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**A Survey of Food Projects
in the English
NHS Regions and Health Action Zones in 2001.**

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Abstract

Background and Objective This article sets out the findings from an analysis of food projects, with a particular emphasis on fruit and vegetables, from the 26 Health Action Zones (HAZs) in England and those taking place within the former NHS regional areas in 2001. The objective was to gather information on the existing practice to inform future work.

Methods A series of interviews with key informants in the London area and a review of all the London Health Improvement Programmes and Coronary Heart Disease Local Implementation Plans were used to inform the development of an interview schedule and questionnaire. A second phase consisted of interviews with leads in the NHS Regional Offices. The third phase involved distribution of a questionnaire to the 26 Health Action Zones (HAZs).

Results Comprehensive data on food projects was not routinely available. The large number of initiatives related to food led some respondents to feel unsure as to under which policy to locate their food and fruit and vegetable work. Projects tended to be based on the development of skills (e.g. cooking classes) or on a settings approach such as activities in schools or workplaces. A strategic focus was reported as being more common at a local level. Evaluation of food projects was at an early stage in many areas.

Conclusions The future sustainability of food and fruit and vegetable projects was identified as a key issue. Future policy development of food projects need to be clearly guided by a coherent policy focus and an integrated approach which clearly tackles the root causes of food access and poverty.

Key words Fruit and vegetables, food projects, nutrition, health promotion, food policy.

Background

In recent decades, health and social policy interventions have identified the necessity to tackle healthy eating and food poverty, resulting in a groundswell of local food projects many funded by the state sector through the NHS at local and regional levels. The rise in the number and range of initiatives, at local level described here as ‘*food projects*’, has increased as the link between food and health becomes more evident and local priorities are dominated by reducing inequalities in health and social exclusion. Despite the growth in the number of local food projects we know little about how funding is allocated, the extent and reach of local food projects or the strategic direction being taken. In this article we present the findings from a review of such food projects within Health Action Zones and the eight former NHS regions and document the extent and range of food projects that were funded by the NHS under the headings of CHD, cancer prevention and 5 A DAY initiatives designed to promote healthy eating with a particular emphasis on fruit & vegetable work. The research was conducted prior to Shifting the Balance of Power¹ and the resulting restructure of the NHS Regions and also at a time when the 5 A DAY programme and the National School Fruit Scheme (NSFS) was in the initial phase of piloting and therefore running in only a small number of areas.

‘Local food projects’ are hard to define and categorise. The term is used by a range of professionals and sectors to indicate initiatives which have in common: *food* (its preparation or consumption), *local involvement* (management, delivery, paid/unpaid workers) and *state support* (funding, space, professional input, transport, equipment) and an explicit social agenda. They can range from practical sessions on cooking, food co-ops or transport schemes, community cafés, gardening clubs to breakfast clubs in schools with a variety of management and organisational structures, and can encompass local activities run by volunteers to those where a statutory worker has been given time to engage with the local community in developing food work. The funding or other support can come from local authorities or health authorities (now Primary Care Trusts (PCTs)), lottery monies or other charitable sources. The term does not usually include commercial or state supported/funded food services such as farmers markets, producer co-ops or meals-on-wheels/welfare foods scheme respectively. The focus is not *per se* on local food sourcing (although some such as those receiving environmental funding may include this as a focus) and the

continuing emphasis on local sourcing and sustainability makes this a pertinent aspect for local food projects.² This latter dimension has received more attention since the farming crises with BSE and foot and mouth disease. Since this research was undertaken these concerns have usually manifested themselves in the development of public procurement policies.³ These often have a concern with local food and add an extra dimension to local food projects in terms of sourcing and sustainability.

The academic literature is unequivocal on the benefits of eating at least five portions of fruit and vegetables a day there is less on the means to achieve such targets.^{2 4} There is a limited amount of evidence in the academic literature on the success of community food initiatives as means of improving the diet of a community or individuals targeted (see the Department of Health reports on the five pilot community sites to promote the uptake of fruit and vegetables <http://www.doh.gov.uk/fiveaday>). This is despite the fact that food co-ops and skills based initiatives are among the most popular initiatives identified by the health sector to tackle food poverty and poor nutritional intake.⁵

Methods

The original aims of the research were to provide an overview of current activities at local level to compare these with guidance recently on the effectiveness of various interventions.⁶ There were 3 phases to the research, carried out during the spring of 2001.

Phase 1

This consisted of series of interviews with key informants and a review of the London Health Improvement Programmes and Coronary Heart Disease Local Implementation Plans to describe the field. This latter process involved analysis of the London Health Improvement Plans (HImPs) and Coronary Heart Disease (CHD) local implementation plans. These were obtained in electronic form, indexed and then searched for using the following terms:

- Food
- Nutrition

- School(s)
- Diet
- Inequal[ity]
- Poverty
- Health promotion
- CHD
- Breakfast [club]
- Eating
- Fruit [and/or] vegetables

This phase helped inform the development of the interview schedule and questionnaire.

Phase 2

The second phase consisted of interviews with the then ‘Coronary Heart Disease’ leads (‘CHD’ leads), ‘Our Healthier Nation’ leads (‘OHN’ leads) and ‘others’ in the NHS Regional Offices. All of the CHD/OHN leads in the Regions were contacted by email and sent a copy of the interview protocol and questionnaire along with a request to take part in an interview. Telephone contact was also made to provide further information and to encourage participation. In several cases we were asked to contact other people identified by the leads as relevant contributors. These were either ‘Cancer’ leads within the Region or individuals who had more specific knowledge of food issues in the Region. Appendix 1 contains a copy of the interview protocol.

