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Derbyshire Food and Health Needs Assessment

A case study of the practical undertaking of a food and health needs assessment in a local area.

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Background and Introduction

The Derbyshire Food and Health Steering Group commissioned a food and health needs assessment to identify key issues in the County and to better inform their local food and health action plan and support more effective planning and targeting of healthy eating initiatives.

This report details the key steps of the needs assessment process that was undertaken, illustrates the outputs that can be generated, and highlights potential challenges to those wishing to undertake a similar task. It is hoped that this report will provide an insight into the practical undertaking of a food and health needs assessment in a local area and support its use as an important component in the planning of future service needs and public health initiatives.

For general information on a health needs assessment and its undertaking please refer to the NICE document *Health Needs Assessment: A Practical Guide* (June 2005) http://www.nice.org.uk/aboutnice/whoweare/aboutthehda/hdapublications/hda_publications.jsp?o=705.

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Methodology

This section is categorised according to the different stages undertaken during the needs assessment process. The methods employed at each stage will be described separately.

Stage 1: Identification of Key Issues and Population Groups

The initial stage of the needs assessment involved contacting the main stakeholders throughout the County working on the food and health agenda. The aim of this stage was to identify the key food and health related issues as perceived by those working in local communities as well as those with a more strategic role. The initial brief was relatively broad and so it was hoped that identification of the key issues would help to focus the objectives of the needs assessment and to inform the direction of the work to be undertaken in subsequent stages of the process.

The majority of the Derbyshire Food and Health Network group were invited to participate in this initial stage. These individuals were chosen to represent a range of perspectives and localities within Derbyshire. Semi structured interviews took place with 19 individuals. A number of additional contacts were provided by interviewees, who would also have an involvement in food and health programmes in the County. However, due to time constraints only the most relevant of these contacts were subsequently interviewed. A total of 21 individuals were interviewed in this initial stage of the needs assessment.

Three contacts were also interviewed on the topic of food safety, and their interviews focused mainly on food safety topics as opposed to more general food and health related issues. A group interview also took place with the workplace health team. All of the individual interviews took place between June and August 2008, and the workplace health team were interviewed in November 2008. A copy of the interview guide used during these interviews is provided in Appendix 1.

All interviews were recorded and transcribed by the interviewer. Information was collected on the following previous relevant local work; interventions and programmes currently in place or planned; perceptions of issues affecting local

population; interventions proposed as suitable solutions to those issues; specific information needs and other key informants.

Data obtained from these interviews was initially grouped within three main themes: knowledge and awareness about food and healthy eating; cooking and food preparation skills; and access to healthy food. The key points within each theme were identified and collated and an attempt was made to make links where possible. It is acknowledged that not all issues may have been included, but it is felt that the main issues that are perceived throughout the County have been identified.

A review of relevant national, regional and local policies was undertaken to examine what have already been identified as key dietary-related issues both nationally and within local areas of Derbyshire County. A brief review of the literature was also undertaken at this stage of the needs assessment, to examine those issues that had been identified as significant and were compared to those identified by stakeholders.

Stage 2: Identification of Case Study Areas

This initial series of interviews with stakeholders also allowed for identification of specific residential areas in which subsequent fieldwork could be undertaken. It was recognized that time and resource constraint did not allow for fieldwork to include all of Derbyshire County, but that specific areas should be identified to act as case study areas from which results could be translated to other residential areas of Derbyshire County.

As Chesterfield is the largest urban district in the County, it was agreed that one case study area would be chosen from this district as this would have needs distinct from other areas of Derbyshire. Bolsover was identified as the most deprived district in the County, and thus a case study area was to be chosen from this district to indicate the issues that may be prevalent in deprived areas. In addition, this district is estimated to have significantly lower intakes of fruit and vegetables and higher

levels of adult obesity than the County average (based on model-based estimates[1]). As much of Derbyshire County is rural, the final study area was to be chosen from the rural High Peak and Derbyshire Dales districts to represent this area type. It was hoped that these three study areas would be representative of the main three area types of Derbyshire County, and results could be translated to different areas.

A range of data was analysed for each district to identify specific residential areas in which diet-related issues were likely to be most prevalent. The following datasets were included: indices of multiple deprivation; life expectancy; heart disease mortality rates; obesity rates in both adults and children, and fruit and vegetable intake in adults. Such analyses identified a number of potential areas in which further work could be undertaken.

In order to identify a specific area within each district, it was deemed necessary to consult with key health professionals working in these local areas to determine where diet-related issues were perceived to be most prevalent. Depending on the area, a number of different stakeholders were consulted due to the complexities of the programmes in place in each area and the initial individuals consulted and their knowledge of the local area. Ideally, individuals would have an adequate overview of the community food projects that were in place and links to community and resident groups within the local area.

Stage 3: Community Consultation

During interviews with stakeholders in the previous stage, older adults and parents of young children were identified as key population groups for further insight into diet-related issues. These interviews also allowed for identification of existing groups of older adults and parents of young children that met on a regular basis. It was decided to undertake further consultation with existing community groups due to a lack of adequate time to suitably recruit residents to focus groups. It was also

[1] The Information Centre (2007). **Neighbourhood Statistics: LA Model-Based Estimates of Healthy Lifestyles Behaviours, 2003-05.** http://www.ic.nhs.uk/statistics-and-data-collections/population-and-geography/neighbourhood-statistics/neighbourhood-statistics:-model-based-estimates-of-healthy-lifestyles-behaviours-at-la-level-2003-05

hoped that such community groups may provide a starting point for future food and health work in each local area.

