

# Evaluation Summary



**A summary of findings from  
the evaluation of the Kent  
Healthy Eating Pilots**

**Prepared for: Kent County Council**

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**Prepared for: Kent County Council**

**Prepared by: BMG Research**

**July 2010**

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## Table of Contents

1	Introduction .....	4
1.1	Background.....	4
1.1.1	‘Towards 2010’ and the community based healthy eating pilots.....	4
1.2	Overall Approach to the Evaluation .....	5
1.3	Report Structure .....	6
2	The Healthy Eating Pilots.....	7
2.1	Pilot 1: Community Cooking Skills.....	7
2.1.1	Pilot 1a: Community chefs .....	7
2.1.2	Pilot 1b: Kent Cooks! cooking competition .....	8
2.2	Pilot 2: Fruit and Vegetable Bag Scheme.....	8
2.3	Pilot 3: Healthy Eating Training.....	9
2.4	Pilot 4: Increasing School Meal Uptake.....	10
3	The Evaluation Methodology.....	11
3.1	The evaluation methods used.....	11
3.1.1	Pilot 1a: Community Cooking Skills – Community Chefs.....	11
3.1.2	Pilot 1b: Community Cooking Skills – Kent Cooks! Cooking competition.....	11
3.1.3	Pilot 2: Fruit and Vegetable Bag Scheme.....	12
3.1.4	Pilot 3: Healthy Eating Training .....	12
3.1.5	Pilot 4: Increasing School Meal Uptake.....	12
3.2	Sample sizes and participant profiles .....	13
3.2.1	Pilot 1a: Community Cooking Skills – Community Chefs.....	13
3.2.2	Pilot 1b: Community Cooking Skills – Kent Cooks! Cooking competition.....	13
3.2.3	Pilot 2: Fruit and Vegetable Bag Scheme.....	13
3.2.4	Pilot 3: Healthy Eating Training .....	14
3.2.5	Pilot 4: Increasing School Meal uptake .....	15
3.3	Identifying and engaging with respondents .....	15
4	Outcomes of the community-based healthy eating pilots – key findings .....	17
4.1	Outcomes on participants .....	17
4.1.1	Increased awareness and knowledge of food and healthy eating.....	17
4.1.2	Confidence and skills in food preparation and cooking.....	19
4.1.3	Changes in food consumption and eating behaviour.....	20

4.1.4	Greater access to healthy foods .....	22
4.2	Outcomes on stakeholders .....	22
4.2.1	Partnership working and stakeholder dialogue.....	23
4.2.2	Enhanced job satisfaction .....	23
4.2.3	Increased skills .....	23
4.2.4	Increased social networks.....	24
4.2.5	Momentum for longer term sustainability.....	24
4.3	Wider outcomes.....	25
5	Implementation of the community-based healthy eating pilots – key findings .....	28
5.1	Establishing partnerships and maintaining stakeholder engagement .....	28
5.1.1	Allowing sufficient time to establish partnerships .....	28
5.1.2	Early involvement of stakeholders.....	28
5.1.3	Maintaining relationships and engagement over time.....	29
5.2	Staff training.....	30
5.2.1	‘Hands-on’ Training.....	30
5.2.2	Multi-disciplinary and multi-level training.....	30
5.2.3	Developing training packages .....	30
5.2.4	Allowing time to participate .....	31
5.3	Setting project objectives .....	31
5.3.1	Aligning objectives .....	31
5.3.2	Setting realistic objectives.....	31
5.4	Delivery locations and timings.....	32
5.4.1	Delivery locations.....	32
5.4.2	Timings.....	32
5.5	Identifying and engaging with target groups.....	33
5.5.1	Promotion of the ‘healthy eating’ message.....	33
5.5.2	Engagement approaches.....	33
5.5.3	Tailoring approaches according to need .....	34
5.5.4	Skilled approaches to engagement.....	35
6	Overview of Outcomes.....	36
6.1	Changes in attitudes, knowledge and behaviour .....	36
6.2	Skill development.....	36
6.3	Wider outcomes.....	37
6.4	Barriers and facilitators to change.....	37

## A summary of findings from the evaluation of the Kent Healthy Eating Pilots

7	Recommendations and Conclusion.....	39
7.1	Conclusion.....	42
Annex A	The Pilots .....	43
Annex B	Key Data .....	44



# 1 Introduction

In March 2010, BMG Research completed a two year evaluation of Kent's Healthy Eating Pilots. This research report is an overview of the key findings from the evaluation, which covered five different pilot interventions. Each pilot was evaluated separately, and individual evaluation reports provide detailed research findings for each pilot – the purpose of this synthesis report is to provide a summary of the main impacts and outcomes, and an overview of issues relating to the successful organisation and delivery of these types of community based interventions.

## 1.1 Background

Healthy eating contributes significantly to the 'being healthy' national outcome for children and young people, as specified in the Every Child Matters government programme to improve outcomes for children and young people. It features prominently within Priority 2 of the Kent Children's and Young Peoples Plan 2008-2011, *Positive about our future* and is a priority area for Kent County Council and its partners within the NHS in Kent. Nationally, healthy eating has been a priority for children and adults alike for some time. Poor diet, concern about obesity levels within the population and its wider impact on the health of the nation – the increase in weight related conditions such as diabetes and hospital admissions for preventable medical conditions - have prompted the development of key initiatives and strategies. Healthy Schools and Change4Life are high profile examples of such initiatives, and coupled with developments such as the creation of the School Food Trust and the development of nutrition standards for school dinners have all had a significant impact on healthy eating and healthy lifestyles. The Kent Community Based Healthy Eating pilots were part of a large programme of work, incorporating a range of diverse projects which were designed with the aim of increasing knowledge and awareness of the importance of healthy eating and to have an impact on attitudes and behaviour around the consumption of a balanced diet for families.

### 1.1.1 'Towards 2010' and the community based healthy eating pilots

The community based healthy eating pilots have been delivered as part of '*Towards 2010*', a visionary document that set out how Kent County Council would deliver on seven key areas, one of which was 'improved health and quality of life'. To achieve improved health, care and well-being for those living and working in Kent, Towards 2010 proposed a number of key actions or 'targets', one of which was to:

*'Encourage healthy eating by providing nutritious lunches through the 'Healthy Schools' programme and launch a range of community-based healthy eating pilots' (Target 51, Towards 2010).*

The objectives of the 'Towards 2010' community based healthy eating pilots were:

- To target areas of Kent with families and communities at high risk of obesity and health inequalities with the aim of increasing knowledge and awareness and changing attitudes and dietary behaviour around healthy eating;

- To develop strong local strategic partnerships between the health, education and community sectors to facilitate the development of effective healthy eating projects across the county;
- To evaluate the effectiveness of partnership working in promoting healthy eating knowledge and behaviour in targeted communities in Kent;
- To effectively disseminate ideas and experiences throughout the lifetime of the pilots and provide relevant resources such as the healthy eating training programme; and
- To produce a final report detailing the most effective pilot(s) and partnerships in increasing healthy eating knowledge and behaviour in the targeted communities.

The community-based healthy eating pilot projects were delivered via Kent County Council Extended Services in conjunction with Healthy Schools and partners from the East and West Kent Primary Care Trusts because it was acknowledged that Extended Services had the ability to reach beyond schools and the school day to families and communities.

Five pilots were delivered and evaluated across Kent. The pilots focused on families with the poorest diets and highest health inequalities, many of which were in the more deprived parts of Kent. The five pilots were (described in more detail in Annex A):

- Pilot 1: Community cooking skills (comprising Community Chefs and the Kent Cooks! school cooking competition);
- Pilot 2: Fruit and vegetable bag scheme;
- Pilot 3: Healthy eating training programme;
- Pilot 4: Increasing school meal uptake; and
- Pilot 5: National Children's Bureau health challenge.

BMG Research was commissioned to conduct an evaluation of the first four pilots (with Pilot 5 being undertaken by the National Children's Bureau). This report provides a synthesis of all the evaluations conducted by BMG, focusing particularly on:

- the impacts and wider outcomes of the four pilots;
- key elements of success and common success factors;
- challenges to development and implementation (ie, lessons learnt);
- factors for future sustainability; and
- recommendations for continued action and activity.

## 1.2 Overall Approach to the Evaluation

The pilots were evaluated using both qualitative and quantitative methodologies to understand which pilot or pilots were the most effective at changing the healthy eating habits of the target population. The range of evaluation approaches included: self-completion questionnaires, site visits, observations, qualitative face to face and telephone interviews, focus groups, analysis of monitoring data, review of administrative data as well as the use of visual evidence such as photographs. Each pilot was evaluated separately, and full evaluation reports are available for each pilot via [www.kenttrustweb.org.uk/healthyeating](http://www.kenttrustweb.org.uk/healthyeating).

This report provides a brief summary of the main impacts and key themes that have emerged from the evaluation, as well as recommendations for future action and activity for Kent County Council and its partners.

Research Governance approval from Kent County Council (KCC) was a requirement for all aspects of the evaluation. This has included the identification of any potential ethical issues and how these will be addressed, as well as approval of research materials by Research Governance. Submissions to Research Governance were subsequently made covering issues such as working with children and young people (including CRB clearance), approaches to those with literacy, language or communication difficulties, data protection, confidentiality and anonymity and the use of different evaluation methodologies. Submissions were also made of the main research tool (a generic self-completion questionnaire) as well as other evaluation tools (for example, tailored topic guides).

In January 2008, BMG Research received unconditional approval from Research Governance.

### **1.3 Report Structure**

Following this introductory chapter, Chapter 2 provides a brief description of the 4 pilot projects. Chapter 3 presents an overview of the evaluation methodology, the different approaches adopted for the evaluation of the pilots, sample sizes and participant profiles. In Chapter 4 the impacts and outcomes that have emerged from the evaluation are explored thematically in terms of increased knowledge, skills and understanding, changing attitudes and values, increased confidence and changes to activity, behaviour and progression. Chapter 5 addresses the key themes and issues identified from the evaluation with regard to setting up and delivering community based healthy eating projects. Chapter 6 focuses on the outcomes and recommendations and the final concluding Chapter rounds up the impact of the community-based healthy eating pilots, the lessons learnt, and on the basis of the evaluation, suggests evidence based recommendations for the future direction of travel of further actions and activities.

Throughout the report reference is made to quantitative data collected from survey work. The charts that support these findings can be found in Annex B.

## 2 The Healthy Eating Pilots

This section provides a description of each pilot.

### 2.1 Pilot 1: Community Cooking Skills

The community cooking skills pilot was developed by Kent County Council and partners to work with local communities to improve cooking skills, primarily in East and West Kent. Within the pilot there were two projects: Community Chefs initiative (Pilot 1a) and Kent Cooks!, a school based cooking competition (Pilot 1b).

#### 2.1.1 Pilot 1a: Community chefs

Two community chefs were recruited to set up sustainable cookery clubs to improve awareness of healthy eating and cooking skills; one community chef was based in the Dartford/Gravesend area and the other on the Isle of Sheppey. The selected localities were identified as areas of multiple deprivation, with the support network and community infrastructure in place to set up a local Community Food Partnership, to identify community needs and steer the work of the community chef. The Partnerships were responsible for key decisions around the role of the chef and scope of work and involved professionals from organisations including Primary Care Trusts, voluntary organisations, churches and schools, etc.

Each chef aimed to set up as many cookery clubs as possible over the course of one year. They were able to design their own courses, course content and course materials which took into account the needs of local communities. In addition, both chefs undertook work with groups on an ad-hoc basis and offered a variety of course models to suit different communities such as: one day-taster courses, evening groups, and weekend courses.

Each chef ran a mixture of groups and sessions: the East Kent chef hosted 21 courses each lasting 8 weeks, and the West Kent chef ran 28 courses which involved 6 classes. Both chefs also ran one day taster courses, weekend events and other ad hoc activities. Data provided by KCC indicates that since the start of this pilot over 3000 individuals were reached by the two community chefs.

The desired outcomes of this pilot were to:

- increase the number of healthy, home cooked meals being prepared and eaten;
- improve children's and parents' knowledge and understanding of healthy eating, nutrition, portion sizes and a balanced diet;
- improve knowledge of cost and access to healthy foods;
- dispel myths that healthy meals are expensive and time consuming to prepare;
- increase confidence about food and cooking;
- improve the diet and health of the family;
- train trainee chefs in colleges to train community members to deliver cooking sessions; and
- provide recipes and easy meals using seasonal produce.

### 2.1.2 Pilot 1b: Kent Cooks! cooking competition

A dedicated Project Manager was responsible for developing and setting up the Kent Cooks! cooking competition, which was launched in secondary schools in January 2009. After contacting all state secondary schools in Kent, twelve schools expressed an interest in participating in Kent Cooks! Schools were provided with sufficient health and nutritional information and background materials for pupils to design a healthy balanced two course meal that utilised local seasonal produce and was low cost (specified as £5 per head or less). Pupils were encouraged to develop their menus and practice the meal preparation at home, thus involving their family members if possible. Menus were then entered into the competition for a panel of judges to select the highest scoring entries. Seven finalists (representing seven schools) were then invited to take part in the final event where they were to cook their two course meal for judges.

The final event was hosted at Thanet Catering College, with entrants mentored and supported by catering students from the college. Parents and teachers were also invited to the event, to observe the cooking and to eat a meal served by the college catering students.