Phase 3

This phase involved distribution of a questionnaire to the 26 Health Action Zones (HAZs). Each HAZ co-ordinator was contacted by email and sent a copy of the interview protocol and questionnaire along with a request to check to see if there was an appropriate person to whom the questionnaire should be copied. The questionnaire along with an explanatory letter was then sent by email with an offer to send a paper copy, if required. A telephone and email contact reminder were also undertaken. A copy is included in Appendix 2.

In phases two and three interviewees were informed that their responses may be used in a report or in other ways become part of the public record, and all respondents were guaranteed anonymity this was a condition of the ethical approval from the University ethics committee.

Findings

Who responded?

Interviews were undertaken with CHD/OHN leads, and others, in six of the eight former NHS regions. In total 19 people were approached for an interview and 9 agreed to take part either in a telephone or face-to-face interview. Those who declined to take part were either new in post, who felt they could contribute little and nominated another person to be the key contact in their region.

Of the 26 HAZs approached, 18 provided information (seven of these were returned by a HAZ co-ordinator or deputy and six by a designated food/policy/access worker). In addition four telephone interviews were conducted to fill in gaps in some of the questionnaires. Details of who responded can be seen in Table 1.

Table 1 Those interviewed in the HAZ areas and NHS regions by job title

	NHS Regions Former (n=9)	Health Action Zones (n=18)
CHD Lead	1	
OHN Lead	4	
HAZ Co-ordinator		6
Food Policy or Food & Health or Access worker	3	7
Head of health promotion	1	1
Dietitian		2
Public Health Specialist		1

Other		1
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Retrieval of data

Neither respondents based at the then Regional Offices or in the HAZs were able to access comprehensive data on food projects. Some were able to retrieve the information by contacting and undertaking a survey of their own networks. Some were able to provide limited information about the local projects they were aware of and others were able to offer contact information to direct us towards others at a local level with a more detailed knowledge of existing projects. Several respondents suggested that, as there was no requirement to collect a core minimum dataset on food related activities at regional level, the information retrieved was likely to be incomplete.

In most cases (both regions and HAZs) only descriptive data about food projects or examples of local food policies was provided. The data received from the HAZs were varied in their nature and possibly reflected the different stages of progress and the policy directions that HAZs had decided to take. The majority of data referred to the process of setting up projects and contained information on the number of projects, numbers attending, number of schools involved etc. Little information was received on intended impacts or outcomes, although this may have been due to the lack of sensitivity of the data collection tool.

Some HAZs also queried what we meant by a food project. This concern is developed later, but for the purpose of data collection it raises issues of whether information is required on dedicated food projects or whether a project such as one dealing with exercise and has some element of food within it, was a food project. Two HAZ areas reported no specific emphasis on food related activities but saw them as part of other projects. One said *'the emphasis is on inequalities and if that happens to be food related or even through food then so be it. But our focus is inequalities.'*

Co-ordination, policy and focus

All of the respondents based in the then Regional NHS Offices agreed that there was limited co-ordination of activities to promote healthy eating, including the promotion of fruit & vegetables, at a regional level. Four regional respondents reported no structured regional processes relating to food issues. One felt that food related activities had mostly been driven by national priorities and cited the focus on setting up breakfast clubs as an example of centrally driven policy that had prompted activity in that Region. Another suggested that a lack of co-ordination at the then regional health authority level might be due to strong district or health authority level autonomy. Both these respondents reported that consideration was now being given to the creation of a dedicated post (such as a secondment opportunity) to investigate options to improve the regional co-ordination of food related activities but one doubted whether limited resources would be allocated to an area which was *'important but not at the top of the agenda'*.

In the two regions where some co-ordination was reported, both had made recent appointments to aid this process. In one region, a long standing food and health group had prompted the creation of the new post in order, amongst other responsibilities, to produce a *'Food and Health Policy for the Region'*. The other region had recently created a new appointment to co-ordinate CHD prevention programmes (including those related to food) across the region supported by a very strong networking ethos across the area.

There were several reasons cited by respondents for the lack of strategic focus in relation to food issues. It was suggested that, in some regions, prevention activities had not been seen as a priority in the past and although a recent increase in political commitment was recognised and welcomed, healthy eating activities still had to compete with other important areas. One respondent reported that food and nutrition had *'taken a back seat'* because of other priorities but felt that there was some activity towards increasing it's priority because of a *'push from districts'*. Some felt that greater action would only be driven by an even stronger national agenda, so that healthy eating (and promoting fruit & vegetables) would be perceived as a higher priority. Others felt that this was a great challenge in light of perceived NHS priorities at the time of interview, such as reducing waiting lists. Even in regions where prevention was seen as a priority, activities are likely to be limited because of a lack of capacity and personnel.

A strategic focus was more common at local level such as a health authority area, with regional respondents citing several examples of local area Food and Health policies existing or currently being developed. Considerable food related activity was also reported at local level within the HAZs. This was sometimes at a PCG level with a cross-over with HAZ based work, there was a great deal of inter-agency working at this level.

One third of those from the HAZs reported the existence of a food policy/food access group or policy within the HAZ. But for the majority of HAZs, there was a lack of programmed activity or a food policy overview related to food but a lot of individual food projects. Many reported that this was because food was dealt with as part of other projects such as those relating to social inclusion rather than being a programme on its own.