Key contacts for each existing community group were identified and provided with background information on the Food and Health Needs Assessment. A copy of the leaflet provided to each group entitled *Information Leaflet for Community Groups can be found in Appendix 2*. After an initial discussion with the contact for each group about the project objectives, each group was invited to participate in informal discussions around food and health related issues. It was agreed that such discussions could take the form of either a group discussion or a one-to-one interview depending on how appropriate either method was for the group in question and their wishes.

The discussions were relatively unstructured. This was to allow issues and views to emerge spontaneously without the participants feeling too constrained by a structured schedule. Discussions were led by two facilitators, one leading the discussion and one taking notes. These aimed to encompass the three main topics of the needs assessment, namely knowledge about food and healthy eating; accessibility and affordability of healthy food; and cooking skills. Respondents were also given the opportunity to provide additional comments. Respondents were invited to complete a questionnaire examining the importance of healthy eating in each group, plus potential solutions for supporting a change to a healthier diet. This questionnaire is entitled *Community Questionnaire - Healthy Eating in Your Area and can be found in Appendix 3*.

Throughout the project it was apparent that responses were potentially biased to those groups already engaged in community work settings and possibly not those that were most likely to be at highest risk or in most need of additional support. Therefore it was deemed appropriate to speak with domiciliary care staff to help identify key issues for those older adults who may have mobility problems and may not be able to access services and support groups easily. In addition, community outreach workers in a Children's Centre were interviewed to discuss key issues for

those families who were most likely to need support for dietary change and the variations that exist within families in need.

Stage 4: Examination of Food Accessibility in Local Areas

A list of all food outlets registered with Derbyshire County Council was obtained from the Trading Standards Department. The following information was provided for all outlets: exact address; postcode; ward; area; the local usage code and the local food type. The latter indicators were used to categorise each outlet into specific categories depending on the food types sold. Address Point references were also provided for the majority (71%) of all food outlets, which were used in the subsequent mapping process. For those outlets where this indicator was not completed, the postcode provided was used to determine the most appropriate point reference by matching with Dotted Eyes/OS MarkerMap. An initial mapping exercise was undertaken to identify those areas which were likely to have poor accessibility to food outlets. Discussions with key stakeholders also provided further information on those areas where access to food outlets may be a problem. This information was combined with the analysis of the mapping process to identify study areas for particular focus in subsequent stages of the needs assessment.

In each study area the following process was undertaken to measure accessibility to healthy food outlets. All food outlets in each study area that was registered as greengrocers, grocers or supermarkets were visited once between February and April 2009. On entering each food outlet, staff were approached and provided with background information on the project and the information to be collected. Permission was obtained from each manager, or those most appropriate, before continuing to collect the required information. Managers were also invited to discuss both the overall project and the topic of healthy eating in their local area after data collection should they wish to contribute to the project. A copy of the leaflet provided to staff, entitled *Healthy Eating in Your Areas - Information Leaflet for Food Outlet Staff,* and a copy of the interview guide, entitled *Healthy Eating in Your Areas – Questionnaire for Food Outlet Staff,* can be found in Appendices 4 and 5 respectively.

An adjusted format of the food basket model developed by Bowyer et al.[2] was followed. A copy of this data collection tool can be found in Appendix 6. The original food basket model used in the referenced report was developed using nutrient profile scores created by the Food Standards Agency to represent a typical food basket which would meet the nutritional requirements of the average adult with no special dietary requirements. The original food basket model contained 33 core items, which was considered to be too large a model for use in this project. Due to time and resource restrictions, an adjusted format of this model was used focusing upon fruit and vegetables availability. It was agreed through personal communication with Martin Caraher (co-author of the above report) that such a method would be suitable for the project in question and adequate in identifying inequalities between areas.

The adjusted food basket model contained 11 items of fruit and vegetables: apples, oranges, satsumas, grapes, bananas, broccoli, onions, fresh tomatoes, cucumber, carrots and cabbage. Information was collected on whether the item was available in the outlet; the number of varieties available; and the cheapest price per kilogram for both loose and packaged varieties. Where price per kilogram was not provided, an available price was noted and price per kilogram was calculated afterwards. It was also noted whether fruit and vegetables were available in other formats, i.e. frozen or tinned formats. After data collection, the total number of items available and the total cost of the food basket was calculated for each food outlet. Outlets were categorised as healthy if fresh fruit and vegetables were available in the outlet, but this does not differentiate outlets according to the number of items available in the outlet.

Accessibility to these 'healthy' food outlets was used in the subsequent mapping process. Walking distance to healthy food outlets was firstly examined. A 500m walking distance was used as the standard as previous work has deemed this distance to indicate reasonable physical access to food outlets[3]. Mapping was used

[2] Bowyer, S., Caraher, M., Duane, T., and Carr-Hill, R. (2006) *Shopping for Food: Accessing healthy affordable food in three areas of Hackney.* London: City University London

[3] Donkin, A.J.M., Dowler, E.A., Stevenson, S.J., and Turner, S. A. (1999) *Mapping access to food at a local level*. British Food Journal: 101(7); 554-564

to identify those areas which were within 500m walking distance of an outlet selling fresh fruit and vegetables. A distance of 500 metres or less[2] represents a walking time of approximately ten minutes for the average person, but this will obviously differ depending on the circumstances e.g. older adults are likely to take longer, and longer travel times are also expected in those areas with steep gradients. Individuals residing within 500m of a healthy food outlet are considered to have adequate access to healthy foods, while areas outside this 500m zone would typically be considered 'poor access' areas. Driving distance to 'healthy' food outlets was also examined as this is a regular mode of transport for many households. Mapping was used to identify those areas which were within ten minutes driving distance from a healthy food outlet, keeping travel times similar to the walking standard that is in place.