The Kent Cooks! competition was launched with the aim to:

- improve children and parents' knowledge and understanding of healthy eating nutrition, portion sizes and a balanced diet;
- improve knowledge of the cost of healthy foods;
- dispel myths that healthy meals are expensive and time consuming to produce
- Increase confidence about food and cooking;
- Increase the number of healthy, home cooked meals being prepared and eaten
- improve the diet and health of the family, and
- gain support for after school cookery clubs.

The initiative was promoted to all secondary schools in Kent. Just over 400 pupils from 12 schools entered the competition and the highest scoring 7 entries (representing, by chance, 7 schools) reached the final. Uptake at the schools (in terms of entering the competition) ranged from 4% to 69% but was generally higher among the younger age groups.

## 2.2 Pilot 2: Fruit and Vegetable Bag Scheme

Kent County Council used mosaic classification to identify deprived communities who had limited or no access to affordable fruit and vegetables and worked in partnership with the community to set up fruit and vegetable bags schemes in four areas. The overall aim of the pilot was to set up a scheme to increase access to fresh and local produce, provide information on diet and health, recipe ideas and opportunities to experiment with food. Following previous bag schemes the East Kent 5 A DAY programme published a toolkit on *How to set up a vegetable bag scheme*. This toolkit was used to set up bag schemes in pilot areas across Kent.

A number of partners were involved in the set up and delivery of this pilot, including KCC and Produced in Kent. One supplier was chosen to supply the fruit and vegetables which were delivered to each of the four locations and were sorted by volunteers and staff at each location.

At the point of developing the fruit and vegetable bag scheme, a number of outcomes were identified which it was hoped would be achieved during the course of the pilot:

- identify with Produced in Kent a Kent based farm to supply the bag schemes;
- identify community groups to run the bag schemes on a voluntary basis;
- increase access to fresh and local produce in deprived communities;
- increase the amount and variety of fresh produce purchased and consumed;
- increase the number of healthy meals cooked and made at home;
- improve knowledge of cost and access to healthy foods;
- increase confidence about purchasing and cooking fresh, unprepared, local food;
- improve children and parents' knowledge and understanding of healthy eating, nutrition, portion sizes and a balanced diet; and
- improve the diet and health of the family.

The evaluation framework for the pilot was subject to change during the intervention, with a shift from collecting both quantitative and qualitative data to a focus on qualitative data *only*. The reason for this was related to operational difficulties with regard to administering questionnaires to respondents in individual schemes. Thus any statistical data reported does not include this pilot.

### **2.3 Pilot 3: Healthy Eating Training**

This pilot was developed by Kent County Council and partners from the East and West Kent Primary Care Trusts after recognising that parents and families may benefit from attending practical workshops about healthy eating in order to pursue healthy lifestyles.

Staff from the education, community and health sectors participated in a two-day training session prior to delivering the courses to parents. For the education sector, the training programmes were run by Parent Support Advisors (PSAs) and Family Liaison Officers (FLOs) and in the community and health sectors, Children's Centre staff, Health Visitors, Midwifery Assistants and volunteers worked together to run the courses. Each trainer was provided with resources, an equipment box and a £30 budget to spend on ingredients for the practical sessions. The scope of the course differed slightly, given the different target groups within each sector (parents of school age children in schools, parents of new-borns/young children in the Children's Centres). Both courses covered the 'EatWell Plate', food labelling and eating behaviours. However, the PSAs/FLOs also ran a practical lunchbox session whilst the Children's Centres covered breastfeeding and weaning.

Ultimately, the objectives of the pilot were to:

- develop a healthy eating training programme for education, health and community professionals; and
- for professionals to use the training to promote healthy eating among communities, targeting families in general, but also specifically families with new babies and young children.

## 2.4 Pilot 4: Increasing School Meal Uptake

Four different interventions to increase school meal uptake were designed jointly between the five Kent School Meal Contractors and Kent County Council. Twenty schools were selected to take part, with each school implementing one intervention; the interventions were evaluated by BMG in ten of these schools. Kent County Council Client Services had responsibility for managing the delivery of each intervention liaising with the contractor, and individual school. In addition, the pilot benefited from being able to draw upon the experience and expertise of a school food dietician and Client Services Monitoring Officers who were engaged from the outset. Each school was allocated a budget of up to £1,500 to spend on items relevant to the introduction of the intervention.

Intervention one was Midday Meals Supervisor training. The aim of the intervention was to develop the partnership between the school staff and catering staff and therefore, benefit the pupils through increased confidence and knowledge of staff about healthy eating and school meals. A training programme was developed by the contractors and delivered by Kent County Council to Midday Meal Supervisors which included, amongst other topics, customer care, food standards and nutrition.

Intervention two was the Partner Support Programme. This intervention focused on a programme of support for Head Teachers, Governors and teachers in the selected schools. It aimed to raise the profile of school meals through improved communication with partners, create a positive relationship, develop a whole school food policy, and review the service provided. Depending on individual school requirements, the intervention included, amongst other topics, audits, theme days, Governors lunch in the dining room and senior staff using and dining in the school canteen.

Intervention three was entitled Improving the Dining Room Environment. The aim of this intervention was to enhance the school dining room area; making it more appealing and generally improve the eating environment. The expectation was that it would involve working with the school council, encouraging children to use the food counter and to particularly benefit those children having school lunches. A list of changes that could be implemented was provided, including posters, new tablecloths, crockery, competitions and promotion.

Intervention four was the choice of offering an Enhanced Food Offer. The aim was to introduce a new food offer using a flexible approach to selection for the school children. The anticipated benefits were improved choice and new foods as well as an increase in pupil knowledge of a balanced diet. The intervention included a review of the school meals service arrangement as well as the introduction of mobile trolleys and self-service of vegetables, salad and desserts.

It is worth noting here that the evaluation design was slightly different for this pilot than for the others, insofar as the main aim of the intervention was to increase school meal uptake among pupils (as opposed to, for example, making changes to family food consumption or cooking knowledge and skills). This will be covered in more detail in the following chapter.

## 3 The Evaluation Methodology

This chapter reports on the range of evaluation methodologies adopted to determine the impact of the healthy eating pilots. This section will cover:

- the evaluation methodologies;
- the different evaluation approaches and techniques employed, and why;
- the sample sizes;
- participant profiles; and
- issues with identifying and engaging with respondents.

### 3.1 The evaluation methods used

#### 3.1.1 Pilot 1a: Community Cooking Skills – Community Chefs

The evaluation of the Community Chefs pilot was conducted in two ‘waves’ – the first wave collected baseline ‘pre-intervention’ data through interviews with the chefs and self-completion questionnaires from participants and the second wave utilised the same methods to collect ‘post-intervention’ data to capture any changes. In other words, quantitative data was collected before and after the intervention. In addition, focus groups were held with participants from one course from each chef to gain more insight into how courses were run, who attended and the impact of the courses. Furthermore, telephone interviews were conducted with a small sample of food partnership members to understand the functioning of the community food partnerships.

#### 3.1.2 Pilot 1b: Community Cooking Skills – Kent Cooks! Cooking competition

The evaluation approach adopted for this pilot differed from the generic ‘before and after’ approach used across the other pilots due to the nature of the intervention. Unlike other pilots where pre-intervention and post-intervention assessments have been undertaken, in this pilot it was not possible to identify the community of interest (i.e. the finalists) until the later stages of the competition, thereby precluding any significant amount of pre-intervention evaluation.

Consequently, evaluation activities centred on the final competition event, and further qualitative assessments involving in-depth interviews with finalists, parents and teachers after the competition had concluded.

As part of the official competition, teachers were asked by organisers to fill in a questionnaire (provided by KCC) evaluating the competition from the schools’ perspective and these were discussed in the interviews with teachers. BMG were provided with copies of five of the seven teacher questionnaires and data from these were included in the evaluation.

Informed consent was obtained in writing from all parents of the seven finalists prior to any interviews taking place.

### **3.1.3 Pilot 2: Fruit and Vegetable Bag Scheme**

Initially it was agreed that this pilot would comprise quantitative data collection using self-completion questionnaires in two waves, ten weeks apart from one another. However, due to a number of design and operational factors, the response rate was far below what was expected and would not provide meaningful analysis. An alternative qualitative evaluation methodology was proposed by BMG and accepted by KCC, which included a combination of site visits, telephone interviews, analysis of uptake records and observation.

As a consequence one visit per site was carried out during Spring/Summer of 2009. Site visits were chosen because of their ability to allow for a 'hands on' experience from a research point of view allowing the setup, operation and organisation of the pilot to be experienced and understood directly by the research team. Observational studies were carried out during the site visits in order to record the bag collection process and customer behaviour. Combined with this, telephone interviews were carried out with the scheme leaders along with a telephone interview with the contact at the farm supplying the produce.

The final addition to the evaluation process was the analysis of uptake records. The records from all sites (where available) were looked at to observe how uptake had changed over time.

### **3.1.4 Pilot 3: Healthy Eating Training**

The pilot was evaluated using both qualitative and quantitative methodologies to understand the impact of the different training sessions.

The evaluation was conducted in two 'waves' – the first wave collected baseline 'pre-intervention' data through self-completion questionnaires from participants and focus groups with staff. The second wave utilised the same methods to collect 'post-intervention' data to capture any changes in attitudes or behaviour. In addition, further follow up telephone calls were made to trainers and participants after courses were completed to ask for course and training reflections.

Each PSA/Children's Centre was provided with 40 self-completion questionnaires, 20 for each wave of workshops, with the trainers being responsible for ensuring that all parents were provided with a pre-intervention questionnaire (plus covering letter) to complete during the first session of the course and a post-intervention questionnaire to be completed at the end of the course.

In addition, focus groups were held with both PSAs and Children's Centre staff after the completion of the first workshops and once again after the second wave of workshops had been completed. The focus groups were designed to provide the trainers with an opportunity to come together to discuss what worked well and what elements of the training they had tailored to meet the specific needs of their groups or aspects of the course which they considered could be improved in the future.

### **3.1.5 Pilot 4: Increasing School Meal Uptake**

Ten schools (from 20 pilot schools) were selected to participate in the evaluation. The evaluation was conducted in two 'waves' – the first wave collected baseline 'pre-intervention' data through school visits, qualitative interviews with staff and self-completion questionnaires from pupils and parents and the second wave utilised the same methods to collect 'post-intervention' data to capture any changes. In addition, analysis of school meals uptake data

over the relevant time period was conducted, along with qualitative consultations with stakeholders from Kent County Council and the school meals contractors.

## **3.2 Sample sizes and participant profiles**

### **3.2.1 Pilot 1a: Community Cooking Skills – Community Chefs**

In total, 297 baseline questionnaires and 241 post-intervention questionnaires were returned by course participants. Three focus groups were also held with participants (with 6-8 respondents in each) plus observations of sessions were undertaken by researchers. The profile of participants (at the baseline stage) was as follows:

- the majority (52%) were aged between 25 and 44, with an age range of 16 to over 75 years of age;
- around a third of the sample was a single adult household, although half (51%) had 2 adults;
- a third had one child, and two fifths had 2 children. One fifth had 3 or more children;
- two fifths (40%) were owner occupiers with the remainder in rented accommodation;
- almost two fifths (37% - full time, part time or self-employed), with most of the remainder looking after the home, retired, unemployed or permanently sick/disabled;
- around a third (29%) reported some form of long standing illness or disability; and
- nine per cent of respondents reported themselves as from a black or minority ethnic group.

### **3.2.2 Pilot 1b: Community Cooking Skills – Kent Cooks! Cooking competition**

The sample for this evaluation consisted of:

- the manager of the competition;
- the seven finalists (age from 11 to 15), their parents/guardians and a representative of their school; and
- the head of Thanet Catering College (the host venue for the final).

### **3.2.3 Pilot 2: Fruit and Vegetable Bag Scheme**

As noted earlier, surveys were not utilised for this pilot, which adopted a more qualitative methodology, thus the sample for this evaluation was relatively small. Four visits were carried out, which included:

- observations of the schemes in practice;
- interviews with scheme leaders, lead volunteers;
- interviews with passing customers;

- interview with staff involved in the host organisation (for example, teaching staff at the school); and
- follow-up telephone discussions with scheme leaders.

### 3.2.4 Pilot 3: Healthy Eating Training

Based on the number of questionnaires provided to both sets of trainers by BMG, a response rate of 42% across all waves and all sessions was achieved (response rates here referring to the number of workshops that actually went ahead). PSAs managed to secure higher response rates than Children's Centres, and this is believed to be largely as a result of PSAs seeing reception class parents on a regular basis. Recruitment and engagement with target communities for Children's Centres was a distinct challenge. However, across both groups of trainers, response rates declined in the second round of workshops.

Overall, questionnaires were collected from 294 respondents who took part in either PSA led or Children's Centre healthy eating training programme; 170 questionnaires were completed in Wave 1 (Wave 1 relates to the pre-intervention evaluation questionnaires completed at the start of the courses) with the remainder, 124 questionnaires, completed in Wave 2 (Wave 2 relates to the post-intervention questionnaires completed after the training). Of the total sample of participants, 157 people took part in PSA courses, and 137 participated in training run through Children's Centres.

