



Community Food Consultation Falkirk Council Area

SEPTEMBER 2005

Community Food Projects

Scotland's health record is one of the worst in the developed world. The bulk of the problems relate to heart disease, strokes and cancer. The links between diet and these diseases have been identified as key areas for intervention in supporting health. While the statistics are improving they are improving at a slower rate than most other European countries.

The policies, the resultant programmes and the community food initiatives which have formed an important part of tackling this situation have had success in changing the eating habits and culture of people across the Falkirk area. This is one of the broad conclusions from a study commissioned by the Nutrition and Dietetics, Forth Valley Primary Care.

The study also concluded that:

*** Local action and community based food initiatives can make a**



Falkirk Farmers market in June 2005

significant contribution to achieving targets.

*** 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 raising.**

Participants identified real changes in diet through the promotion and provision of healthy food and eating practices. Improving nutritional training and hygiene, work with disadvantaged and vulnerable groups and providing good, easily understood advice and information were identified as contributors to the improvement.

The most important considerations though, were access and affordability.

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The Background



NHS Forth Valley Community Dietetics commissioned Linked Work and Training to undertake a study funded by Falkirk Community Planning Partnership to identify the

current position with respect to food projects and activities, the availability of facilities to develop food 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 project was based on a mixture of desk research and consultation through focus groups, questionnaire survey and interviews. Overall the consultation involved 133 people (58 focus group participants, 65 survey respondents and 10 interviewees) between February and June 2005.

Focus Groups



Comments from focus Group participants (Frequency in brackets)

Really enjoyable (7)
 The breakfast thing was a good start (1)
 It is good we are getting feedback (2)

I look forward to the next meeting (4)
 I met people I have not met before and can work together with (3)
 Can we come to the next one (2)
 I felt that was useful and that my comments were listened to (1)
 Discussion was really good (5)

QUOTES

“Craft/ home economics classes taught you to iron, sew, look after a baby and cook but it is no longer widely available’

“I used to always buy everything in Grangemouth. Now I have to go further away’

The focus groups were held in the Falkirk regeneration areas. Four were held in areas which are geographically discrete (Grangemouth, Denny, Bo’ness, and Stenhousemuir). A further covered the largest of the Falkirk Town areas (Dawson) and the remainder were clustered.

All focus group participants had expressed a good awareness of what is healthy and what is not. While this is positive, it was felt that it did not necessarily reflect the true picture as some of the facts expressed were not always accurate.

Attendance at the focus groups was self selecting and therefore those who are already active or had an interest in

community food initiatives and healthy eating were more likely to attend and those for whom healthy eating was not a priority less likely.

Health advice during illness, health promotion campaigns, media reporting and advertising, health scares, diet and nutrition classes, educational work done pre-school, in school, through community food projects, television documentaries and cookery programmes were all thought to have contributed to a growing awareness.

There was also felt to be a greater awareness of what was termed the basics: sugars, salts, fats, E numbers, preservatives, colouring, ‘fizzy

drink’, grilling not frying. While awareness of healthy food among participants was high yet still a significant number chose not to use it. It is important therefore to make healthy eating easier in terms of time, cost and access to healthy food to make it the first choice.

Supermarkets are by far the preferred option for shopping, the main reasons being convenience and cost. Community based initiatives to provide healthy food need to address these issues. There is a particular issue in disadvantaged areas where car ownership is low and income limited. Shopping for the week ahead was the norm.

The ‘Hungry for Success’ initiative in schools was felt to have had a significant impact. We should learn the lessons from this and apply them wider. In particular community food initiatives should build on these both to maximise the effect in schools and within communities to build links between pupils and parents

In all seven focus groups half or more participants’ cooked at least once a week. Less than a quarter in two groups that they never cooked. ‘Can’t cook’ as a reason not for eating fresh, healthy food only featured in 2 of the 7 groups. Time and convenience featured twice as much. The emphasis therefore in community food projects should be on quick and easily prepared healthy meals as opposed to ‘cookery classes’.

Elderly: Were thought less likely to eat food from other countries preferring traditional fare. They were likely to have good cooking skills and knowledge, particularly women. 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: 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: 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.

*** All groups identified broad generation differences ***

Some hard work at the focus groups



Participants in three groups mentioned pressure from children for fast food as a determinant for where they ate out. Two groups highlighted 'take away' meals as being not particularly healthy.

The interest in home growing was minimal. The key challenge from the focus groups is providers making available locally grown and produced food of a good quality at affordable prices and with easy access for consumers.

projects that needed a small investment of money and/or access to particular expertise, and facilities. Connections were made at the focus group and proves was made on each. It was felt that the Community Health Partnership should have a positive impact on joint working but that this needed to happen at local community level as well as across the area.

At two of the groups the need to

target disadvantaged communities was emphasized. 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.

At two of the groups the need for more development workers on community health was identified. Participants felt that workers should focus on but not work exclusively in disadvantaged areas and they should be tasked with establishing local initiatives to increase healthy eating and support and to encourage networking.

At two of the groups the need to access resources and facilities for community health was recorded. It was felt that this needed better use of existing facilities, better knowledge of sources of funds and resources and training in funding projects.

At three of the groups the need for better networking of those involved in community food initiatives was identified. The benefits claimed were in exchanging information and sharing experience, better joint working, more effective training and keeping up to date with policy, programme and funding developments.

Three examples of joint working were developed during the focus group meetings. These involved



From topics identified by participants, the most frequent and the focus for future work was suggested:

1. Education for young people and children
2. More local community food initiatives
3. Better joint working and networking
4. More development workers
5. Better promotion and advertising using media and messages suited to target audiences



"There used to be a Butcher's in Linlithgow"

"I wouldn't buy bread that was uncovered in a supermarket, I would in a baker's"

"It was fish on Friday, 3 courses on Sunday and mince and tatties on a Tuesday"

"Family learning is a good context for healthy eating as you are working with parents and children together"

"In our youth clubs we promote healthy eating through special events"

"Community regeneration needs to address all aspects and health is an important part"

"In playgroup we make it an aim to give children different healthy food experiences"





Questionnaire



One hundred and twenty eight questionnaires were distributed and 65 responses were received. This represents just over a 50% return.

Of the respondents 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.

Commenting on their job, respondents highlighted the importance of community food initiatives in family learning, with young people and children, in schools, in church activities and in community regeneration. Just over $\frac{3}{4}$ felt that community food activity was very relevant or fairly relevant to their work and only 11% not very or not at all.

Respondents were asked to rank a list of 12 food topics on a scale of 1-10 with 1 being first priority. If we simply rank the priorities on the basis of the percentage of respondents ascribing each topic a score 1, the highest priorities then are cost, availability of unhealthy food, access to good food, education, and health awareness in that order.

Respondents were also asked about whether their organisation was involved in community food initiatives—48% were and 46% were not, about the resources allocated to community food activities—only 22% of respondents' felt that the resources allocated to community food initiatives were adequate, specific plans to engage with different sections of the community on community food and skill requirements for staff working on community food activities.

The key messages coming from the survey were;

- ◇ **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**
- ◇ **The biggest skills and knowledge gaps identified by respondents are in process skills and practical skills, getting better at involving people and developing projects and initiatives.**

We also need a better awareness of what others are doing, sharing experience better; making links with other agencies to develop joint practice; getting better at the support and training of workers involved in community food projects; getting better at accessing resources and funds.

The views expressed in this Executive Summary 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.

The Linked Work and Training Trust would like to thank everyone who participated for their time and effort.



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