Individuals with no regular access to a car are believed to be at higher risk of poor food access, especially in rural areas. This group are heavily reliant on local public transport networks; thus access to public transport was also examined in each study area. This information was provided by Nottinghamshire County Council using Accession software. The standard used for this indicator identifies those areas which are within ten minutes walking distance from a bus stop where there is a bus at least once every 30 minutes. While this does not necessarily examine direct access to a food outlet, it can discriminate those areas which would be considered poorly serviced by public transport networks and are possibly at higher risk of poor accessibility to healthy food outlets.

It was not possible to examine public transport accessibility further at the time, but it would have been of use to examine total journey time to a healthy food outlet for different residential areas. This would have taken into account walking travel time on public transport plus walking time at either end, which is a better indication of accessibility.

Maps were produced using MapInfo Pro version 9.0 as the base GIS, with RouteFinder Pro version 3.41 being used to produce drive-time isochrones. Accession version 1.6.1 was used to model the frequency of public transport in Derbyshire (we are grateful to Jonathan Hall of Nottinghamshire County Council for his help with this). The road network used in the drive-time mapping was based on

OS Strategi. Points (e.g. shops etc) were geocoded using Dotted Eyes/OS MarkerMap where OS Address Point grid references were not available.

The maps created for the rural area in the Derbyshire Dales district mainly concentrated on access to the shops located in Tideswell, although for the process of mapping, distance to the nearest supermarket in Buxton was also included when examining accessibility to healthy food as this was reported as being a typical shopping outlet for many in the study area.

On completion of the mapping process, maps were analysed to identify those areas where residents were most likely to experience poor access to healthy foods based on the accessibility standards described previously. The number of people resident in these 'poor access' areas, along with the proportion of the population which they represented, were estimated to assess service need in each case study area. The following groups have been identified as those most likely to be at risk of accessing healthy food: older adults (>75); lone pensioners; lone parents; and households with no access to private transport. Using Census 2001 data it was possible to estimate the main population groups which reside in 'poor' access areas and are most likely to be at risk.

Stage 5: Analysis of Data Collected

5a) Stakeholder Interviews

The purpose of the interviews was to collect information and views from a range of professionals working in relevant stakeholder organisations in order to inform the direction of the work to be undertaken in subsequent stages of the needs assessment, and to combine this information with that from other sources to provide a broader picture of the issues in Derbyshire County.

Information was collected on the following:

- previous relevant local work
- interventions and programmes currently in place or planned
- perceptions of issues affecting local population
- interventions proposed as suitable solutions to those issues
- specific information needs
- other key informants

Each interview was examined to identify the key dietary-related issues as perceived by the stakeholders. Secondary analysis of the data identified three main themes as the key issues cited by the majority of stakeholders. The data was initially grouped within these three main themes: knowledge and awareness about food and healthy eating; cooking and food preparation skills; access to healthy food. The key points within each theme were identified and collated, and there was an attempt to make links where possible.

Secondary analysis also identified those population groups that were currently targeted for dietary related initiatives and those that were identified as in need of further targeted work. The population groups that were cited by the majority of stakeholders were deemed to be the key population groups on which further insight work should be undertaken. Findings from this stage of interviews will be briefly described in later sections.

5b) Community Consultation and Discussion Groups

The purpose of community discussion groups was to collect information from those groups that had been identified as target population groups for dietary-related initiatives, and those most likely to be at risk of dietary-related issues.

Each interview was examined to identify the key dietary-related issues as perceived by each of the groups being interviewed. Primary analysis identified those issues that related to the three main topics of the needs assessment, namely knowledge about food and healthy eating; accessibility and affordability of healthy

food; and cooking skills. Secondary analysis of the data identified additional issues that were dietary-related but outside of these main themes, plus those issues that related to wider community problems but potentially impacted on lifestyle behaviours.

Older adults and parents of young children were the population groups that were interviewed. Although there were a number of common themes from both groups, it was felt to be more appropriate to divide these responses into their specific groups. Key points were identified for each group within each of the main themes and these were collated and links were made where possible. Community consultation was undertaken in three different localities. Analysis attempted to identify those issues that were common to all three localities, plus highlight those issues that may be specific to that area type. This identified those issues that were likely to be key issues throughout Derbyshire County, plus area-specific issues that may be more prevalent in only a small number of areas.

Stage 6: Final Analysis

A detailed literature review was undertaken for each of the three main topics of the needs assessment, namely knowledge about food and healthy eating; accessibility and affordability of healthy food; and cooking skills. There was also an attempt to identify, where possible, effective interactions to address these key issues and their potential for implementation at a local level.

This evidence was combined with the findings from the other stages of the needs assessment to provide a detailed view of each key issue. The combination of a variety of information and data allowed for the identification of service need for local residents and the prioritisation of public health initiatives.

Findings from the Derbyshire Food and Health Needs Assessment

As described previously, there were three key issues that were the main focus of the food and health needs assessment in Derbyshire County. The focus areas were: knowledge about food and healthy eating; accessibility and affordability of healthy food; and cooking skills. The main findings from each of these focus areas will be described in the following sections, examining the main issues within each topic and potential solutions to such issues as identified by community residents and local health professionals.