Where a food policy/co-ordination group existed within a HAZ, the breadth and depth of the food work was greater than in those areas without such initiatives. In the absence of such support structures, food work falls to the '*usual suspects*', such as dietitians or health promotion specialists. Some of these identified a lack of support and the problem of existing on the fringes of core HAZ work as a barrier. As one worker in such a position put it '*food work is nice but not as core and as long as you don't look for extra resources.*'

There was a concern expressed by some that what they saw as the '*imposition*' of a specific fruit & vegetable agenda upon food work would inhibit the adoption of a broader food and environmental policy. There were a number of HAZs who were adopting a policy approach to food which went beyond individual projects but which tended to be focused on inequalities as opposed to food or nutrition agendas.

In terms of having a co-ordinated and coherent policy, issues such as coterminous boundaries and an ability to work on a scale that allowed '*big policy issues*' to be addressed were identified as important. Those HAZ areas organised on a county basis were able to fund lots of projects but also to focus on '*upstream policy*' issues such as the supply of food and food chains. As one worker in such a situation put it '*we fund well*

over 21 food projects directly and are able to include them under a broad policy umbrella'. One city-based HAZ co-ordinator identified this as problem by noting that 'most developments are in the city of [...] and this may ignore the development of needs in areas of the County'.

National policy initiatives were reported to influence support for food programmes. It was felt that they gave meaning to work at a regional or local level, provided a clear policy context and gave legitimisation for work on food and fruit & vegetables.

Some key policy initiatives identified as important were:

- The National Service Framework for Coronary Heart Disease, The Cancer Plan, The NHS Plan and the National Healthy Schools Standard as major influences on HAZ food and fruit and vegetable work;
- The usefulness of the Health Development Agency Coronary Heart Disease Guidance for implementing the preventive aspects of the National Service Framework, although there were requests for a summary version of this for use with food projects; ⁵

On the other hand, respondents reported little influence from the learning from a number of national pilots, though some were at an early stage at the time of this research and their findings may not have been broadly disseminated.

Further analysis of the data from the HAZ respondents who found the HDA 6 guidelines useful to plan and evaluate initiatives found that it was mainly those engaged directly in setting up food projects who reported it as being useful rather than those at a policy or planning level. A number of the HAZ respondents mentioned the lack of learning from other HAZs in the area of food.

Types of food projects

There were many food projects within HAZs, but fewer dedicated fruit & vegetable projects. The areas where fruit & vegetables were identified as a separate issue tended to be those involved as part of the national 5 A DAY pilot sites. One dietitian talking of the HAZ area reported that *'fruit & vegetables, not major issues of concern, the reality around here is that five-a-week is what we are aiming at not five-a-day!'*

The most common types of projects receiving support can be seen in Table 2.

Table 2 The ten most common types of food projects in the 8 NHS Regions and HAZ areas.

Ten most commonly supported food projects reported in the former eight NHS Regions	Rating	Ten most commonly supported food projects reported from the HAZ areas
School based food projects (including the National Healthy Schools Standard, School Nutrition Action Groups, lunch or after school clubs)	1	Skills based projects, such as cooking or shopping pilots
Breakfast clubs	2	Food co-ops
Fruit & vegetable promotion projects	3	Community or youth cafés
Skills based cooking/shopping projects	4	Breakfast clubs
Food co-ops	5	Fruit tuck shops
Community gardening/allotment/box schemes/grow it yourself/patchwork gardens	6	Healthy Schools Award
Primary care based activity like training, resource provision or clinical services	7	Obesity weight management groups
Community cafes or luncheon clubs	8	5 A DAY community pilots
Heart Beat Award Scheme	9	Growing schemes or community allotments/grow it yourself/patchwork gardens
Work with food retailers	10	Community food assistants/educators

There appears to be consensus in the types of projects being supported and developed, with food co-ops, community cafés, breakfast clubs, projects with a food skills component and work in schools receiving emphasis from both those at local and regional levels. Mapping projects were also identified as popular initiatives, resulting from food project work such as the setting up of co-ops, box schemes or ‘grow your own’ projects. These fell into two categories. The first were concerned with mapping current areas of food poverty and access to food and food supply. The second involved developing a directory of available food shops/outlets, to inform a community of where food was available.

More detailed analysis of food projects within HAZs found that they could be classified under the following four typologies:

- Integration into the work of the HAZ, supported by either a key worker or policy group;
- Separate from core HAZ funding but integrated in other ways (expected to find other funding streams). Often designated as ‘funding in kind’ in the questionnaire;
- Running parallel to HAZ work but not integrated, e.g. many school-based initiatives;
- Food as part of community development project such as an exercise programme or a community café.

Food Project or not Food Project?

As noted earlier defining what constitutes a food project became an issue for many respondents. Food was an element of many of the projects reported, but not always the primary focus. Many of the projects that were included as examples of food projects had food as a secondary issue. So physical activity or obesity prevention programmes were seen to include food but the prime aim was not food related. This was also true of many of the schools programmes identified, with food as a component part but not always the primary focus. Food was seen as a convenient hook on which to hang community development projects and was a means to an end as opposed to an end in itself.