In terms of demographic profiles, this pilot attracted a diverse range of participants. Different ages, ethnicities and family life stages were all represented. The profile of participants was as follows:

- a large proportion of respondents were aged between 25 and 34 (49%), with smaller but sizeable proportions of respondents in the 18-24 (19%) and 35-44 (25%) categories. Those aged 16-17, 45-54 and 65-74 were represented, but these groups compared to the presence of other age groups were a minority;
- around three quarters of respondents (75%) lived in a house with 2 adults (including the respondent). Roughly 1 in 6 respondents lived in a household with one adult aged 18+;
- the vast majority of respondents had children living in their household at the time of the surveys - Most respondents had either 1 or 2 children living with them, with a smaller proportion living with 3 children. Only 5% of respondents had no children living with them;
- just under half of the sample (46%) was owner occupier or buying with a mortgage. Smaller proportions rent from a private landlord, rent from a housing association or rent from the Council;
- just under half of respondents (48%) were looking after the home or caring for dependants, with 15% of participants working full time and a further 15% working part time;
- thirteen per cent of respondents mentioned that they had a long standing illness or disability; and
- In terms of ethnicity 90% were of a white British background with the remainder from other white or black or minority ethnic groups (BMEs).

### **3.2.5 Pilot 4: Increasing School Meal uptake**

In each of the pilots the intervention was school-wide. However, for the evaluation, a sample approach was taken. Each school was provided with 180 self-completion questionnaires for distribution to parents (via children), with schools taking responsibility for ensuring that a class from each year group was provided with copies of the questionnaire (plus covering letter) to complete at home and return to the school (for collection by BMG staff). The questionnaires focused on views about healthy schools and school meals and were designed for parents to complete the first part, and their child to complete the second part.

Based on the number of questionnaires provided to the schools by BMG (3,178 across both waves), an overall response rate of 23% was achieved (response rates here referring to the numbers of questionnaires provided to the schools, against those returned by parents/children), which was in line with expectations for this type of 'third party' approach. However, response rates were significantly higher for the first wave (28%) than for the second wave (17%) and there were also wide variations between schools. Notably higher response rates were evident among those schools that were able to offer incentives for returned questionnaires (for example, extra play times) or issued the questionnaires as a part of a homework exercise.

During the qualitative case study visits to the 10 schools, discussions were held with a range of staff members including:

- head and/or deputy head teachers;
- kitchen manager and kitchen staff;
- healthy schools co-ordinator (where present)
- midday supervisors; and
- teachers.

In addition, observation of the dining room environment, lunch time service and food preparation was also made, along with informal discussions with children.

Discussions also took place with representatives of the school meals contractors and with Kent County Council Client Services schools contacts, as well as with the Healthy Schools Dietician and the Client Service Manager.

### **3.3 Identifying and engaging with respondents**

The success of the evaluation in part depended on the ability to engage with, and gather evidence from, those involved in the interventions – either in terms of management, organisation and delivery or as participants. In some of the pilots, participants were largely a 'captive audience' through being involved in cooking sessions, or being finalists in a competition. However, in others active participation was more tenuous (for example, by collecting a 'one off' fruit or vegetable bag or as a parent of a child whose school was piloting a school meals initiative. This presented some challenges for evaluation and required a degree of flexibility and innovation on the part of the evaluation team and KCC.

Some key issues have emerged with regard to the identification and engagement with target groups, including

- negotiating access with host organisations (such as schools) as early in the process as possible; consider running an evaluation briefing at the inception phase so as to introduce the evaluation and aid understanding from the outset;
- careful scoping is important at the start of the evaluation to identify all of the key stakeholders to involve in evaluation activities;
- recognising and working to minimise the impact on staff time of being involved in evaluation activities (for example, distribution/collation of questionnaires, arranging focus groups etc);
- timing of fieldwork – fitting in with other commitments, opening/term times, school hours etc, and ensuring that researchers are available out of normal office hours if required;
- considering the feasibility of offering an incentive for participation (for example, a free fruit and vegetable bag, extended break time for pupils etc);
- some initiatives may have a transient or sporadic target population (as in the case of the fruit and vegetable bag scheme) which makes any kind of tracking or statistical evaluation challenging and warrants a more qualitative approach;
- schemes that are reliant on volunteers who may be reluctant to engage in the evaluation (for example by distributing questionnaires or monitoring uptake/participation), warranting an innovative approach to facilitating their involvement; and
- where respondents have limited time and where venues do not lend themselves to sitting down to fill out a survey or complete an interview, very short, straightforward self-completion questionnaires should be used.

## 4 Outcomes of the community-based healthy eating pilots – key findings

This section looks across the four pilots to explore the impacts of pilots on participants and stakeholders involved in the design, management and delivery of the initiatives. It also explores the wider outcomes of the pilots.

### 4.1 Outcomes on participants

The outcomes on participants are discussed around:

- awareness and knowledge of food and healthy eating;
- confidence and skills in food preparation and cooking;
- changes in food consumption and eating behaviour;
- access to healthy food; and
- wider issues such as social networks and self-confidence.

The different pilots all aimed to achieve change in these areas to a greater or lesser extent – with some variation on focus depending on the nature of the pilot intervention. For example, the school meals intervention (Pilot 4) focused specifically on improving the uptake of school meals among school children via improved provision and delivery, whereas the Community Chefs pilot (Pilot 1a) had a wider focus on raising knowledge and skills and improving dietary behaviour. These variations in focus need to be taken into account in understanding the range of impacts that were evidenced in the evaluation.

Furthermore, evidence on impact was collected both qualitatively and quantitatively for three of the interventions (excluding Pilot 1a, Kent Cooks!, which predominantly collected qualitative data; and Pilot 2, the fruit and vegetable bag scheme, which also primarily focused on qualitative evidence). In total 546 respondents completed questionnaires at Wave 1 (before participating in the pilot) and 346 completed questionnaires at Wave 2 (at the end of participating in the pilot). Qualitative evidence was gathered using a range of research methods including focus groups, observed sessions and in depth interviews.

#### 4.1.1 Increased awareness and knowledge of food and healthy eating

Across the pilots (other than the school meals intervention, which did not collect data on awareness issues) participants demonstrated greater awareness of issues such as food preparation (including preparing healthy meals), minimising waste and using seasonal and fresh ingredients. There were also significant increases in awareness of issues relating to salt, fat and sugar content and food labelling. For example, overall:

- the proportion of the sample recognising the Eatwell plate rose by 14 percentage points, from 82% prior to participation to 96% after participation;
- the proportion always reading food labelling rose from 24% prior to participation in the pilot to 32% after participation – particularly looking at salt, sugar and saturated fat content of items;

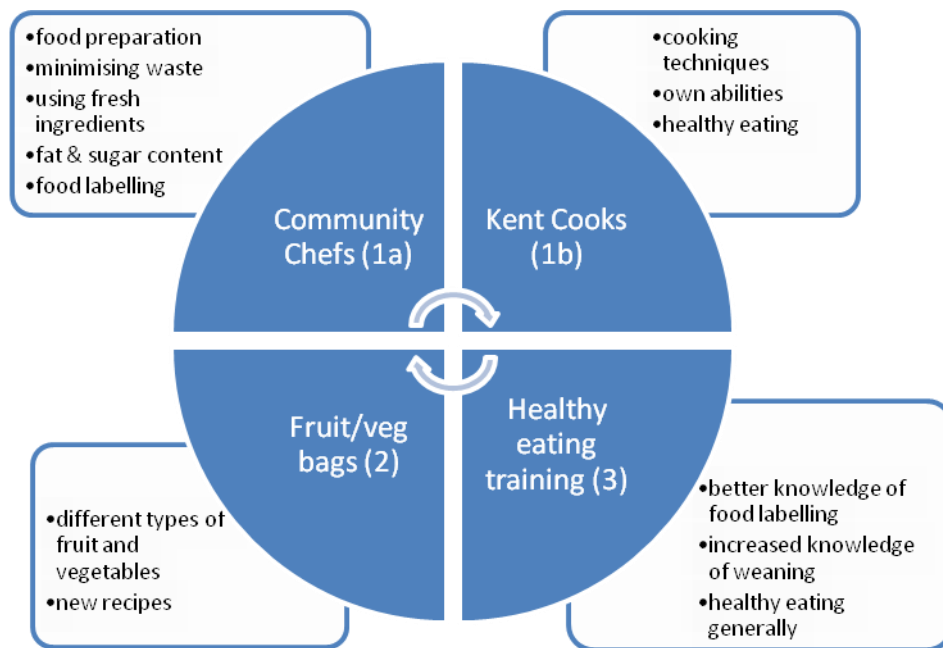
- with regard to the healthy eating training pilot, the proportion of participants reading food labels for information about fat levels rose from 49% to 66%, reading information about sugar content rose from 33% to 52% and reading information about salt content rose from 30% to 51% after participation.

In the Kent Cooks! pilot pupils reported increased confidence in terms of both cooking confidence and social confidence generally, as well as a raised awareness of healthy eating and a desire to continue cooking in the future.

[she] thought she was no good at cooking but getting to the final has given her the belief that she can cook – *comment by parent of one of the Kent Cooks! finalists*

For those who participated in the Children's Centre healthy eating training, the vast majority felt that they had a better understanding of food labels, healthy weaning, dealing with fussy eaters, making healthier changes to diets and of healthy eating generally. Similarly, participants in the PSA delivered healthy eating training cited as positive outcomes a better understanding of healthy eating, making healthier packed lunches and a greater awareness of food hygiene. In both cases, expectations of participation were exceeded. However, evidence from several of the pilots indicated that some participants were starting from what might be perceived as a relatively low knowledge base with regard to some basics around fruit and vegetables and the essentials of food preparation. For example, in the fruit and vegetable bag scheme it was clear that some participants did not benefit as well as they might have done from the recipe cards, as the cards already assumed a certain amount of knowledge (such as how to prepare the item of fruit or vegetable, which parts could be eaten and which parts should be discarded) – knowledge which not everyone had.

**Figure 1 Impact on awareness and knowledge**



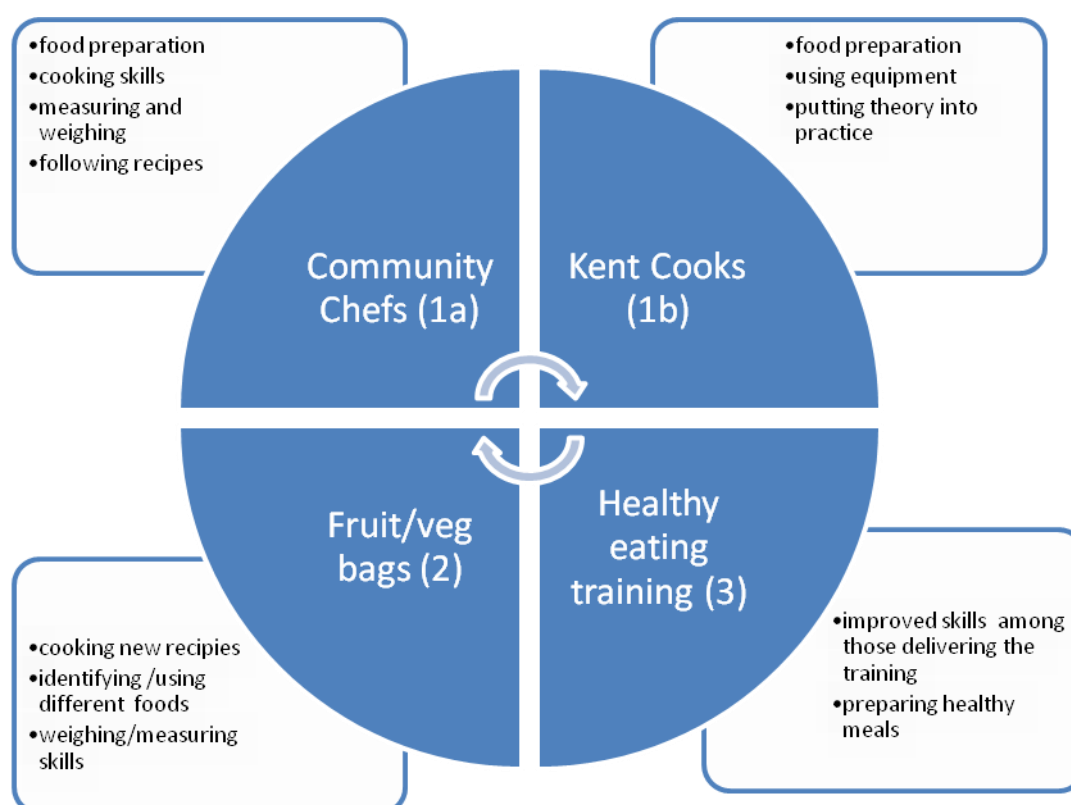
#### **4.1.2 Confidence and skills in food preparation and cooking**

The Community Chefs pilot and the Kent Cooks! pilot both had as their objective imparting new food preparation and cooking skills and in both cases this was achieved among participants (other pilots aimed to impart new *knowledge*, and they did not necessarily focus on providing opportunities to develop and practice new *skills*<sup>1</sup>). For example, in Pilot 1a, Community Chefs, participants were more likely to follow recipes and to include new food items into their repertoire and over four fifths (84%) of participants said that their cooking skills had improved since taking part in the sessions. In Kent Cooks!, the pupils learned new skills in food preparation and how to use kitchen implements and the course allowed them to put the theory that they had learned at school into practice. Other notable overall changes observed in knowledge and skill development included:

- an increase in confidence in preparing raw foods at home between the two waves, with 38% stating that they were very confident at wave 1, rising to 53% saying that they were very confident by wave 2;
- an increase in the numbers trying out a new recipe at home at least every fortnight, from 22% at wave 1 to 49% at wave 2 – which can in all likelihood be attributed to gaining new food preparation and cooking skills (as well as increased confidence); and
- a rise of 9 percentage points from wave 1 (pre-intervention) to wave 2 (post-intervention) in those rating their cooking skills as fairly or very good (from 83% to 92%).