Accessibility and Affordability of Healthy Food

Accessibility to healthy and affordable food varies between the different areas of Derbyshire County. In each study area, some segments were reported to have poor access to healthy food outlets but the proportion of the population that this represented differed vastly between study areas. Poor accessibility to healthy food outlets was seen to affect a considerable proportion of the local population in the rural study area, with 34% of this population residing outside acceptable distance from a healthy food outlet. In comparison, approximately 1% of the total population in each of the other study areas were estimated to be affected by poor access to a healthy food outlet. It was also apparent that different population groups were affected in each of the study areas. In all study areas, lone parents and lone pensioners were the main population groups that were residing in areas considered to have inadequate access to healthy food outlets. Older adults were also resident in poor access areas in significant proportions, and may also be considered a key target population group for improved services and initiatives.

In rural areas, it appears that a lack of food outlets in local areas and a lack of an adequate public transport network are the main causes of poor accessibility in this study area. However, the majority of households in this study area are reported to have adequate access to private transport. As access to private transport plays a major role in determining accessibility to food outlets, it is possible that this group are not at great risk of “poor access”. However, specific groups in these areas are likely to experience problems in accessing healthy food outlets. These groups include both

lone pensioners and lone parents, who are less likely to have regular access to private transport and may have problems in travelling longer distances to access public transport. Public transport was not viewed as a suitable option for many of those residing in rural areas, mainly due to the irregularity of the service and no bus service within walking distance of their home. Community transport was also in place in some rural areas, but it was not considered as a suitable alternative by a small number of respondents. It usually involved a half-day journey to the nearest town which was viewed as inappropriate for some elderly adults as such a journey would be too onerous and these individuals may also need a certain level of support on such outings.

In urban areas, public transport was found to be adequate in both of these study areas with a majority of the local population within acceptable walking distance of a regular public transport service. A large number of households in both urban study areas do not have access to private transport and will be heavily reliant on public transport, but this was not always seen as an appropriate option. A number of parents with young children reported problems in using this service due to certain buses unsuitable to take pushchairs and a limit on the number of pushchairs allowed at one time. This caused difficulties for some parents, especially for those with more than one young child.

Accessibility to unhealthy food outlets, such as take-aways, was also examined. A similar number of 'unhealthy' outlets compared to 'healthy' food outlets were identified in each study area, although there were a higher number of 'unhealthy' food outlets in one of the study areas. In addition, there were also a number of outlets registered as cafes and restaurants, and it is unclear whether these outlets can be classified as unhealthy or healthy outlets. However, such outlets should be taken into consideration when examining access to 'eating-out' outlets as are likely to influence individual food choice. The diversity of food outlets present in each study area also differed, although this depended to a large extent on the number of food outlets within an area. There was more likely to be a wider range of food outlets available in a local area if there were an overall larger number of food outlets.

The availability of all the items from the healthy food basket model varied between different outlets. Typically more than half of the food outlets in each study area were seen to stock fresh fruit and vegetables. However, the number of items available differed between outlets, with one outlet stocking less than 50% of the items listed in the food basket model. This meant that certain residents had to travel to more than one shop to access all items from the healthy food basket model. It must be noted that the food basket model only examined the availability of fresh fruit and vegetables, and did not examine those items available in packaged form nor did it examine the healthfulness of other items available in the outlet. It is possible that outlets did stock alternative healthy options apart from fresh fruit and vegetables but that was not the focus of this study.

On consultation with community groups, it was apparent that not all respondents viewed access to healthy food outlets as a problem. Respondents from rural areas did not necessarily consider themselves to have poor access to healthy food as most residents had access to private transport. However, there was consensus in this area that access to private transport would be a necessity to access food outlets on a regular basis, and individuals without such facilities would be dependent on others to meet their shopping needs. In urban study areas, food access was also not reported to be a problem for many residents as most were within walking distance of food outlets or had access to private transport.

However, there were specific population groups that reported problems with accessing healthy food regularly. Older adults, mainly those with restricted mobility, relied on support from others, e.g. neighbours, family members or domiciliary care staff, to access food outlets. While this was not seen as a major problem for the majority of this group, a small number of older adults reported that such circumstances limited their intake and their ability to consume a healthy diet.

The weight of groceries was also an important factor for many individuals that impacted on their ability to purchase sufficient amounts of healthy food. This was especially true for older adults but many of this population group purchased food items daily ensuring they only needed to carry a small number of items each time. It was a greater problem for those unable to walk to food outlets or visit food outlets on a daily basis. It was also cited by some parents of young children as an important

influence on shopping habits. One mother commented that this limited the fresh produce that she could purchase as she would be unable to carry large amounts along with a pushchair and young children. It also appeared to be a greater problem in those areas with a hilly terrain.

In addition, parents of young children also reported that the cost of healthy food was a barrier to consuming a healthy diet. In particular, fruit and vegetables were seen as being too expensive to consume the recommended 5 A DAY for the whole family. As many families did not have access to private transport, some parents stated that they used taxi services to return from shopping and the additional cost of this approach further reduced the money available for food items.

In one urban study area older residents spoke about the use of mobility scooters to undertake shopping, and there were mixed views about their use. While some were able to use mobility scooters to access outlets, this option was not viewed positively by all respondents. A number of respondents, mainly older females, reported that they limited their personal use of mobility scooters as they felt a nuisance on the road and in the way on the pavement. However, those members of the group that were happy to use the scooters to get to food outlets felt that most of the shop owners were happy to help with their shopping and would sometimes get the items that they needed to make it easier for them. This older adult group stated that they were relatively happy with the food outlets in the local area, but issues did arise relating to the size of the aisles in some outlets, which was especially a problem for those with mobility scooters.