The role of food in some projects was seen as an additional burden. One respondent said that in the early stages of HAZ development HAZ projects were about *‘addressing inequalities, then came along a plethora of policy initiatives to do with CHD and food and we had to reorient ourselves to meet these objectives’*. A HAZ co-ordinator supported this view when they pointed out that new policy initiatives had to be *‘over layered on existing projects so what was a community café to tackle social isolation became a CHD heart health project.’* This comment was echoed by a number of respondents who saw projects as having to meet two sets of objectives, one on inequalities and, as one person told us are *‘now lumped with the additional burden of having to meet policy initiatives which came afterwards e.g. CHD plan etc’*. This was also pointed out as a problem for projects looking for funding. Many of those involved in running projects complained of the constant changing of funding streams and having to reorient projects to meet new requirements. As one HAZ co-ordinator put it *‘many of the projects that had come forward had been projects that been ‘stored up’ for when funding became available which meant that many of the projects were well developed in their own right.’*

Having a champion

Key champions for food or fruit & vegetable work in a HAZ were identified by respondents as important in furthering activity. This often seemed to account for the distinction of food as a key element of work in a HAZ. Some reported that such posts needed to be at a senior level within the HAZ in order to make an impact at a policy level.

At the regional level the championing of food work by an individual was often the reason cited why food work had a high profile or was successful in attracting money and resources. Where regions had recently made a new appointment to co-ordinate food-related activity at regional level it was felt that progress would now be made, as one respondent put it *‘having an extra person makes all the difference’*. However, there was a concern that since funding had been provided from short-term monies and posts not substantiated that food based work would be difficult to sustain in the longer term. Three regional respondents commented on the dedication, expertise and hard work of those running food projects at a local level but one suggested that *‘it’s probable that there are quite innovative people blazing away but we’re*

not very good at sharing this'. Some local areas had an appointed healthy eating co-ordinator and other areas had named people with designated responsibility to implement action plans. Several respondents noted richer activity in such areas.

Evaluation of projects

Examples of evaluation were very general, for example, in one HAZ, the measure of success in the setting up of a food co-op was *'distribute leaflets, ensure that 20% of GP surgeries distribute leaflets by March 2002'*. Similarly another HAZ identified success as being related to the *'steady growth in the number of food projects'*. There was little distinction made between monitoring and evaluation. One respondent reported that *'current evaluation is monitoring and based on funding requirement[s]'*.

Very little information was available from the regional contacts about the evaluation of local food projects. In fact, only a handful of examples of evaluated projects were cited. There was a common view that local projects were monitored to a greater or lesser extent by the then health authorities and/or PCGs. However, although the focus on evidence based practice was generally welcomed, most respondents recognised that local level evaluation was *'piecemeal'* and that people were not very confident about evaluating local projects. Both HAZ and regional respondents thought that there was a danger of too much or inappropriate evaluation *'stifling innovation'*. There was also some concern about the type of evidence that was thought acceptable to funders to assess the value and impact of food-related projects, particularly as many are complex interventions in community settings. For example, one respondent felt there should be an *'opportunity for projects to produce longer term, softer outputs looking at, for example, continuity of support and linkages instead of making projects operate in isolation'*.

Evaluation of food projects was also at an early stage in many HAZ areas. Some had only begun to think about the process, in effect after the establishment of projects. As one HAZ area put it *'evaluation is planned rather than on going we are putting together a group of key people from public health and local academic institutions to establish an evaluation framework to support this work'*. For many, the process of setting up and establishing projects had been a time consuming process. As reflected in the literature on

food projects, a two year lead-in period is normal. Now that many had reached this stage, they were beginning to consider evaluation. However, one HAZ area has been successful in identifying and rolling out lessons from evaluation.⁷

A number of comments made by respondents suggested that the responsibility for evaluation was placed firmly with the projects themselves *‘projects must specify how they will monitor and evaluate their project in a useful way – they must also be able to show they have had a positive difference. Regular updates are requested by our finance team.’* Evaluation measures were developed on a project-by-project basis as one respondent said *‘we have not designed an evaluation tool to be used by all projects but would be interested in receiving details of any tools developed elsewhere.’* The use of projects’ staff as evaluators and that of outside evaluators (such as academic departments) was evenly split between the HAZs who responded, with two intending to use both approaches. Reflecting the approach taken by the national HAZ evaluation team, the use of ‘logical framework analysis’ as a tool for evaluation was mentioned by three HAZs. Two of these provided training on this process. There was general agreement that there is a need for considerable support to enable people working at all levels to develop relevant competencies related to evaluation, as evaluation is not a core component or skill of many food workers. There was a plea for guidance on what is expected. There was also recognition that training and support in evaluation methods was required.

Good practice

As noted previously, the presence or appointment of someone with responsibility for food and nutrition was likely to result in continuity of food projects and support. Some key findings from within the old regional structures were:

- Local needs assessment was seen as particularly important in influencing food related activity. Food issues were very commonly an issue raised by communities during needs assessment although a dichotomy between local needs and available funding sources was described. There was a concern expressed about the quality of some local needs assessment activity and also about the quality and relevance of local disease prevalence data.

- Health Improvement Programmes were thought to be a powerful lever to stimulate local action but as one respondent reported *'food isn't in it much'*.
- There were mixed views regarding national schemes such as the National School Fruit Scheme (NSFS), which was at an early stage of development at the time this research took place. One respondent felt that the NSFS would have a powerful supporting influence whereas another felt that although it was too early to comment on its impact there was some concern about how the Scheme would operate and how well it would be received in localities.
- There was a reported lack of influence (or knowledge) attached to non-health led initiatives like community planning, regeneration funding, Education Action Zones or Local Agenda 21 initiatives. However, several people commented that this would be a growing area of influence in the future.