<sup>1</sup> Pilot 4 – Increasing School Meals Uptake – is not included in this section as it did not aim to change participant skills.

**Figure 2 Impact on skills**



#### 4.1.3 Changes in food consumption and eating behaviour

There was evidence of changes in behaviour as a result of the pilots, and in particular in relation to foods consumed. Overall, the following changes were noted:

- over two thirds of respondents (67%) said that they had changed what they ate recently/since they had taken part in the pilot, including trying out more varied types of food, more home cooking, reduced salt intake and reading labels more:
  - 24% of participants that took part in the healthy eating training were monitoring their salt intake, compared to just 3% before the training. Likewise 24% of participants were monitoring their sugar intake, compared to just 7% who did before the training;
  - Of the participants that took part in the Community Chefs pilot, 21% said they were trying more varied types of food, compared with 2% at the start of the pilot, and 17% were eating few takeaways/doing more homecooking as opposed to 7% at the start of the pilot;
- the majority of respondents also expected to make further changes in the future, with less than a third (29%) stating that they did not plan to make future changes to what they ate;
- there was an 8 percentage point increase in the numbers of respondents saying that their child(ren) had a healthy diet (from 76% at wave 1 to 84% at wave 2); and
- there was a 7 percentage point increase in the numbers of respondents who said that they themselves had a healthy diet (from 71% at wave 1 to 78% at wave 2).

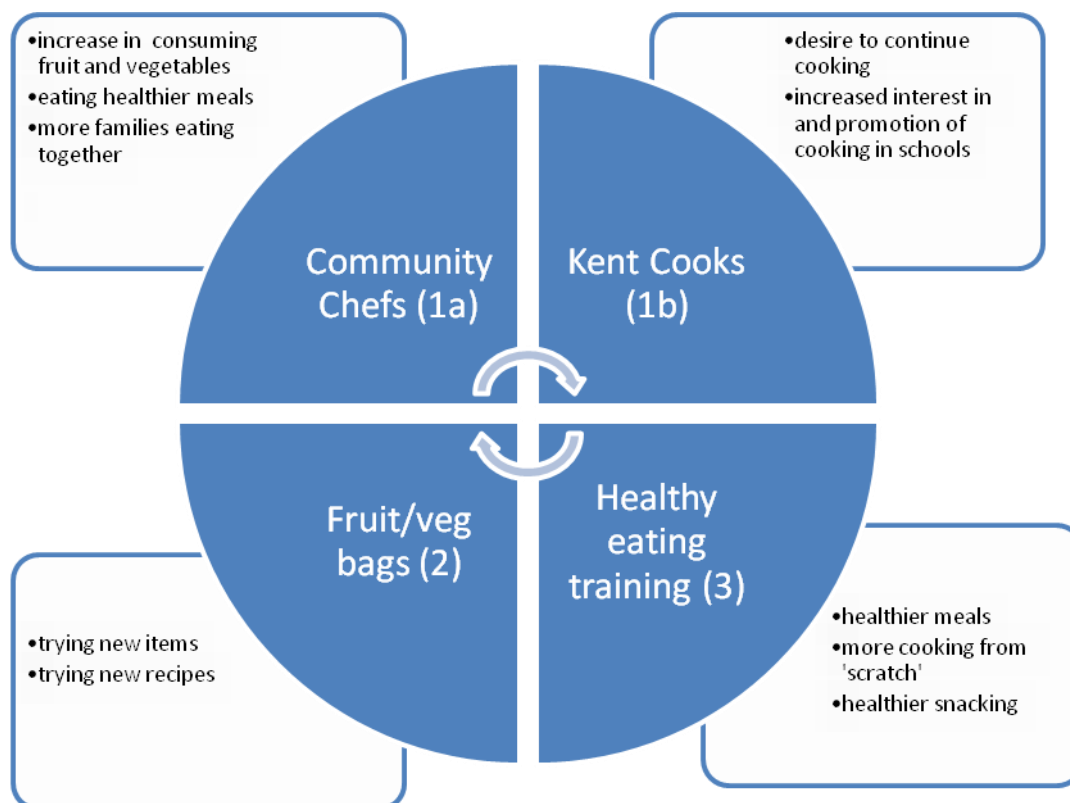
In Pilot 1a, Community Chefs, fruit and vegetable consumption among participants rose, and participants were more likely to describe their consumption as healthy after taking part in the programme than they were before participation. Participants also demonstrated an increase in families eating together and sharing meal times, and there were also examples of overcoming food 'fears'.

In Pilot 3, in both the PSA and Children's Centre healthy eating training, there appeared to be a significant impact on the behaviour of course participants. In respect of the PSA courses, the vast majority stated that they had a better understanding of healthy eating as a result of the courses, which in turn had had an impact on their behaviour – for example, in making healthy improvements to the packed lunches they made for their children. Respondents from both the PSA and Children's Centre courses also stated that they had changed to a salt free diet, had started cooking 'from scratch' instead of using ready made meals, were replacing snacks with healthier ones, recognising fat content on food labelling, and sharing such information amongst family, friends and peer groups.

For Pilot 2, the fruit and vegetable bag scheme, there was less evidence to suggest that the scheme had brought about any substantial changes in behaviour or consumption. Staff suggested that most of those who purchased the fruit and vegetables were already conscious of health issues and of the importance of fresh fruit and vegetables, although some customers did report that they had tried new items and new recipes (from the recipe cards) as a result of participating in the bag scheme. However, the impact of the scheme was potentially reduced in the early stages due to reported difficulties with produce quality.

The school meals pilot evaluation (Pilot 4) revealed little overall change in the numbers taking up school meals during the evaluation period (partly related to the timing of the intervention and evaluation period, which ran from the spring to the summer term, when school meal uptake would generally tail off). However, subsequent information provided by KCC after the evaluation ended indicated that there was a rise in school meal uptake over a longer time period. For example, in one school average school meals per week has risen from 130 to 155, and in another from 80 to 136 (representing a 35% and 40% increase respectively). Furthermore, qualitative evidence revealed a number of behavioural changes including children having more involvement in the selection of their school meal choices, improvements to queuing and changes to the dining room environment leading to a more relaxed atmosphere.

**Figure 3 Impact on behaviour and consumption**



#### 4.1.4 Greater access to healthy foods

Increasing access to healthy foods was the primary objective of the fruit and vegetable bag scheme. There was evidence to indicate that the scheme made it easier for people to get fresh fruit and vegetables at a convenient venue (for example, at school or community base) and for a reasonable price – particularly if they did not have transport or had mobility difficulties. However, issues noted earlier with regard to produce quality meant that at least in the early stages take-up was not as good as it could have been (although data on the number of bags distributed by the different schemes is patchy). Thus, the scheme had been a success with some as it had provided an opportunity for individuals to purchase fruit and vegetables which they would not have ordinarily been able to buy.

*I tried that pumpkin risotto, but wouldn't have even thought about trying it if it wasn't for the recipe card*

#### 4.2 Outcomes on stakeholders

There were several different types of stakeholders involved in the pilots including staff involved in the *delivery* of the plots (chefs, volunteers, trainers, PSAs and Children's Centre workers, teachers, school meals staff) as well as those involved with the *operation and management* of the pilots (including the Kent Cooks! project manager, chefs, KCC staff, senior school staff and school meal contractors). The impact of participating in the pilots for these different stakeholders included:

- partnership working and stakeholder dialogue;
- job satisfaction;
- skills;
- social networks; and
- momentum for longer term sustainability.

#### **4.2.1 Partnership working and stakeholder dialogue**

The pilot interventions clearly showed that new partnerships and working relationships had been developed that had not been in existence previously, which in turn led to strong relationships. For example, Pilot 3 (healthy eating training) provided an opportunity for dietician and nutrition specialists to work together in a way that they had not previously achieved in order to produce the training programme and materials for the pilot. Relationships have been continued throughout and beyond the pilot and staff have subsequently worked jointly to develop 'off the shelf' training packages for packed lunches. Thus, the sustainability of relationships between different organisations and between different professionals within nutrition and dietetics has been particularly successful – there are now quarterly meetings between the nutrition specialists and Kent and Medway healthy eating group to share joint working practices and develop ideas.

In Pilot 4, the School Meals intervention, one of the most striking impacts of the intervention was improved relationships between midday meal supervisors, the school, the contractors and KCC – improvements that continue to have benefits across the schools. It has also for the first time facilitated closer collaboration and working between the individual school meals contractors within Kent and all stakeholders have maintained a commitment to partnership working. The contractor, school, school council and Kent County Council have all worked together to implement the changes and the intervention itself has acted as a catalyst to improve the communication and working relationships between these groups. Other relationships between the school and contractor and school catering staff and pupils were also improved.

Longer term outcomes of improved partnership working were also evident in other pilots. For example, in the Kent Cooks! cookery competition, the pilot improved the relationship between Kent County Council and Thanet College and further discussions have taken place to use third year catering students from the college to provide cookery demonstrations in schools, with assistance from Kent County Council.

#### **4.2.2 Enhanced job satisfaction**

Delivery staff – particularly those involved in the Community Chefs and Healthy Training interventions – reported the satisfaction seeing participants increase in skills, knowledge and confidence as they progressed through the programme. Volunteers that were involved in the delivery of the pilots (notably in Pilot 1a, Community Chefs and Pilot 2, the fruit and vegetable bag scheme) reported positive impacts of participation in the programme which related to intrinsic satisfaction and 'pride' of having been part of something that was of value to society.

#### **4.2.3 Increased skills**

Skills learnt by being involved in the pilot – both for paid workers and for volunteers – were cited as an impact among stakeholders. For volunteers, additional knowledge had been

gained in healthy eating as a result of being involved in the pilot, in particular skills that they had gained through involvement could be transferred to employment situations and could help to enhance a cv. For paid staff, for example, in the healthy eating training, all staff enjoyed running the training sessions; especially as the pilot facilitated a deeper interaction with a small group of parents than they would normally work with, enabled them to learn new skills and knowledge, gain confidence and increased their interest in working more closely with health colleagues in the future. Although a large proportion of staff were 'volunteered' by their line managers or senior staff to deliver the training, despite initial concerns about lack of knowledge and skills, they all enjoyed and learned from the experience.

One school hosting the fruit and vegetable bag scheme enlisted the support of children with special needs to 'bag up' the fruit and vegetables for customers. The teaching staff here reported that this involvement had helped the children to develop their maths skills as well as learning about fruit and vegetables that they may not have been familiar with.

#### **4.2.4 Increased social networks**

Evidence of increased social networks among participants in the Community Chefs initiative indicated that friendships were formed and new networks established as a result of participation. Volunteers also indicated that involvement in the pilots had provided them with an opportunity to meet people that they would not have normally met, thus enhancing their social networks. The schools that were involved in the fruit and vegetable bag scheme, reported that being involved in distributing the bags to parents meant that they were able to develop stronger relationships with parents through more frequent contact as they collected the bags, which they felt was beneficial to both the school and the parents.

#### **4.2.5 Momentum for longer term sustainability**

Although all pilots were developed with future sustainability in mind, across the pilots, opportunities have been created for longer term activities as the pilots have gained momentum and developed over time, and awareness of and interest in healthy eating activities has increased. For example, the Community Chefs pilot has provided the opportunity for further community work to establish the cookery classes within the local food community, as there has been a clear identified demand from the community and from host venues. Both Chefs had been proactive in this area, with plans to approach those involved in food that work locally, for example, shop keepers to hold classes in their shops, to introduce participants to local sources and working more closely with market traders to increase healthy food provision. Schools and pupils indicated interest in future cookery competitions and schools were keen to promote the achievements of their pupils who had made it into the finals.

Opportunities for future linkages with other projects were also apparent. For example, links were being made between the Community Chefs programme and an existing project 'Don't Sit, Get Fit' based at a Living Well Centre, which enabled parents to attend the community cooking skills course whilst their children attended the class. It was also reported that other schools in Kent had been in touch with fruit and vegetable bag schemes to discuss the possibility of starting up similar schemes themselves. Furthermore, Kent County Council have advised that Kent Farmers Markets have expressed an interest in using the recipe cards supplied to support the vegetable bag pilots, and to work in conjunction with community chefs to raise awareness of how locally sourced seasonal produce can be prepared and eaten.

Other pilots such as the Kent Cooks! cookery competition had potential to link in to the Licence to Cook and Let's Get Cooking national initiatives on the back of the interest gained from schools and pupils. The pilot had already paved the way for schools and KCC to engage in collaborations with the local catering college (Thanet College), with the hosting of the final event at the college working particularly well and being mutually beneficial for all stakeholders.

### 4.3 Wider outcomes

*It's not just about cooking – it's not about teaching people – it's about empowering people – Mike Spackman, East Kent Community Chef, February 2009*

There was also evidence of wider outcomes for both participants and other stakeholders (ie, delivery staff) which extended beyond changes in diet, eating, knowledge or food purchasing and consumption to include:

- enhanced social networks;
- increased confidence and self-esteem;
- bringing together and involving extended family members; and
- a sense of well-being and achievement.

In many of the community based pilots, friendship groups were established and support or social networks strengthened. Participants were often introduced to other activities taking place in the community which they may not have been aware of such as learning or training opportunities, child development support, or other activities underway in the community venue or school.