Mobile vans and delivery services were viewed positively in all areas, and this was especially true for older adults. It was seen as a good option for those that had mobility problems and thus could not access shops or carry bags of shopping easily. A number of these services appeared to be operating in all areas, but they were not widely known and in some cases they only sold produce to regular customers as opposed to the general public. A number of respondents stated that they would like to see the return of these mobile vans but providing a larger number of items. However, it was agreed that this service would only be used if it was regular and items were not too expensive. This issue was also addressed in discussions held

with food outlet managers. A number of small independent outlets did offer delivery services to their customers, and this was mainly taken up by older adults unable to carry large amounts of shopping. It was seen as a necessary service by outlet managers in small villages as older adults had limited options. However, establishing a mobile shop was not viewed positively by many food outlet managers as demand was seen to be quite low in communities and it was not seen as profitable.

There was general consensus amongst older adults that the concept of a meal delivery service and food shopping delivery was something that they were likely to use and felt positively about these suggestions. This was especially true in the urban study areas. The majority of the group said they would prefer hot meals to be delivered and did not like ready-made meals to be delivered as they did not know their ingredients, which was a clear issue for this age group. Older adults experiencing mobility problems expressed an enthusiasm toward home delivery but appear not to have accessed this service despite it being available in the local area.

Increased availability of locally sourced produce in food outlets was seen as an important issue for a large number of the respondents, especially those in the older adult age group. While this was mainly from those respondents living in rural areas and who had links with the farming community, it was also cited as an important issue by a number of parents in the urban study areas. While such produce was available in farmers markets, these did not appeal greatly to some respondents as they were seen as too expensive and not completely accessible to all residents. Many understood the importance of supporting their local producers but felt that they could not afford to do so as the items were currently too expensive.

There were differing views on the benefits of shopping at supermarkets by community residents. A number of community residents appreciated the ease of accessibility that larger out-of-town supermarkets gave, and this was especially true for older adults who often found parking in town centres too difficult. Respondents also preferred the greater variety of produce that was available in larger supermarkets, although a number of parents preferred to shop at smaller greengrocers where they could easily purchase a small number of items cheaply.

Cooking Skills

It was apparent that there was a clear need to improve the cooking skills of the local population through discussions with key stakeholders and community residents. It was felt that this could be achieved by educating local populations about food through cookery course provision and providing recipe ideas that were both easy-to-make and could be made on a low budget. Most people were aware of the types of food that they should be eating as part of a healthy diet, but a large proportion did not feel that they were able to translate this knowledge into practice. Several reasons were given for this with time pressure frequently mentioned as a barrier to healthy eating and this was particularly reported among parents juggling multiple responsibilities. Those who are time-pressed may therefore be attracted to less healthy ready-meals for the convenience they offer. Similarly, across the groups there was a feeling that eating healthily can be expensive; therefore cheaper, less healthy food may be purchased by those with a limited budget.

Both time and financial restraints were felt by some to be a change brought about by modern living. Where in the past, people may have had the skills and time to grow their own food, cook whole meals and eat together; there was a feeling that now cooking and eating is about instant gratification specifically with regards to children who do not expect to have to wait for meals. As a result of this, it was felt that traditional cooking skills have been lost or become redundant, particularly among younger generations. Another, less frequently mentioned reason for not eating a healthy diet was the variety which convenience foods could offer. For example, one mother said she used ready-made sauces to provide variety because she did not have the cooking skills to make them herself. A lack of motivation or interest was cited as a potential problem by domiciliary care staff working with an elderly population, and this was generally due to social isolation encountered by this group.

It was felt that local courses in cooking skills could address some of the underlying causes for unhealthy eating. Older men (mainly those that were widowed) and families with children in all three districts felt that learning how and what to cook would help them to eat more healthily. There was a tendency for older females to state that they already had adequate cooking skills and knowledge and thus had no need for cookery lessons.

Suggestions were put forward as to how cookery classes could help improve dietary intake by some community members. One of the key issues cited was that courses needed to be useful and beneficial to the participants and that recipes featured must be appropriately targeted. It was felt that courses should include affordable recipes as well as information on shopping and budgeting skills. Participants (particularly time-pressed parents) wanted recipes which are quick to prepare and easy to cook, meaning that both the ingredients are readily available and also that the recipes themselves are simple to follow. The simplicity of recipes may also be of particular benefit to older people who may not usually be able to cook for themselves. Parents often mentioned that a combination of having information on what children should be eating and knowing more recipes would enable them to ensure their children have a more balanced, nutritious diet. Consequently, this group would potentially benefit from courses which can help educate them further on food whilst giving them the skills to provide more varied menus.

In addition to cookery courses for adults, it was also suggested that courses should be developed for young people and possibly that projects/initiatives could be established in which young people could collaborate with older adults who are unable to cook for themselves. There was also a suggestion that cookery demonstrations for the local community could be provided in village halls as some individuals may be wary of attending courses on a regular basis, while a drop-in session may be beneficial to promote longer courses. For older adults, cooking demonstrations could be undertaken at day centres or at sheltered housing coffee mornings. It was hoped that creating more social events for this age group would reduce the social isolation felt by many and increase their motivation to maintain and develop cooking skills.

Outreach professionals who work with individual families in areas of need identified a number of issues specific to such families. This group were seen to lack even the most basic level of knowledge and skills related to cooking and food hygiene. It was stated that there is a need to have a flexible approach with such communities as some households will require individual cooking sessions held in their own household as many are reluctant to attend group sessions. An additional issue relates to the general lack of basic cooking equipment in a number of households, and this needed to be considered when undertaking courses with individuals, either in their households or if they are attending a group session. It was

noted that a number of households depended on a microwave for their cooking needs, and such practice would be difficult to overcome.