The setting up and sustaining support for food projects at a HAZ level was not often addressed at a strategic level. Evidence of this was seen in that the majority of food worker posts were funded on a short-term basis. Once plans were established there was sometimes a gap between getting a worker into post, securing the next round of funding and moving forward with the agenda resulting in *'community scepticism'* over undelivered promises.

The future sustainability of food and fruit & vegetable projects was identified as an issue by many HAZs. One HAZ co-ordinator said that the advantage of HAZs was that they have *'enabled an accelerated development especially in community development related projects. Major issue will be mainstreaming of these when outcomes are likely to be long term. Developments in primary care are difficult because of overload in the agenda.'* Many HAZ respondents were concerned about the future sustainability of food projects. The problem of *'mainstreaming'* what had been pilot projects was a concern of many project workers once pump priming or short term funding ended .

Discussion

Since this research took place in 2001, there have been a number of developments as outlined in the introduction and including Shifting the Balance of Power,¹ the new Regional structures, the development of the Food and Health leads posts, the roll out of 5 A DAY and the National School Fruit Scheme and the demise of health authorities and the creation of Primary Care Trusts. Many of these begin to address the concerns raised in this article. The key lessons from this research remain in that structures need to be in place to support food and nutrition work both upstream and downstream.⁸

Despite the plethora of local food projects at the time of our survey in 2001 there was a lack of a clear, coherent policy context for food and fruit & vegetable work. This was apparent in the lack of a co-ordinated approach to data collection and the lack of a strategic direction for food in the HAZs or then Regional Health Authorities. Food projects were funded on an individual basis, on their merits, but there was little policy overview of the role of food projects in contributing to the elevation of poverty or of improving nutritional intake. For example, local co-operatives were established to provide affordable food and provide an alternative source of food, in practice they often had to compete with local retailers, thus putting pressure on an already threatened local economy. Carley and colleagues⁹ in their review of local food economies clearly relate improvements in food provision to economic regeneration of an area, a similar conclusion was reached by Rampton¹⁰ in a report to the Greater London Authority on food access and social exclusion. Yet, local food projects were consistently cited by respondents at both local HAZ area level and regional level as ways of addressing and alleviating food poverty, with no mention of the role of the retail sector and local authority planning structures in addressing such issues. The Acheson Inquiry into inequalities¹¹ which identified food access as a key issue did not see or find evidence for the use of food projects to alleviate food inequalities. The Department of Health (DH) report on tackling health inequalities¹² focused on local initiatives as a means of improving food and nutrition through for example:

- grants to 257 **Healthy Living Centres** (HLCs) in England
- The 5-a-day programme.
- **Sure Start** local programmes with a key role for health professionals, including GPs, midwives and health visitors.

The delivery mechanisms in this DH report emphasise the role that local healthcare professionals can adopt by, for example, involving local planners in mapping ‘*food desserts*’ (sic) so local 5-a-day programmes can improve food access (p 33).

This stands in contrast to the Acheson report on inequalities ⁷ which saw the solution to food access as lying with the retail sector and as a structural and planning issue. The above quote from DH seems to suggest a partnership approach between 5-a-day initiatives and retailers based on a health education model. While our research did identify a small number of projects aimed at working with retailers, these were best described as health education activities (engagement with retailers as partners in an education process), as opposed to attempts to make any major structural changes in the food supply chain. The key issues remain: what are the expectations of local food projects and what should they be addressing? There is a need for a balance between local food projects which involve the community and those which work at a structural level to improve access and involve the retail sector.

There was at the time of the research no requirement for Regional Offices, HAZs or PCGs to collect standardised information on food projects or develop strategies for evaluation. The new structures implemented since this research took place, in the guise of regional government and the NHS (re)organisations such as the creation of Strategic Health Authorities and PCTs, have similarly not been given any definitive guidance or responsibility for data collection or research. The exception to this is the requirement from the NHS plan to collect data on activity to promote fruit and vegetable consumption among lower income groups in particular, yet currently in the monitoring role of Strategic Health Authorities there are no performance indicators for this area. So the reality of food work becomes a ‘nice to do’ as opposed to essential as NHS staff at a PCT level are not performance managed on this issue but are on issues related to waiting lists etc.

Food projects need to be clearly set within a national, local and regional food policy context, so PCTs and Regional Government Offices are clear on what they are expected to achieve and to deliver on in terms of food projects. ² Our respondents constantly cited the role and influence of national agendas on local

practice; the influence of the FIVE A DAY programme was highlighted as a lever to keep food and nutrition based work on the local agenda in the light of competition from waiting lists and clinical issues. While, funding for individual food projects can be justified on a case for case basis there was a lack of clarity as regards the bigger picture. This was not a fault of projects per se, but of the lack of a clear national strategy in which to locate their work. We are aware that a number of the new regions are beginning to address these issues and that the Strategy for Sustainable Farming and Food¹³ sets out the framework for future development, but at the moment this development is piecemeal as the new Regional Government Offices develop their own strategies.