*The all made friends on the group – they didn't know each other beforehand but they do now keep in touch...I saw people share things about other things going on in their lives outside the course...it showed she [Meryl O'Shea, West Kent Community Chef] had created a very safe environment and if someone was having a bad week then the group rallied round. I think that's quite special.*

*Because we had a crèche it was the first time that they'd [participants] left their children and they still talk about how valuable that was because some of them are now going back into paid work and it really prepared them for that.*

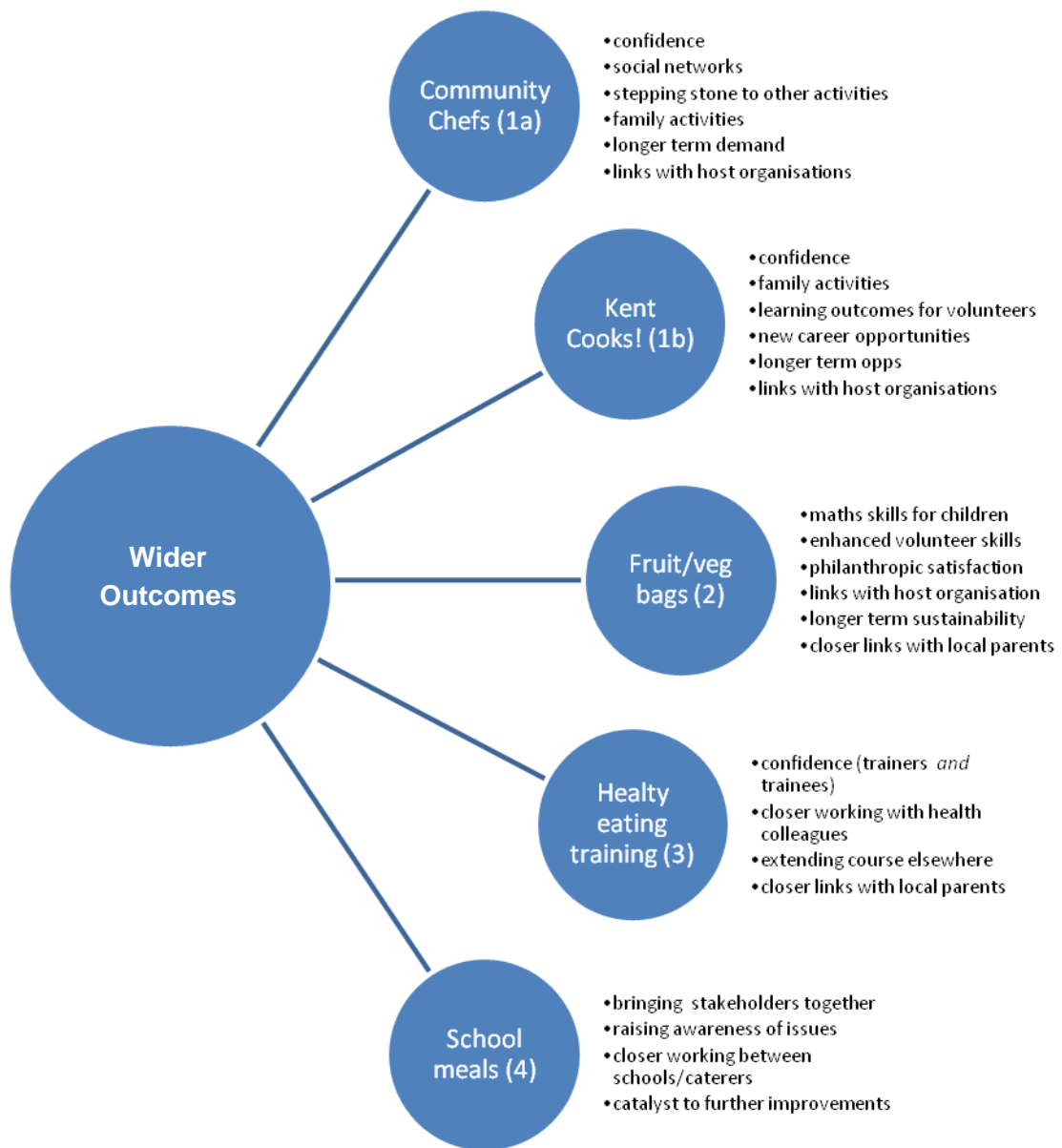
Across the pilots there was widespread evidence of wider positive outcomes on confidence (beyond confidence around food) and self-esteem was raised. For example, an increase in participants' confidence was particularly noted by the chefs delivering the training in the Community Chefs pilot and among both the trainers and the trainees in Pilot 3. Furthermore, it was evident that being involved in the Kent Cooks! Competition had had a positive impact on the participating young people (and their parents), who felt 'proud' of what they had achieved.

A somewhat unexpected benefit of the Community Chefs programme was the way in which they encouraged inter-generational learning. More children were involved in sessions than initially expected and the result was that courses showed many families how food could be used as a joint social and learning activity. The parents of the pupils involved in the Kent Cooks! cookery competition felt a sense of pride of their child taking part in the competition and expressed a keenness to encourage the family to continue to be involved in food and healthy eating at home. Parents also benefited indirectly by being more aware of the cost per head of meals, some were more involved in cooking themselves and encouraging other siblings to become more involved and interested in food and healthy eating at home. In a few cases, being involved in the competition had opened up new possible avenues for future career choices for the participating child. For the pupils themselves, the pilot demonstrated that the outcomes for those involved in the final extended beyond learning new cooking skills to increased confidence and a sense of achievement. Thus, the pilot has a potentially wider role to play, with the capacity to link up with other child focused initiatives and contribute to additional Every Child Matters outcomes.

In the fruit and vegetable bag schemes, pupils who had been involved in the bagging up of items learnt valuable measurement and weighing skills, and volunteers spoke of the increase to skills which might benefit them elsewhere (for example, in job search) as well as the intrinsic satisfaction of being involved in that type of activity.

Other outcomes related to a greater knowledge of others' roles, closer links with other professionals and improved relations with wider stakeholders – all of which fostered positive future working relationships. In some cases, projects had extended (or planned to extend) to other settings as a result of these renewed partnerships and enthusiasm for sustaining and developing the activities underway.

**Figure 4 Wider outcomes**



## 5 Implementation of the community-based healthy eating pilots – key findings

This section of the report highlights the key themes and issues that have emerged from the evaluation with regard to the successful set-up and delivery of the pilots. These relate to:

- establishing partnerships and stakeholder engagement;
- staff training;
- setting project objectives;
- delivery locations and timing; and
- identifying and engaging with the target group

### 5.1 Establishing partnerships and maintaining stakeholder engagement

#### 5.1.1 Allowing sufficient time to establish partnerships

Crucial to the establishment of stakeholder partnerships was consideration of the time needed to plan/set-up the projects and to establish working relationships between different stakeholders – some of which had not previously worked together in this way. For example, within Pilot 3, healthy eating training, there were approximately eight days of meetings over the eight month planning period. Considerable time was also required to set-up, promote and co-ordinate events or activities such as preparation of lesson plans, timetabling of activities, securing venues etc. Also, in Pilot 1b, Kent Cooks!, the project manager needed to invest time and energy over several months to establish the project, engage with schools, develop the necessary materials and arrange the cooking competition final. Frequent communication (thus including a time investment) was required between the project manager, the schools, the teachers, the pupils and their parents or guardians about the competition, both in terms of what is required for the competition (i.e. in terms of type of menu, seasonal produce, etc) as well as practical arrangements (for example, venue details, timings).

In the Community Chefs pilot (Pilot 1a), the short set-up time meant that the chefs were predominantly focused on the design and delivery of the schemes and, as such, the recruitment of volunteers to assist in delivering the courses was difficult (compounded to some extent by concerns that volunteer involvement would affect their benefits entitlement).

#### 5.1.2 Early involvement of stakeholders

In order for partnerships to be established it was imperative that all stakeholders were involved from the start of the project to ensure that they had knowledge of the pilot and of their role to enable them to contribute towards shaping the interventions and to maintain commitment throughout the pilot. There have been several occasions highlighted where it was felt that earlier involvement, communication and explanation to stakeholders involved in delivery would have helped to facilitate a stronger, more supportive, partnership. Within Pilot 3, healthy eating training, the delivery staff were unanimous that more work should be undertaken by Kent County Council (KCC) to explain to stakeholders and participants (parents, pupils and the schools) about the training and the benefit of assisting the delivery

of courses as there was misunderstanding with regards to the roles, responsibilities and additional workloads for stakeholders. This was despite KCC staff spending time at the start of the pilot attending Children's Centre Managers' Steering Group meetings explaining commitments, followed up by detailed emails from KCC to Managers. Managers who committed to the activities then signed up to Service Level Agreements and were responsible for passing on the necessary information to nominated delivery staff. This may suggest that more face-to-face contact directly with the delivery staff would have helped them to understand their roles and responsibilities (although in practice time and resource constraints would have made this difficult).

The circulation of official background literature by the Council to the schools prior to contact by the trainer was felt to assist with the project buy-in from schools. Within Pilot 1a, Community Chefs, the project did not necessarily grow 'organically' and consequently not all the stakeholders gave support and assisted with the development of the project. The need for early engagement with the school senior management team and support from the head teacher was essential for all the pilots involving schools, but specifically (Pilot 1b, Kent Cooks! and Pilot 3, healthy eating training and Pilot 4, increasing the uptake of school meals), in order to secure commitment, support, enthusiasm and success. Within Pilot 4, increasing school meal uptake, initial set up of interventions and negotiations with schools was in some cases weak because stakeholders had different levels of understanding at the point of introducing the pilot to school representatives. As such, there was confusion and mixed interpretations of the interventions. Furthermore, the school meals contractors chose the school and the intervention measure to adopt, but upon evaluation, it appeared that the school wanted more of an input in such decisions within the early stages of the pilot development. The development of a positive contractor-school relationship was as significant as the actual intervention adopted.

The advantages and benefits of being involved in the pilot exercises should also be presented to all stakeholders. A critical factor for each of the pilots was that it matched the brief, goals and vision of the organisations and partners that worked alongside it. For example, within Pilot 1a, Community Chefs, one partner commented that the pilot helped him to '*tick his boxes*' and as such the project is valued by the board as being a worthwhile connection and partnership to invest in. It is also likely that there will be a stronger buy-in if the pilots benefit or complement other work undertaken by the stakeholders.

### **5.1.3 Maintaining relationships and engagement over time**

For partnership working to be effective and for relationships to be strengthened, continued commitment from partners was needed (and the value of such commitment recognised). For example, in Pilot 1a, Community Chefs, for it to be successful, more drive and support was identified as being necessary from partners in the future, and regular attendance at meetings needed to be complemented by partners taking responsibility and ownership for certain aspects of the projects.

Within Pilot 4, increasing school meal uptake, as a result of ongoing partnership working involving those who undertook the 'dining room environment intervention', high levels of interest have been maintained by all stakeholders. The increased use of e-technology was suggested for future pilots to reduce the need for face-to-face meetings (for example, project websites, electronic circulation of news updates etc). Furthermore, using electronic means

of communication could help stakeholders to keep abreast of developments and to share ideas.

Several pilots benefited from having a diverse range of stakeholders and agencies with local knowledge and community links. For example, within Pilot 1a, combining health, educational and community sector representatives was key to ensuring that community links, projects and contacts were capitalised on and maintained.

In two of the pilots, it was evident that relationships between stakeholders and partners were disrupted where there were changes to key personnel. In Pilot 1a, Community Chefs and in Pilot 3, healthy eating training, both experienced difficulties with maintaining momentum when there were staff changes and several additional projects and staff training sessions did not materialise as a result of lack of engagement when staff had changed jobs and their position was vacant for a number of months. The overall KCC initiative itself experienced a gap of a number of weeks with no project manager and this also caused a few difficulties for some of the projects.

## **5.2 Staff training**

### **5.2.1 'Hands-on' Training**

Unsurprisingly, the training of staff involved with the delivery of the pilot was essential to its success. Training was most successful when it was interactive and participatory. For example, the 'hands on' training approach within Pilot 3, healthy eating training, was valued by all involved particularly where they were fully engaged with the course content, materials and participatory exercises.

### **5.2.2 Multi-disciplinary and multi-level training**

In Pilot 3, healthy eating training, the delivery staff were trained in mixed groups, in terms of their professional background and ability, which meant that they learned from and supported each other. Further, the materials distributed could be referred to whilst delivering the course and after the training were felt to be extremely helpful. However, the training needed to take into account the different professional backgrounds and skill sets of the individuals involved. On several occasions stakeholders felt that it did not. For example, Pilot 4, increasing school meal uptake, the midday meal supervisors felt that the training was more aimed at those who cooked the meals. Also, those who undertook training in Pilot 3, healthy eating training, felt that it did not always account for sometimes low levels of knowledge, awareness and familiarity with health messages. As a result, the training left some feeling short on the required breadth and depth of knowledge in order to deliver sessions.

### **5.2.3 Developing training packages**

The training should be sufficiently flexible to allow for stakeholder input and be tailored to individual needs. For instance, Pilot 4, increasing school meal uptake, the training course was generic and it was felt that there was a lack of school involvement in its design to ensure that the content reflected schools' individual circumstances and abilities. In Pilot 3, healthy eating training, whilst it was made clear to trainers that they could tailor their training programmes, there was a reluctance to do so, perhaps because of confidence issues.