Knowledge about food and healthy eating

Most people stated that they had access to sufficient information on healthy eating and what a healthy diet should contain. There was general consensus that there is a lot of information available from various sources, especially from the media, and also the internet. An exception to this appeared to be when an individual has been diagnosed with a health problem and advised to change their diet accordingly. It appeared that individuals may appreciate additional advice and support at this stage. Some parents found receiving advice from a health visitor at the weaning stage to be particularly helpful as many thought that healthy eating needs to be introduced when the child is very young to establish good habits. A number of people stated that they had received conflicting information/advice from different sources, and in some cases experiences of misleading or inaccurate information had made people sceptical of healthy eating messages. There is a clear need for consistent messages to be delivered by all health professionals to counteract such behaviour and prevent further confusion.

Most people considered healthy eating to be important. However a few felt that there was an overemphasis on this. Some parents stated that they would like to improve their diets but most of the older adults stated that they would prefer to eat what they are used to. The majority of older adults considered their current diet to be reasonably healthy, consisting mainly of a traditional diet of meat/fish and vegetables and as such did not need to change to a healthier diet. Different taste preferences were frequently mentioned with many different likes and dislikes for certain foods, including fruit and/or vegetables. These individual taste preferences made it challenging in some cases for parents to provide a healthier diet to their children, or if in their own case, to eat more healthily themselves.

Most parents thought that initiatives to promote healthy eating and improve access to a healthier diet in schools were a good thing. However, there was a minority that felt that this had gone too far and some children were rejecting the new

menus and refusing to eat them. Some parents had accessed materials from the Change4Life campaign and thought that this campaign was a good idea. One mother stated they she was not happy about prescriptive information/advice and felt that it is being delivered in an inappropriate way. It was stated that this method generally does not empathise with the challenges that parents may face in getting children to eat healthily and the pressures that they may be under generally.

A small number of respondents, mainly parents, expressed a concern about additives in their food and their potential effect on children's health and behaviour. There appears to be a need for more information and awareness-raising on this topic so that parents can fully understand their impact. Some respondents (both parents and older people) found food labels difficult to understand and would find it useful to receive advice on their interpretation. In addition, some older adults found food labels were often too small which made it difficult to read them, while some expressed a lack of interest in using food labels.

From the perspectives of outreach workers in one of the study areas, healthy eating was not a high priority for some families and other issues took precedence. Snacking and a lack of regular meal times were often observed. Engaging with people on these issues requires sufficient time to build up a relationship of trust and as such these issues can often not be tackled straight away with these families.

From the perspectives of care staff in one of the study areas, many older adults with support and care needs who may live alone preferred to have a snack or a ready made meal rather than cook with fresh food. The reasons for this are not fully clear but it was observed that there is often little interest in nutrition in this group and many do not wish to waste money on food that is perishable. It is thought that improving the availability of perishable food in smaller portion sizes; improved services to reduce social isolation; initiatives to help maintain older people's interest in food; support for older adults in maintaining their skills and independence; and better access to healthier food may help to increase their motivation to eat healthier.

Development of an Action Plan

Quarterly meetings were held with the Derbyshire Food and Health Network group to discuss the main findings from each stage of the needs assessment process. This ensured that the findings complied with local knowledge and current issues already identified in local areas. It also allowed for the needs assessment to be focused to a greater extent, based on feedback from the members of the Network. This was important and useful due to the broad remit of the needs assessment at the outset of the project. It was also useful for the members of the Network group to be involved as this ensured that they had a greater ownership of the findings from the needs assessment and could relate such findings to their own work programme. Their continued involvement ensured a greater understanding of the final outcome than would possibly have been achieved if only the final results were provided. The NICE guidance recommends the involvement of the steering group/commissioning body throughout the project for this purpose and that findings are relevant to the needs of the commissioning body.

On completion of the described stages of the needs assessment process, an action planning meeting was held. This comprised of all key stakeholders throughout Derbyshire County involved in the food and health agenda. It was important to involve individuals from all districts of the County, and also representatives from non-NHS organisations e.g. district councils and relevant third sector organisations. This is important as a wide range of organisations will potentially be involved in the delivery of future action plans. It was also important to involve people from different working backgrounds, from those working directly with community groups on healthy eating initiatives to those individuals with a more strategic role. This is important to ensure that all potential actions are feasible and complement existing work programmes and local policies.

Prior to the day of the action planning meeting, all participants were asked to read through the findings of the Food and Health Needs Assessment and to provide comments on these findings, e.g. if they disagreed with any of the findings in the report. On the day of the action planning meeting, three discussion groups were formed based on the three main topic areas previously identified as key issues in Derbyshire County, i.e. knowledge about food and healthy eating; accessibility and

affordability of healthy food; and cooking skills. Each group was facilitated by an individual who worked on that specific agenda in Derbyshire County. All participants attended each group and were invited to discuss the key issues for each topic and identify potential actions to address such issues. At the end of all discussions, the group facilitator was asked to identify the key actions that were proposed for further discussion and to possibly take forward into an action plan.