Although numerous policy documents provide opportunities for local food activity they also run the danger of spreading such work across a number of policy arenas e.g. CHD, inequalities etc what remains unclear are the processes to deliver such agendas. A current policy concern in the UK is to reduce inequalities in health and social exclusion, using a mix of public and private sector partnerships. In these circumstances, professionals have seen food projects as a way of attaining targets such as reductions in heart disease or cancer rates, or contributing to sustainable food supplies (under Local Agenda 21), without the need to engage in protracted debate or conflict with regeneration or business/planning developments, some of which potentially contribute to the problems of food poverty. In practice, local community members engage with food projects in various ways, not necessarily primarily to improve their health. Local food projects have a role nonetheless, as they may enable people to access the basics of life and not to feel socially excluded from the cultural norms. Yet the public private partnerships so evident in other areas of government policy such as education or the building and running of hospitals are not evident in the area of food. We found a number of what might be termed health education type initiatives working with the industry or local retailers to deliver advice on healthy eating or concerned with the promotion of food such as fruit and vegetables, an approach which is further reinforced by more recent report on tackling health inequalities.⁸ While many food workers may be wary of partnerships with the food industry to alleviate food access issues, believing that the motivation for such partnerships to be driven by profit as opposed to social concern, the fact remains that such partnerships are under-explored areas, especially those based on

physical access issues as opposed to health education based activities (see work in Sandwell and Seacroft as examples of this structural approach^{14 15}).

At the time of our survey, we found little evidence of strategically focused, integrated programmes of activity to promote healthy eating, including the promotion of fruit & vegetables, at the then regional or HAZ level reflecting the precedence that clinical care and waiting lists assume over prevention activities. Respondents expressed a concern that local food projects funded and started in their pilot stage from sources outside the NHS they may not in time become embedded in the work of PCTs as the funding is additional and therefore not guaranteed in the longer term. Their long-term sustainability and or expansion into other areas of the local community are vulnerable as they depend on external funding for their continuance. The importance and value of food and fruit & vegetable projects as prevention activities needs to be stressed and given equal importance in relation to other priorities such as waiting lists and included as a measured activity for managers in PCTs, strategic health authorities and the new regional government offices. This is necessary in order to guarantee their ongoing sustainability. Many of those we interviewed welcomed the injection of extra resources but pointed out that many projects were set up to address other policy initiatives and had to change to meet these new agendas. This shifting of priorities was seen as distracting for the work of community based food projects and was seen as a distraction from getting the work done. Such a fact was mentioned in a report by the Chief Medical Officer on public health skills when he noted that community development is a skill that not many public health specialist possess and that¹⁶.

Short term, marginal projects are rarely a cost effective investment and lead to disillusionment in communities as well as workers (p21)

Respondents expressed a genuine concern about the sustainability of food and fruit & vegetable activities because of capacity and resource issues. Where successful food work was occurring this could be related to two factors, firstly, the existence of a dedicated co-ordinator/champion and secondly, the existence of a regional/local food network or policy. Also important in establishing clear, sustainable food projects are the funding arrangements which need to support the development of strategically focused, co-ordinated programmes of activities and to enable food projects to develop, grow and to deliver outcomes. This can be

contrasted with the current situation where food projects are often funded on a year to year basis and many workers are on short-term contracts.

The lack of rigorous evaluation of projects gave cause for concern and can possibly be related back to the lack of an identified core or minimum dataset with regards to food projects and fruit and vegetable work. There are difficulties in agreeing on appropriate methodologies and outcome measures. Evaluation was far too often tagged onto a project, as Ostasiewicz¹⁷ found in a review of co-ops in Tower Hamlets. Similarly, Kaduskar *et al*¹⁸ found that despite the calls for evaluation of community based food projects there seems to be a lack of commitment to evaluation in practice. They conclude that *‘those involved in funding, and in otherwise supporting community-based projects, should provide practical help to enable evaluations to be carried out’* (p 353).

Conclusions for policy

The findings from this piece of research are timely as the Government launches a response to the various crises in the food sector.¹⁹ The development of a Food and Health Action Plan led by the Department of Health requires action in all sections of the food chain will be an important document in these respects. In addition it is also clear that the new Regional Government Offices require public health expertise to integrate and keep food and nutrition on the policy agenda if it is to avoid being swamped by a focus on the economics of farming. The Strategy for Sustainable Food and Farming requires that Directors of Public Health in each PCT work with local authorities to ensure that Local Development Plans provide for action to overcome local barriers to healthy eating,¹¹ yet it has been that public health at PCT level lacks the staff and possibly the resources to deliver on such a wide-ranging public health agenda.

The current national policy context is favourable towards the establishment of local food projects, there is however a lack of guidance, clear direction and an integrated policy context for the establishment and evaluation of local projects. The Defra document on the *Farming and Food*¹¹ assigns responsibility to key agencies in an attempt to integrate the various strands and of particular importance is the forthcoming Food and Health Action Plan.

Guidance should be provided to help with routine collection of information and evaluation at all levels. The learning from pilots should feed into the system and help guide practice. Guidance for implementing policy initiatives should be reproduced with different versions for different audiences such as commissioners/public health specialists, public health practitioners, Regional Government Offices and those engaged in setting up and running food projects.

Appendix 1 Interview protocol for Regional co-ordinators

Thanks for agreeing to this interview which will take about 30 minutes to complete. As we go through the questions, you might find it helpful to make a note of any documents or reports which you think might be useful for us to see. We'd be happy to receive them in hard or electronic format.

