the health theme are the health improvement plan 2005-2008 and the Forth Valley Health Plan 2002-2005 also of particular relevance as components are Community Learning and Development Strategy, the Children's Service Plan and the Sustainability Strategy which contribute to achieving healthy eating aims.

Local action and community based food initiatives have made a significant contribution to achieving targets elsewhere in Scotland.

Eleven disadvantaged areas have been identified as targets for community regeneration in the Falkirk Council area. These are; Dawson (Falkirk), Grangemouth, Hallglen, Thornhill Road (Falkirk), Bo'ness, Westquarter, Camelon, Stenhousemuir, Maddiston, Denny, High Flats (Falkirk)



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