Each of these potential actions were discussed further according to the following five criteria[4]:

- ***Substantial***: delivers tangible benefit in the short term to many frontline practitioners and offers a good return on investment
- ***Simple:*** can be implemented within one year at modest cost
- ***Synergy:*** reinforces other recommended actions so that the total benefit of the portfolio of actions is greater than the sum of the benefits of the actions if they were taken individually
- ***Strategic fit:*** consistent with existing policies and initiatives for building capacity and capability and with any others that are already planned
- ***Sustainable:*** likely to endure and to provide a sound platform for future developments in the medium term

Each action was scored based on these criteria, and those actions that achieved the highest overall scores were taken forward as suitable for inclusion in a future food and health action plan. Such actions were to be further discussed by relevant management teams and presented to relevant steering boards to determine how best they fit with current work programmes and to identify potential funding sources for some of these actions.

Overall, the health needs assessment process was viewed as a positive method of achieving appropriate evidence to inform future action plans. The evidence

[4] Information Centre for Health and Social Care. Building Frontline Information Management Capacity. May 2009

was grounded in the needs of the local residents which ensured that future actions would be relevant and more appropriate to the targeted communities.

Appendices

Appendix 1 Stakeholder Interview Guide

1) What is your role?

(Job title/accountability/areas of work /localities covered)

Do you work with any particular groups?
(e.g. ethnic minority; age; gender etc.)

2) What is your role in relation to food & health?

(Previous relevant local work/current work/future plans)

What, if any, targets/strategies do you work towards?

On what are these based?
(E.g. local/national research/strategies/policy directives)

3) What do you consider are the main issues and needs in relation to food & health?
(E.g. *access (geographical/economic/social); knowledge about healthy diet; cooking)*
How would you rank these in order of importance/priority?

4) What variations are there in age/gender/social class/ethnic group in relation to the above?
Are there any other relevant sub groups?

5) What interventions would you like to put in place?

On what are these based?
(E.g. local/national research; strategies; policy directives)

What constraints (if any) are there to prevent the above happening?

6) What information do you need to help you with your work?

7) What sources of information do you have access to?

8) Are there any other people it would be useful for us to talk to?

Appendix 2 Information Leaflet for Community Groups

Healthy Eating In Your Area

Who are we?

Sarah Jane Flaherty – Public Health Researcher, East Midlands Public Health Observatory
Lynne Irving – Research Officer, Derbyshire County Primary Care Trust

We are working on behalf of the local health service to find out what the people of Derbyshire think about healthy eating and what can be done in your area to help people eat more healthily in the future.

What are we trying to find out?

- What people think about healthy eating – is it important to them or not?
- Whether people think it is easy or difficult to buy healthy foods locally. If it is difficult to buy and prepare healthy food, what are the problems?
- We want to know how the local services could be improved or changed to help people eat more healthily or get healthier foods more easily.

What will the results be used for?

- What people write and say to us is completely confidential.
- At the end of the project we will be summarising the information people give us, along with the other pieces of work that we are doing for this project, into a final report on *Healthy Eating in Derbyshire.*
- This report will be given to health workers and managers in the N.H.S., Local Authority, Voluntary Organisations and other organisations who will use this information to improve services and/or plan new services for the future.
- At no point will any individual be identified or names be included in the report
- A summary of these findings will be made available to participants on request.

If you would like more information on the project please contact us:
Lynne – lynne.irving@derbyshirecountypct.nhs.uk or 01246 514113
Sarah Jane – sarah.flaherty@empho.nhs.uk or 01623 812069
We really do hope that you can help us in this project. Your views are very important in helping the local community in the future. Thank you in advance for your time and cooperation.

Healthy Eating in Your Area

Part A. What do you think about healthy eating?

1) Is healthy eating important to you?

☐	☐	☐	☐	☐
Very Important	Quite Important	Neither Important nor Unimportant	Not Very Important	Not At All Important

Comments.....

.....

.....

2) How healthily do you eat at the moment?

☐	☐	☐	☐	☐
Very Healthily	Fairly Healthily	Neither Healthily nor Unhealthily	Fairly Unhealthily	Very Unhealthily

Comments.....

.....

.....

3) Would you like to eat more healthily?

YES ☐ NO ☐ Not Sure ☐

Comments.....

.....

.....

4) What would help you eat healthier or make healthy eating easier?

*1. Please tick the box next to **all statements that apply** in Column 1*

*2. Out of those you have ticked, please tick **up to five** of these statements that you would find **most helpful** in Column 2*

3. Please add any comments you wish to make in the spaces provided.

What would help you eat healthier or make healthy eating easier?	**Column 1** *Please tick the box next to each statement that applies*	**Column 2** *Please tick **up to five** of these statements that you would find **most helpful***
Better information about what to eat and what not to eat		
More will-power		
Better information about how to read food labels		
Individual advice/support		
Better information about how my health is affected by what I eat		
If healthy food were cheaper to buy		
More fresh food available in my local area		
Less 'Take-aways' in my local area		
Better public transport		
Cheaper public transport		
Better design of shops and supermarkets (e.g. more seating/easier access)		
More help/advice in shops and supermarkets		

Fresh food delivery services e.g. fruit/vegetables; meat; fish		
Ordering food in bulk with others and sharing delivery charges		
Someone to do my shopping		
Healthy meals delivery service		
Help with cooking		
More confidence in cooking		
Cookery classes available in my local area		
Cheap and easy recipes available		
More time for cooking		
Having access to the internet to order supermarket delivery		
Local café/restaurant with good healthy affordable food		
Local lunch club with good healthy affordable food		
Healthy food available at my workplace		
Learning how to grow my own food		
More allotments available		
Other (please state)		

5) Is there anything else you would like to say about healthy eating? Please write any additional comments you would like to make in the space below.