#### **5.2.4 Allowing time to participate**

Adequate time and resources also needs to be considered to allow training to happen. In some pilots (for example, Pilot 1a), a focus on delivery and getting programmes up and running meant that there was insufficient time to fully train some people, including volunteers. Furthermore, it was felt that one-off inputs (i.e. singular training sessions) sometimes did not provide sufficient opportunity for changes to be embedded and issues to be dealt with (for example, in Pilot 3, healthy eating training programme).

Time off to attend training sessions was also an issue in some cases. Pilot 3, healthy eating training, also revealed a need to allow, or negotiate with senior managers, for sufficient time during training for familiarisation with and understanding of the resources and agree for continual revision and preparation time to be incorporated into daily routines. Furthermore, despite managers agreeing to make staff available for the time required, it was clear that for some the intensity of the course over two days was felt to be too much and some stated that they had little time to digest the wealth of information.

### **5.3 Setting project objectives**

#### **5.3.1 Aligning objectives**

Ensuring that the objectives of the pilot interventions were communicated and shared between all stakeholders at the beginning and throughout the pilots were essential to their success and the effective development of stakeholder and partner relationships (see earlier sections).

Aligning the pilot objectives with the objectives and aspirations of the other stakeholders and partners was important for engaging with all involved. For example within Pilot 1a, Community Chefs, aligning the objectives of the pilot with other community groups which had similar aspirations (such as improving skills and raising awareness of healthy lifestyles) was successful for their buy-in to the projects.

There is also a need to ensure that objectives are clearly understood by host organisations or venues such as schools or community centres. For example, hosting a fruit and vegetable bag scheme requires a host organisation to have a clear understanding of the project objectives (for example, a fruit and vegetable bag scheme being run as a social enterprise) and their 'fit' with their own objectives and focus.

#### **5.3.2 Setting realistic objectives**

Of particular note was the apparent tension between the overall objectives of focusing on healthy, low-cost, seasonal and locally sourced meals. For example, within Pilot 1b, Kent Cooks!, there was some difficulty in meeting the requirements for the menu dishes to be low cost and healthy using locally sourced seasonal products (which are typically more expensive). Additionally, some felt that the food budget amount of £5 per head was too generous and beyond the affordability of some families, and was thus potentially a deterrent for cooking 'healthily'. For future events, narrowing the focus to 'low cost and healthy' with a smaller cost per person would be more practical.

Setting costs was also an issue in some of the other pilots. For example, the fruit and vegetable bags in Pilot 2 were also felt to be too expensive particularly given the fact that the buyers were unable to know and see the contents of the bag in advance, and upon receipt,

supply problems meant it was sometimes of poor quality. Finally, the budget of £30 for materials for Pilot 3, healthy eating training, was also felt to be too limited to enable the purchase of fruit and vegetables for demonstration purposes (particularly given the rise in food prices during 2008-09).

Project objectives sometimes focused on engaging with specific target groups – but identifying and engaging with these groups could prove challenging. For Pilot 3, healthy eating training, whilst innovative recruitment tactics did assist in meeting participation targets, trainers were agreed that the recruitment criteria (targeting reception class parents, teenage mothers, or women beyond 30 weeks of pregnancy) were initially too restrictive because these participants were unlikely to be at the Children’s Centres (the host venues for some of the Pilot 3 projects).

## 5.4 Delivery locations and timings

### 5.4.1 Delivery locations

The venues selected impacted on the success of the pilot, as they needed to be easily accessible for the target participants. Stakeholders from community groups were often able to suggest suitable, well-known venues to hold the sessions. There were often specific needs from a venue, for instance, in Pilot 1a, Community Chefs, a room was needed that was large enough to hold groups of individuals and as well as having access to childcare facilities (with the flexibility of involving the children in the classes). The mobile element to this pilot was also felt to be a distinctive advantage allowing chefs to get out into the communities, breaking down potential barriers to participation such as lack of access to transport or cost of travel. However, there were also disadvantages to this approach, particularly in terms of the time it took to unload, set-up, clean down and reload equipment which meant a loss of time available to actually conduct sessions. Furthermore, travel between sites meant that chefs were limited to offering three courses a day (maximum) which often translated to a ten or eleven hour day.

Delivery of sessions also needed to take into account the needs of the host venue. For example, in Pilot 3, healthy eating training, the timetable of the Children’s Centre was already established as a term of five to six weeks so the pilot had to shape to this.

### 5.4.2 Timings

The time of year that each pilot was undertaken was critical to its success. In Pilot 1b, Kent Cooks!, for instance, the best time for seasonal availability of produce was September and October or June and July, but this did not give schools sufficient time to implement the competition and arrange the final (which required a three month timeline) and it conflicted with both the school time table and key exam/assessment periods. The time of the year also had an impact on participant recruitment and retention within Pilot 3, healthy eating training. When the sessions took part (June 2008 - July 2008), parents were no longer ‘new’ to the school and had established routines, the sessions were also often affected by limited turnouts due to end of year school trips and were restricted to only parents who were available to attend during school hours. Also, within Pilot 4, increasing school meal uptake, some stakeholders raised concerns about the time of the year of the pilot (January 2008 – July 2008) as school meal numbers naturally reduce in the summer months as children prefer lighter lunches and often have the opportunity to eat them outside. This made it more difficult to assess the impact of the intervention.

The length of the pilot also had an impact on how participants and stakeholders perceived its success. Further to the completion of Pilot 3, healthy eating training, it was felt that the sessions could have been delivered over a longer period to allow time to accommodate a summary session as well as a separate evaluation session. Within Pilot 4, increasing school meal uptake, stakeholders unanimously felt that the interventions were not over a long enough period to enforce lasting change. However, subsequent anecdotal evidence from after the intervention ended did reveal longer term positive changes in school meals including further Midday Meals Supervisor training, continued improvements to the dining room environment which appear to be having a positive impact on school meals uptake, and continued development of positive working relationships between KCC, school meals contractors and the schools themselves.

## **5.5 Identifying and engaging with target groups**

### **5.5.1 Promotion of the ‘healthy eating’ message**

In order to engage with target groups effectively across all of the pilots it was evident that the initiatives needed an alternative ‘strap line’ because of the negative association with ‘healthy eating’. In every pilot, concerns were raised from stakeholders, partners and participants with regard to the term ‘healthy eating’ evoking pre-conceived ideas about the term and general negativity amongst participants. These perceptions may have impacted on the initial uptake of and engagement with the projects among the target groups. For instance, within Pilot 1a, Community Chefs, participants had an expectation that courses may involve ‘preaching’ or by their nature would be targeted at people who have been labelled as ‘unhealthy’. In Pilot 1b, Kent Cooks!, teachers reported young people were discouraged from participating in the cookery competition because of the focus on ‘healthy eating’. Within Pilot 2, the fruit and vegetable bag scheme, and Pilot 3, healthy eating training, volunteers and scheme leaders were also concerned about the term ‘healthy eating’, which could deter some people because of preconceived ideas of what healthy eating is and that they were going to be ‘told’ how to feed their families and that there was an implied perception that they needed help. Although delivery staff were advised that the terminology could (and perhaps should) be changed to move away from ‘healthy eating’, it appears as though few did so.

### **5.5.2 Engagement approaches**

Although target ‘areas’ or communities were identified by KCC using MOSAIC mapping, upon completion of the pilots it appeared that reaching some of the ‘target’ participants within the identified communities was challenging. In order to engage with target groups and for the pilot to be successful, there was a reliance on the stakeholders and partners to promote the initiative and recruit participants. Overall, the technique worked well for the pilots as a multi-stakeholder approach ensured that a range of suitable individuals were often reached quickly and efficiently (although there may be gaps in reach if stakeholders did not cover certain locations or communities). Further, the use of other technologies (i.e. mapping software in Pilot 1a, Community Chefs) to identify areas to target participants was also successful. Promotion techniques were also used in trying to target and engage with key groups, but with less success – it was apparent that word of mouth was often the most effective method. Pilot 2, fruit and vegetable bag scheme, initially used written posters that were displayed in schools and small write-ups were placed in the school newsletters, but this was also deemed insufficient in generating interest; again word of mouth was more effective.

However, it was felt that where the target group profile was young, as was the case with the Kent Cooks! pilot, a more appropriate and effective way of engagement would be via social networking sites. That said, it was apparent that using these kind of approaches would conflict with KCC policy on engaging young people.

There were some issues whilst trying to engage with certain target groups, notably those who had had little previous exposure or knowledge of healthy eating, with initiatives often tending to attract those who were already interested in healthy eating and cooking. For example, Pilot 1b, Kent Cooks!, engaged mostly with those who already had an interest in cookery and an awareness of healthy eating. Consequently, a need was identified to specifically target those who were not interested in the subjects in future, perhaps using more innovative approaches to engagement. Furthermore, it was evidently much easier to engage the younger age groups (i.e. years seven and eight) than the older age children (years nine and ten).

Recruitment and retention of participants was one of the most challenging aspects of delivering Pilot 3, Healthy Eating Training. PSA trainers for parents of school children used a number of approaches in order to attract and recruit to the courses, for example, offering incentives, rearranging courses and timings to suit groups, focusing on friendship groups and meeting and greeting parents in the playground. The Children's Centre staff found it difficult to recruit people because the target groups (expectant mothers, teen mums, etc) were not individuals who they usually had contact with (or were not generally users of the Children's Centres). The staff approached midwives, health colleagues and other group members with reportedly limited response/interest. Furthermore, advisors stated that the majority of parents involved in the sessions were *"the ones who come to everything"* and were those who were able to attend during the day time (and it was noted that a significant proportion of the target population were actually working during the day). It was also felt that the letters provided by Kent County Council (which, in practice, staff were encouraged to adapt but again few did so) were too lengthy and were at risk of not being seen by parents and consequently they would miss the opportunity to take part.

In the Community Chefs pilot, it was felt that the partners and stakeholders perhaps could have done more to use their resources to assist the recruitment of participants, suggesting that recruitment should be more of a shared priority in the future to make the best of local knowledge and networks.

### **5.5.3 Tailoring approaches according to need**

Flexibility was crucial in order to engage participants. Communication methods needed to be varied and flexible to ensure all target participants could be reached. In Pilot 1b, Kent Cooks!, the promotion of the initiative worked well but some teachers required electronic access to documentation to save on photocopying as well as to be able to tailor materials to their needs (for example to allow for poor literacy skills among pupils). The need to tailor the approach to take into account different levels of literacy was also evident in other pilots. For example, in Pilot 2, the fruit and vegetable bag scheme, recipe cards were produced as an additional support resource and whilst the cards were developed to be basic in terms of how to prepare the vegetables and use basic cooking skills, very low literacy skills (perhaps lower than expected) among some could make the cards difficult to understand.

In order to recruit individuals, flexibility was key for Pilot 3, healthy eating training. Various approaches were used to recruit, including incentives offered to parents (for example, a draw

for a food voucher based on full attendance, offering free fruit at breakfast time), rearranging courses to suit the group needs (such as reducing sessions from four single to two double sessions to reduce the length of commitment), all of which ensured a better take-up.

Within Pilot 1b, Kent Cooks!, there appeared to be some communication issues (between schools and pupils) with regard to the arrangements for the final cooking event. Thus, it was suggested that in future a project website should be set up to enable information to be downloaded, as well as to provide information about the competition timetable and details of the arrangements for the final. It is worth noting here that online materials were available in an earlier pilot of the competition, but difficulties were encountered by staff attempting to download materials, hence the move to paper copies for the main pilot.

#### **5.5.4 Skilled approaches to engagement**

To successfully deliver the pilots, individuals with strong interpersonal and social skills were needed. For instance, the chefs within Pilot 1a, Community Chefs, were overwhelmingly credited for their personality, enthusiasm and commitment which combined to develop attractive, topical sessions which engaged and retained participants. Within Pilot 1b, Kent Cooks!, it was clear that engagement was greatest where the teacher within the school was fully committed to and enthusiastic about the pilot.

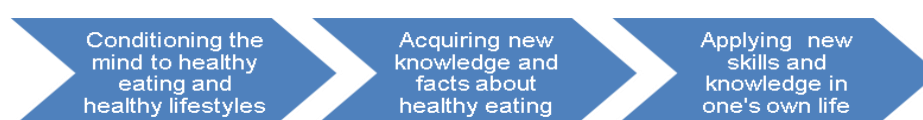
Engaging participants also required considerable time and effort on the part of the delivery staff, for example, in preparing marketing posters, attending meetings, meeting and greeting parents in the playground to encourage participation. Again, these activities required a certain degree of confidence and skill beyond that which might be required to deliver healthy training.

## 6 Overview of Outcomes

This final section provides a brief overview of the main outcomes relating to changes in attitudes, knowledge and behaviour and skill development as well as wider outcomes. Factors that may facilitate or hinder changes are outlined, followed by recommendations for future activities in Section 7.

### 6.1 Changes in attitudes, knowledge and behaviour

There is no doubt that the Kent Community Based Healthy Eating pilots have successfully changed attitudes, knowledge and behaviour around food and eating for participants. Evidence from all pilots indicated that the pilots had had a positive impact on attitudes, knowledge and behaviour, generally following a model of change that was outlined in one of the individual pilot evaluation reports (Pilot 3):



The evidence revealed changes in people's knowledge of what constitutes a healthy diet – including fat and salt content, the 5 a day principle and the Eatwell plate, ways to prepare healthy meals for their families at a low cost, and different approaches to food purchasing and shopping behaviour. Whilst some of these changes have been quantifiable through the survey data, many of the changes have also been evidenced through the qualitative data – through discussions with staff involved in the design and delivery of the pilots as well as with the large number of participants in the different pilots. That said, for many the sustained changes in behaviour will only be truly evident over a longer time period as families as a whole make changes to their diet and their lifestyles – changes that may in time filter on through future generations.