To remind you, the aims of this interview are to help us to:

- a) gain an overview of local planned and current activities in the promotion of healthy eating in general and specifically related to fruit and vegetable consumption in your Region
- b) identify the type of support which should be offered to local professionals and groups in the future
- c) identify interventions which are currently being evaluated and which could potentially add to the evidence base in future
- d) identify innovative interventions from which learning may be shared among those working in this field.

Contact details?

Contact person

Person being interviewed
(if different from the contact person)

Title

Role

Contact details

Address

Phone no

Fax

Email

Web site

1. What types of food programmes are planned or are currently being supported in your Region?

(this includes activities related to the promotion of healthy eating in general, the promotion of fruit and vegetables in particular and/or more general projects where food plays an important part e.g. a community café)

Programme name	New or existing project?	Description (including time scale, who initiated the project)	How much money and funded by? (e.g. health – HA/PCG /local authority; other)	Please indicate the main focus of each programme			
				Healthy eating	Fruit and vegetables	Prevention of overweight and/or obesity	Other (e.g. community development or social inclusion)

Any additional reports/documents that provide further details of any of the projects above (e.g. needs assessment reports, monitoring reports, annual reports etc) which could be provided?

2. How are the food programmes targeted in your Region?

- ☐ Across the whole local population
- ☐ Specific ethnic or minority groups within the local population
- ☐ Population groups (e.g. older people, rough sleepers)
- ☐ Settings (e.g. schools, workplaces)
- ☐ Other?

Please give details

Why?

3. Are there any funding policies relating to food programmes?

(for example, do they have to be based on increasing knowledge, skills acquisition, access, reducing inequality etc?)

Please give details

4. What has informed the process of development and funding of food programmes/projects?

(for example, are there local structures like a food planning group or designated people such as a public health nutritionist or an interested public health specialist etc.)

Please give details

5. Do you see any conflicts between the requirement to support food related projects which are based on a sound evidence base and those which are innovative but highly speculative and less likely to succeed?

☐ Yes

☐ No

What? Provide details.

6. How far have the following influenced the development of food programmes in your Region?

	Major influence	Moderate influence	Little influence	No influence
Findings from local needs assessment	☐	☐	☐	☐
Local disease prevalence (e.g. diabetes/obesity)	☐	☐	☐	☐
Healthy Living Centre	☐	☐	☐	☐
Health Improvement Programme	☐	☐	☐	☐
The Community Plan	☐	☐	☐	☐
Single Regeneration Budgets	☐	☐	☐	☐
other Health Action Zones	☐	☐	☐	☐
Education Action Zone	☐	☐	☐	☐
NHS Beacons	☐	☐	☐	☐
National Service Framework for Coronary Heart Disease	☐	☐	☐	☐
Health Development Agency Coronary Heart Disease Guidance for implementing the preventive aspects of the National Service Framework (Local Implementation Plan)	☐	☐	☐	☐

continued

	Major influence	Moderate influence	Little influence	No influence
The Cancer Plan	☐	☐	☐	☐
The NHS Plan	☐	☐	☐	☐
Department of Health funded Five-a-day Pilot projects	☐	☐	☐	☐
The National School Fruit Scheme	☐	☐	☐	☐
Other 'five-a-day' initiatives (please specify)	☐	☐	☐	☐
National Healthy Schools Standard	☐	☐	☐	☐
Other healthy schools initiatives (e.g. SNAGs)	☐	☐	☐	☐
Evidence of effectiveness	☐	☐	☐	☐
LA21 work	☐	☐	☐	☐
Other? Please specify	☐	☐	☐	☐

Please give details

7. So, in your Region, how strategic do you think funding decisions have been?

Provide a description of the process::

8. Which types of needs assessment have been carried out to inform the development of food programmes? (Please tick as many as apply)

- ☐ none
- ☐ objective/formal/comparative (e.g. epidemiological)
- ☐ local knowledge (e.g community workers/dietitians working in the area)
- ☐ felt or expressed needs assessment (e.g. focus groups, survey of local community),
- ☐ mapping of food supply
- ☐ citizen panels/juries
- ☐ other? (please specify)

9. One of the milestones in the NHS Plan Implementation Programme for 2001-02 requires that “Each health authority to prepare quantified plans to increase access to and consumption of vegetables and fruit, particularly among those on low incomes, to support the national five-a-day programme, which will be launched during 2001.” How is this being tackled in your Region?

10. Which stakeholders and/or other agencies have been or are currently involved in the food programmes in your Region?

(e.g. health promotion departments, dietitians, community development workers, voluntary agencies, LA21 committees etc.)

11. Who co-ordinates the food programmes/has overall responsibility for making them happen? (e.g. HA/PCG or T/LA)?

12. What monitoring and evaluation is taking place/expected?

13. What indicators have been/are being used by programme as measures of success?

(This includes assessment of progress, impact or outcomes of programmes)

14. Have any evaluations been carried out and/or any tools developed relating to healthy food programmes?

- ☐ Yes (where can we get details?)
- ☐ No

☐ Currently underway (where can we get details?)

(we are particularly interested in innovative techniques to gather data or innovative approaches to evaluation)

15. What future plans are there for food projects in the Region?

16. What support do you anticipate will be needed from the HDA and/or other agencies in supporting food programmes in your Region?