Part B. Please can you provide the following information about yourself and your household:

1. Your age: ☐ 16 – 24 ☐ 25 -34 ☐ 35 – 44
☐ 45 – 54 ☐ 55 – 64 ☐ 65 – 74
☐ 75 – 84 ☐ 85 or over

2. Sex: ☐ Male ☐ Female

3. Do you live: ☐ Alone ☐ With my partner (married or unmarried)
☐ Alone with my children ☐ With parents or other relatives
☐ With other adults

4. The number and age of children living in my household is:
Tick the first box or write a number in the spaces

☐ There are no children living in my household

☐ Child(ren) aged under 5 years

☐ Child(ren) aged 5 – 16

5. Do you or your household have access to a car?

YES ☐ NO ☐

6. Which of the following best describes your main occupation *(tick one box only)*

☐ Working in a full-time paid job or self employed

☐ Working in a part-time paid job

☐ Retired

☐ Unemployed and looking for work

☐ Permanently sick or disabled and not able to work

☐ Looking after the home or family full-time

☐ Student on a training course

6. Place where I live or nearest town/village:

……..

7. Postcode *(if known)*

…….

THANK YOU very much for your help in completing this questionnaire. The information you have provided will be treated in COMPLETE CONFIDENCE

Appendix 4 Information Leaflet for Food Outlet Staff

Healthy Eating In Your Area

Who are we?

Sarah Jane Flaherty – Public Health Researcher, East Midlands Public Health Observatory

Lynne Irving – Research Officer, Derbyshire County Primary Care Trust

We are working on behalf of the local health service to find out what the people of Derbyshire think about healthy eating and what can be done in your local area to help people eat more healthily in the future.

What are we trying to find out?

- What people think about healthy eating – is it important to them or not?
- Whether people think it is easy or difficult to buy healthy foods locally. If it is difficult to buy and prepare healthy foods, what are the problems?
- The experiences of shopkeepers working in the local area
- What food is available in local shops and the reasons for stocking this food
- If there are any changes the shopkeeper would like to make and why
- How local services could be changed to help people eat more healthily or get healthier foods more easily

What will the results be used for?

- What people say to us is completely confidential.
- At the end of the project we will be summarising the information people give us, along with the other pieces of work that we are doing for this project, into a final report on *Healthy Eating in Derbyshire.*
- This report will be given to health workers and managers in the N.H.S., Local Authority, Voluntary Organisations and other organisations who will use this information to improve services and/or plan new services for the future.
- At no point will any individual or business be identified or names included in the report
- A summary of these findings will be made available to participants on request.

If you would like more information on the project please contact us:

Lynne – lynne.irving@derbyshirecountypct.nhs.uk or 01246 514113

Sarah Jane – sarah.flaherty@empho.nhs.uk or 01623 812069

We really do hope that you can help us in this project. Your views are very important in helping the local community in the future. Thank you in advance for your time and cooperation.

Appendix 5 Healthy Eating in Your Areas – Questionnaire for Food Outlet Staff

Healthy Eating In Your Area

- How long have you worked in this shop/in this local area?

- How would you describe your experiences of working in this local area? E.g. crime, level of demand, local population

- I see you stock fresh fruit and veg – is there adequate demand in this area for these items?

OR

- I see you don't stock fruit and veg – is there not enough demand for these items in this area, or are there other reasons for not stocking this?

- Would you like to stock more fresh fruit and veg items?

- What do you think could help with this, who would you need support from?

- Is stocking healthy food items important to you? Any reason for this.

- Any other comments related to healthy eating in your local area, or problems with supplying/accessing healthy food in your area.

Appendix 6 Shopping Basket Data Collection Tool

Identification Number:

Date of Visit:

Product	Available		Number of varieties	Cheapest variety of each product and price loose and pre-packaged (please indicate when not available in both)	
Apple	**Yes**	**No**		**Cheapest Apple Type**	**Name**
				Loose Price/kg	
				Pack Size + Price/kg	
Oranges	**Yes**	**No**		**Cheapest Orange Type**	**Name**
				Loose Price/kg	
				Pack Size + Price/kg	
Satsuma or similar	**Yes**	**No**		**Cheapest Satsuma Type**	**Name**
				Loose Price/kg	
				Pack Size + Price/kg	
Grapes	**Yes**	**No**		**Cheapest Grapes Type**	**Name**
				Loose Price/kg	
				Pack Size + Price/kg	
Bananas	**Yes**	**No**		**Cheapest Bananas Type**	**Name**
				Loose Price/kg	

				Pack Size + Price/kg	
Broccoli	**Yes**	**No**		**Cheapest Broccoli Type**	**Name**
				Loose Price/kg	
				Pack Size + Price/kg	
Onion	**Yes**	**No**		**Cheapest Onion Type**	**Name**
				Loose Price/kg	
				Pack Size + Price/kg	
Fresh Tomatoes	**Yes**	**No**		**Cheapest Fresh Tomatoes Type**	**Name**
				Loose Price/kg	
				Pack Size + Price/kg	
Cucumber	**Yes**	**No**		**Cheapest Cucumber Type**	**Name**
				Loose Price/kg	
				Pack Size + Price/kg	
Carrots	**Yes**	**No**		**Cheapest Carrots Type**	**Name**
				Loose Price/kg	
				Pack Size + Price/kg	
Cabbage	**Yes**	**No**		**Cheapest Cabbage Type**	**Name**
				Loose Price/kg	
				Pack Size + Price/kg	

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ASSOCIATION OF PUBLIC HEALTH OBSERVATORIES

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