### 6.2 Skill development

Skill development has been evident across all stakeholders ranging from those involved in the delivery of training to the participants themselves. Skills have been acquired, or strengthened, in a range of health related activities including food purchasing and preparation as well as cooking full meals. However, skills that have been developed during the pilots extend far beyond those related to healthy eating to other 'softer' skills. Many respondents spoke of increased confidence and self-belief – for example, children who participated in the Kent Cooks! cookery competition gained confidence in their abilities and in being able to cook 'under pressure', and volunteers in the fruit and vegetable bag scheme

and in the Community Chefs scheme spoke of increasing skills that might be of benefit to employers in the future – team working, being involved in training activities and so forth.

### 6.3 Wider outcomes

Wider outcomes relating to increased confidence, improved communication skills and wider skill enhancement have already been noted. However, other outcomes have included greater strength in partnership working. Evidence indicated that the momentum gained during the pilots was continuing with partnerships planning and develop services to support the healthy eating agenda beyond the pilot timeline. These ‘ripple effects’ of the pilots will no doubt continue to be felt across Kent.

### 6.4 Barriers and facilitators to change

Changing behaviours, which are typically deep rooted and complex, takes time and is often incremental. However, a number of barriers and facilitators to change have been identified through the evaluation.

- *‘Healthy’ messaging.* Some respondents were ‘put off’ by the promotion of healthy eating. Where initiatives shifted the focus to family cooking, or learning new cooking skills, engagement was more likely to be positive. Despite flexibility in use of language and terminology in the individual pilots, not all adopted alternative ‘straplines’ for their activities.
- *Synergy between pilots.* One of the greatest barriers to the pilots having a greater impact than they had was the limited opportunity each pilot had to work with other pilots. For a variety of reasons, the pilots tended to work in isolation of each other, often working at different times over the two years and with different communities. However, there was much potential for linkages between the pilots and this was noted by many of the stakeholders and delivery staff involved. Opportunities for fruit and vegetable bag schemes to link into local Community Chef initiatives, using the items purchased in the bag schemes was one such suggestion; another was linking in the Kent Cooks! cookery competition with the Community Chef courses.
- *Engaging with target groups.* Some of the initiatives struggled with take-up (for example, the Kent Cooks! competition and some of the Healthy Eating training courses). Innovative approaches and a large degree of energy were required to ensure that interventions successfully engaged with target communities.
- *Responding to variations in skill levels, knowledge and confidence.* It was clear that there was considerable variation in people’s skills, knowledge and confidence, and assumptions sometimes had to be adjusted to take into account often relatively low skill levels (both in cooking skills and in literacy). Furthermore, there was a wide range of familiarity with healthy eating knowledge among the trainers themselves which needed to be taken into account in their training to ensure that they felt sufficiently confident to disseminate their training to others.
- *Timings and venues* were critical. Logistic difficulties (for example, in finding rooms large enough or with the right facilities) could hinder progress, and fitting in with existing provision (for example, ensuring bag collection times coincided with school pick-up times was critical. Seasonal timing of activities was also critical –

fitting in with school term times ensuring that fruit and vegetables were available at the right time.

- *Partnership working.* Where partnerships came together effectively, and understood different partner's objectives and perspectives, progress in the pilots was swifter. Where partnerships were weaker, progress was more problematic.
- *Stakeholder engagement.* Where stakeholders were engaged in, and supportive of the pilot throughout its life course it was easier to make progress and to subsequently achieve outcomes, for example in facilitating take-up.
- *Flexibility and innovation.* Being able to make changes to the pilots, to ensure that they best met the needs of the target population or host organisation was important in achieving project outcomes.

## 7 Recommendations and Conclusion

As this summary report has shown, the community-based healthy eating pilots have delivered significant outcomes for individuals and for organisations. For each individual pilot a number of recommendations for both policy and practice have emerged from the evaluation evidence, and these are discussed in detail in each individual pilot report. However, the recommendations in this report have more of a strategic focus, suggesting the future direction of travel for healthy eating initiatives in Kent.

### **Recommendation 1 – Roll out community-based healthy eating initiatives to targeted communities throughout Kent**

The evaluation of the community based healthy eating pilots has evidenced significant positive outcomes for communities throughout Kent. In particular research has found that Pilot 3, healthy eating training and Pilot 1a, Community Chefs have had a significant impact on increasing knowledge and skills and changing attitudes and behaviours around healthy eating amongst targeted communities. On the basis of the evaluative evidence gathered it is recommended that community-based healthy eating initiatives are rolled out further to targeted communities across Kent; with an emphasis on initiatives that work to support the local community in gaining the skills, confidence and knowledge needed to help them to make healthier changes to their diet, delivered via locally based practitioners – as has been seen in the Community Chefs and Healthy Eating Training pilots (Pilot 1a and Pilot 3). Positive outcomes were evidenced for all pilot projects and any roll out needs to be planned and considered in order to match the most appropriate intervention with the community need. Networks and partnerships forged between Kent County Council, Children’s Families and Education Directorate (Extended Services), Eastern and Coastal Kent NHS and NHS West Kent and the voluntary and community sector within Kent should be utilised fully to support and manage any planned roll out.

Evidence suggests the greatest impact on communities has been via Pilot 3 (Healthy Eating Training) and Pilot 1a (Community Chefs). The Kent Cooks! cooking competition also demonstrated considerable positive impacts on participants who reached the final, although the sample was relatively small. However, as with all initiatives there are cost implications to be considered. Pilot 3 has the ability to be run in a flexible and cost effective manner, utilising the skills and staffing resources represented by existing locally based Parent Support Advisers and Children’s Centre staff. Pilot 1a has start-up costs associated which need to be budgeted for as well as the continued cost of employing a Community Chef. However, the impact of the Community Chefs on the Dartford/Gravesham and Isle of Sheppey communities has been extremely positive as it has equipped communities with the knowledge, skills and confidence to make informed changes to their diets and lifestyles. In order for healthy eating initiatives to have the greatest impact they need to be planned and positioned within the wider health and wellbeing agendas and plans for the community and need to be seen as part of a wider commitment to improve quality of life and life chances for all.

### **Recommendation 2 – clear, realistic and achievable objectives**

One of the challenges of delivering the pilot projects was the focus on multiple aims relating to healthy eating, low cost, locally sourced and seasonal produce. Achieving all of these aims proved particularly challenging as they were not necessarily harmoniously achieved. With this in mind, careful consideration needs to be given to the development of future healthy eating initiatives; with a clear and tangible focus being developed from the outset on the aims objectives and outcomes for the initiatives, and with an impact focused evaluation process embedded from the start of each intervention.

### **Recommendation 3 – Utilise the evidence base to inform policy and operational decisions around healthy eating**

The evaluation of the community based healthy eating pilots has provided a significant evidence base demonstrating the impact of the healthy eating pilots on communities and organisations across Kent. In the future, it is vital that this evidence base is drawn upon when developing policy and delivering community-based services aimed at addressing health inequalities where poor diet and/or poor dietary behaviours are a cause for concern.

### **Recommendation 4 – Ensure healthy eating is embedded within key policies and strategies for Kent**

In order to ensure healthy eating has a consistently high profile within Kent it is essential that healthy eating is reflected as a significant focus and is embedded strategically within key policies and strategies for Kent – both by Kent County Council and its partners from the health and community and voluntary sectors.

### **Recommendation 5 – Adopt a partnership approach to delivering healthy eating initiatives**

The ability to forge effective partnerships has been critical to the successful delivery of the healthy eating pilots. Community food partnerships, social enterprises and Kent wide healthy eating and community fruit and vegetable forums could be mechanisms for managing delivery. Further partnerships could also be explored with Farmers' Markets and with community based food festivals and initiatives.

### **Recommendation 6 – Sustain stakeholder buy-in**

Where stakeholders were engaged in the pilots from an early stage and where they remained engaged throughout the pilot, progress was swifter, impacts were more evident and activities were sustained. This requires strong direction from those responsible for the pilots.

### **Recommendation 7 – Adopt an holistic approach to increasing school meal uptake**

The South East region has the lowest percentage uptake of school meals at primary level out of all nine Government Office regions across England. Evidence from the evaluation of Pilot 4, increasing the uptake of school meals, has revealed there is no individual specific intervention that is guaranteed to significantly increase the uptake of school meals. Rather, adopting a whole school approach with buy-in from a senior level within the school, an effective partnership with catering contractors and a willingness to pursue a range of initiatives relevant to the school can make a significant impact in raising the profile of healthy

eating, and health and well being more generally, to support the delivery of the Healthy Schools agenda.

### **Recommendation 8 – Interlinking projects**

For this pilot, individual projects tended to run in isolation (in part because of practical reasons) but there is the potential capacity to link projects, for example, fruit and vegetable bags with community chef cooking courses and cooking skills, or a cookery competition linking with community cooking skills for the family. There is the potential for greater impacts to be achieved by interlinking projects. For example, the evaluation of the healthy eating pilots has found that the fruit and vegetable bag scheme did not have the same impact on changing attitudes and values and increasing knowledge and skills as either the Community Chefs or the healthy eating pilots; however viewed as complimentary activities alongside other initiatives (Community Chefs and healthy eating training) bag schemes have the potential to significantly impact on healthy eating behaviours. A greater synergy between different activities with the same overall aim is thus recommended.

### **Recommendation 9 – Encouraging volunteer involvement**

Where pilots include volunteer time, there were clear benefits attached including developing skills and acting as a stepping stone to other activities and enabling progression. Providing opportunities for learning outcomes for volunteers would enhance their role and potentially lead to wider outcomes around increased confidence, improved communication skills and greater community and family cohesion. The impact of any volunteering activity on benefit receipt would need to be clarified to maximise the fully potential that volunteering presents.

### **Recommendation 10 – Enhance the opportunities for family focused activities**

One of the positive outcomes of the pilots was that they engaged wider family members in learning about and discussing food and health, which is an excellent opportunity to develop activities that encourage family involvement (for example, cooking together). Community chefs and healthy eating training offer excellent opportunities for intergenerational learning. Building further on Kent Cooks, the focus of future cookery competitions could be around family cooking; links to wider community activities such as local food festivals and family learning events should also be explored.

### **Recommendation 11 – Ensuring sustainability**

Sustainability (or an appropriate exit strategy) needs to be considered and planned from the outset where an activity is time limited. This will help to ensure that knowledge and expertise that has been built up (for example, by staff and volunteers) is not lost, and that as far as possible participants and the wider community can continue to benefit from the successes of the project. Clearly some of the more successful pilots benefited from the expertise of key individuals, which needs to be retained as far as possible (a good example of this is the Community Chefs programme).

## 7.1 Conclusion

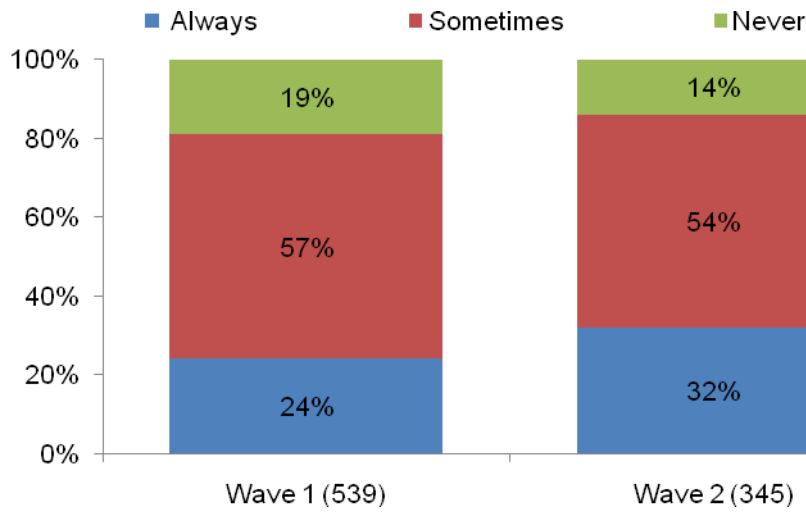
The evaluation of the community-based healthy eating pilots has resulted in an evidence base of qualitative and quantitative data that have captured both the processes involved in implementing community based initiatives, and the impacts of the initiative both on the participants as well as those involved in the organisation and delivery. The evidence clearly demonstrates the benefits of participation on individuals, on host organisations and on the wider community. These benefits can be observed both in the short term (for example, direct changes to the types of food consumed) and in the medium term (for example, increased knowledge and skills). Longer term sustained changes are more difficult to measure, often requiring many years of observation and measurement of attitudes and behaviour although the evidence does suggest that the 'travel' is moving in the right direction. However, in order for momentum to be continued, it is important that both good practice and lessons learnt from this programme of evaluation continue to inform future policy and practice around community based healthy eating interventions.