17. Any thing else?

Thank you for your time

Appendix 2 Copy of questionnaire sent to HAZ co-ordinators

Introductory letter introducing researchers, the aims of the research, the funding body, return address including email and deadline for return of completed questionnaire. This was sent as a hard copy and as an electronic text (by email) so respondents could fill it in whichever form suited. It was pointed out that the questionnaire was likely to take about 25 minutes to complete. In addition the purpose of the questionnaire was set out as follows: :

- provide an overview of current activities in the promotion of healthy eating and fruit and vegetables in HAZs.
- to identify the type of support which should be offered to local professionals and groups in the future
- to identify interventions which are currently being evaluated and which could potentially add to the evidence base in future
- help to identify innovative interventions from which learning may be shared among those working in this field.

Respondents were asked to complete the questionnaire by writing in the information requested and by putting in a ✓ where appropriate. This could be done in the electronic form and returned by email or by post to the researchers.

Contact person

Person filling in questionnaire
(if different from the contact person)

Title

Role in HAZ

Contact details

Address

Phone no

Fax

Email

Web site

1. Types of food programmes/projects in the HAZ

Tell us about all the food programmes that are planned or are currently being supported in your HAZ.

(this includes activities related to the promotion of healthy eating in general, the promotion of fruit and vegetables in particular and/or more general projects where food plays an important part e.g. a community café)

Programme name	Description	Funded by?	Please indicate the main focus of each programme			
		(e.g. total HAZ funding; joint health /local authority; other)	Healthy eating	Fruit and vegetables	Prevention of overweight and/or obesity	Other (e.g. community development or social inclusion)

Please attach any additional reports/documents that provide further details of any of the projects above (e.g. needs assessment reports, monitoring reports, annual reports etc).

2. How are the food programmes targeted?

- ☐ Across the whole local population
- ☐ Specific ethnic or minority groups within the local population
- ☐ Population groups (e.g. older people, rough sleepers)
- ☐ Settings (e.g. schools, workplaces)
- ☐ Other?

Please give details (or attach or send on relevant documentation)

3. Tell us about any HAZ policy/view relating to the funding of particular types of food programme or project.

(for example, are they based on increasing knowledge, skills acquisition, access, reducing inequality etc?)

Please give details (or attach relevant documentation)

4. What has informed the process of development and funding of food programmes/projects?

(for example, are there local structures like a food planning group or designated people such as a public health nutritionist or an interested public health specialist etc.)

Please give details (or attach relevant documentation)

5. Specifically with reference to food programmes, are there any conflicts between the projects you would like to fund and the requirement to fund projects which are based on a sound evidence base and those which are innovative but highly speculative and less likely to succeed?

☐ Yes

☐ No

Please provide details

6. How far have the following influenced your support for the food programmes?

	Major influence	Moderate influence	Little influence	No influence
Findings from local needs assessment	☐	☐	☐	☐
Local disease prevalence (e.g. diabetes/obesity)	☐	☐	☐	☐
Healthy Living Centre	☐	☐	☐	☐
Health Improvement Programme	☐	☐	☐	☐
The Community Plan	☐	☐	☐	☐
Single Regeneration Budgets	☐	☐	☐	☐
other Health Action Zones	☐	☐	☐	☐
Education Action Zone	☐	☐	☐	☐
NHS Beacons	☐	☐	☐	☐
National Service Framework for Coronary Heart Disease	☐	☐	☐	☐
Health Development Agency Coronary Heart Disease Guidance for implementing the preventive aspects of the National Service Framework	☐	☐	☐	☐
The Cancer Plan	☐	☐	☐	☐
The NHS Plan	☐	☐	☐	☐
Department of Health funded Five-a-day Pilot projects	☐	☐	☐	☐
The National School Fruit Scheme	☐	☐	☐	☐
Other 'five-a-day' initiatives (please specify)	☐	☐	☐	☐

National Healthy Schools Standard	☐	☐	☐	☐
Other healthy schools initiatives (e.g. SNAGs)	☐	☐	☐	☐
Evidence of effectiveness	☐	☐	☐	☐
LA21 work	☐	☐	☐	☐
Other? Please specify	☐	☐	☐	☐

Please give details (or attach documentation)

7. Which types of needs assessment have been carried out to inform the development of food programmes? (Please tick as many as apply)

- ☐ none
- ☐ objective/formal/comparative (e.g. epidemiological)
- ☐ local knowledge (e.g. community workers/dietitians working in the area)
- ☐ felt or expressed needs assessment (e.g. focus groups, survey of local community),
- ☐ mapping of food supply
- ☐ citizen panels/juries
- ☐ other? (please specify)

8. Which stakeholders and/or other agencies have been or are currently involved in your food programmes?

(e.g. health promotion departments, dietitians, community development workers etc.)

Please give details (or attach relevant documentation)

9. What support (apart from financial support) has been offered to those running food projects? (this includes, for example, advice on setting aims, objectives, project management support, training, advice on monitoring/evaluation etc)

Please give details (or attach relevant documentation)

10. What monitoring and evaluation requirements (if any) have been specified as part of the funding process?

Please give details (or attach documentation)

11. What indicators have been/are being used by programme as measures of success?

(This includes assessment of progress, impact or outcomes of programmes)

Please give details (or attach documentation)

12. Have any evaluations been carried out and/or any tools developed relating to healthy food programmes?

- ☐ Yes (please provide further details)
- ☐ No
- ☐ Currently underway (please provide further details) (we are particularly interested in innovative techniques to gather data or innovative approaches to evaluation)

Thank you for spending time completing this questionnaire.

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