## Annex A The Pilots

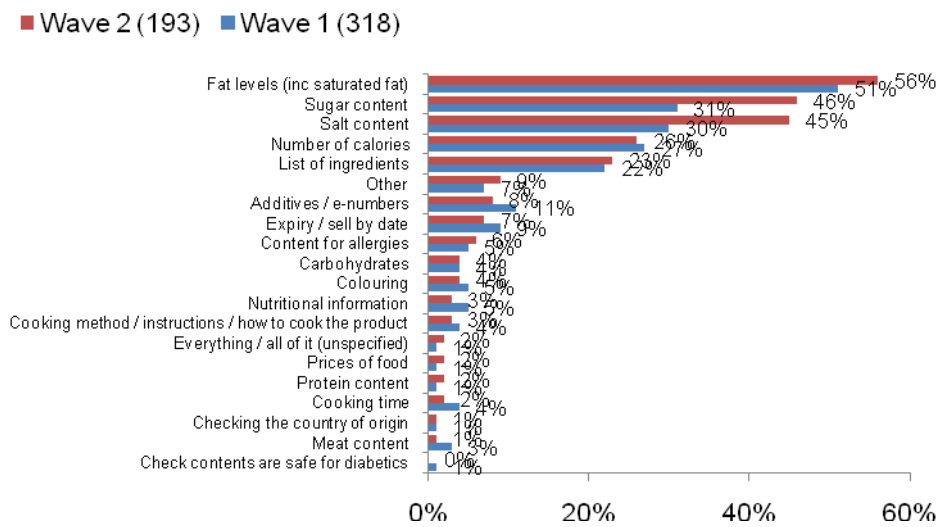
Pilot Name	Key Partners	Other Partners
<b>Pilot 1 – Community cooking skills</b>		
<ul style="list-style-type: none"> <li>• The community chef pilots (Pilot 1a)</li> <li>• Kent Cooks! (Pilot 1b)</li> </ul>	<p>Healthy Living Centres, and PCTs in East &amp; West Kent</p> <p>All schools in Kent, Community Dietician</p>	<p>Community groups for vulnerable, elderly etc, Children’s Centres, School Food Partnerships, Dietetics departments</p> <p>Healthy schools, Extended Services, Client Services, Catering colleges, catering and hospitality industry, local businesses</p>
<b>Pilot 2: Fruit and vegetable bag schemes</b>		
<ul style="list-style-type: none"> <li>• Fruit and vegetable bag schemes</li> </ul>	<p>Schools, Community organisations, Healthy Living Centres, PCT Nutritionists, Produced in Kent</p>	<p>Community volunteers and local farmers/suppliers</p>
<b>Pilot 3 – Healthy eating training programme</b>		
<ul style="list-style-type: none"> <li>• Development of the modular training package</li> <li>• Training Parent Support Advisors</li> <li>• Training Children’s Centre Staff</li> </ul>	<p>Core Team of Dietitians and Nutritionists from East and West Kent PCTs, KCC and Medway Council</p> <p>Parent Support Advisors</p> <p>Children’s Centre Staff</p>	<p>Schools</p>
<b>Pilot 4: Increasing school meal uptake</b>		
<ul style="list-style-type: none"> <li>• Increasing school meal uptake</li> </ul>	<p>KCC Client Services, KCC Healthy Schools Dietitian, five school meal contractors</p>	<p>Schools</p> <p>Healthy Schools Team</p>
<b>Pilot 5 – National Children’s Bureau Health Challenge</b>		
<ul style="list-style-type: none"> <li>• Health Challenge</li> </ul>	<p>National Children’s Bureau, Food Standards Agency</p>	<p>Schools, Healthy Schools, external agencies supporting schools around emotional health, physical activity and healthy eating.</p>

# Annex B Key Data

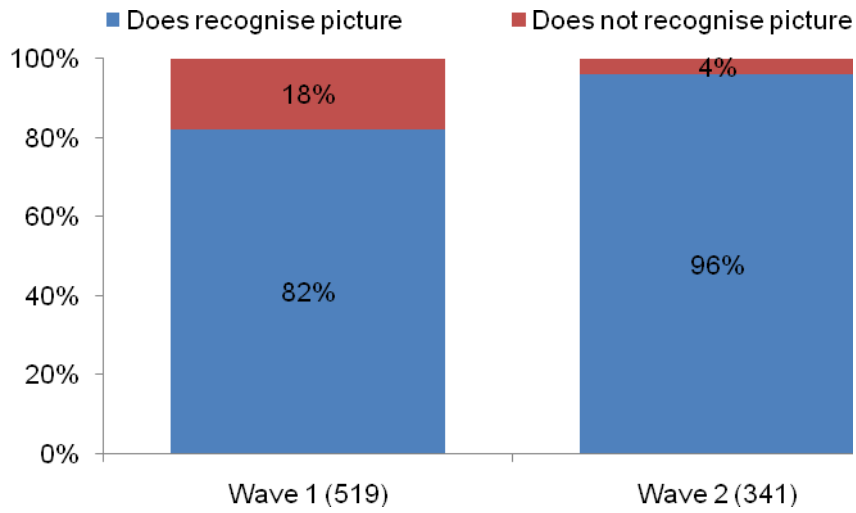
**Figure A1 Q14. Do you read food labels?**



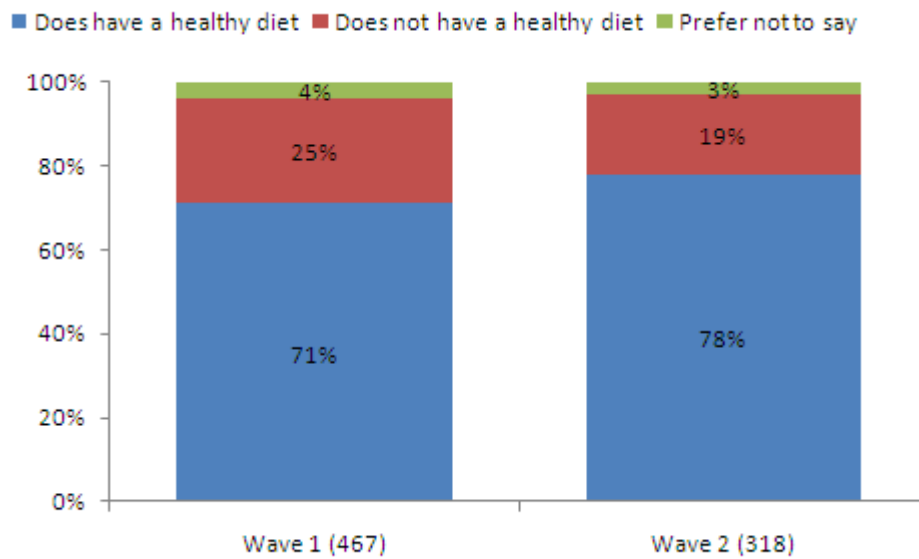
**Figure A2 Q14A. What information do you read?**



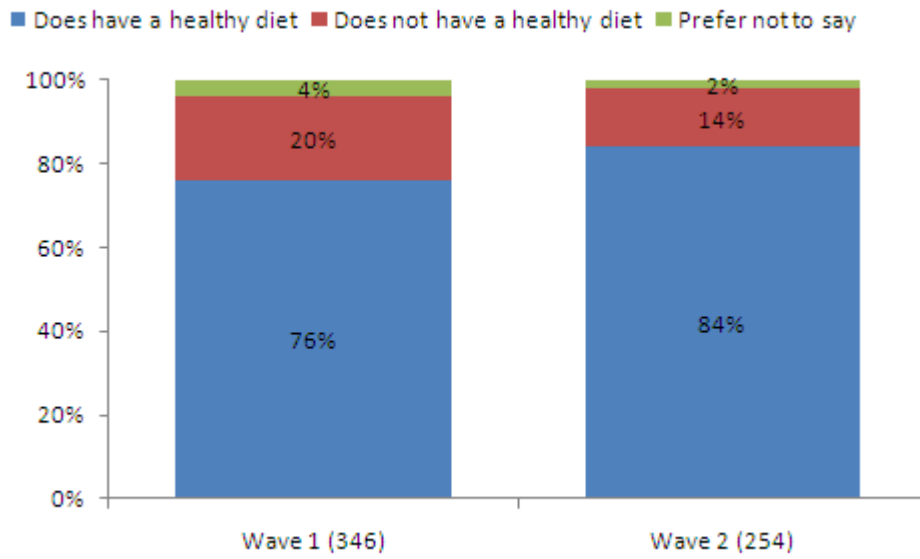
**Figure A3 Q15. Do you recognise the picture overleaf of the Eatwell Plate?**



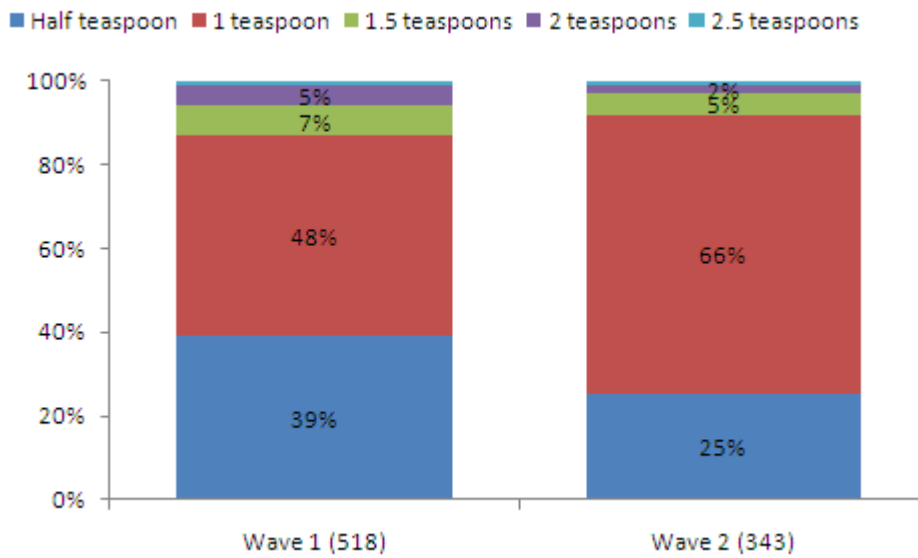
**Figure A4 Q16. Based on the Eatwell Plate do you think you have a healthy diet?**



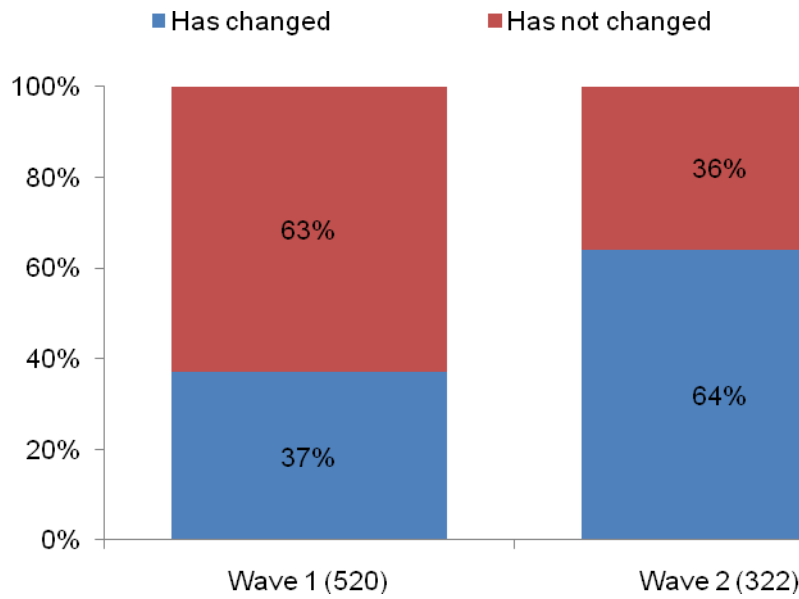
**Figure A5 Q17. Based on the Eatwell Plate do you think your children have a healthy diet?**



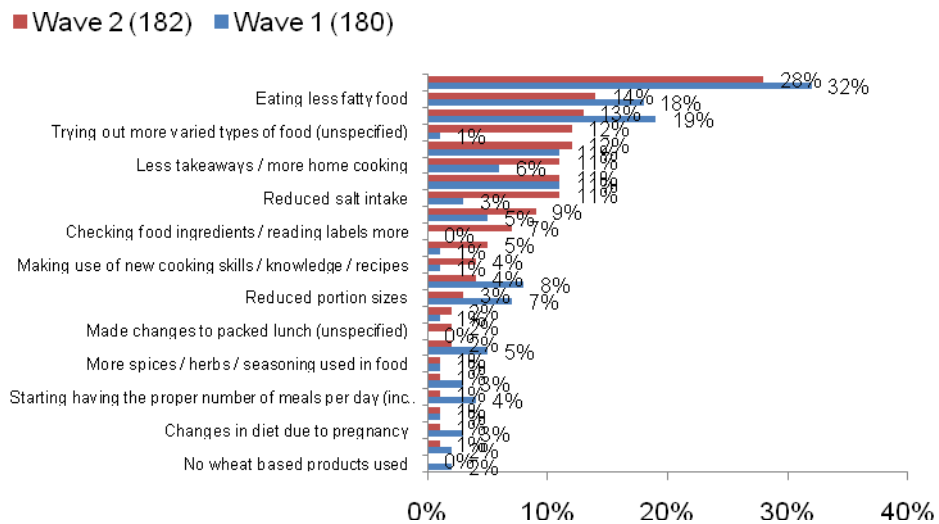
**Figure A6 Q19. What is the maximum amount of salt the Government recommend that you eat every day?**



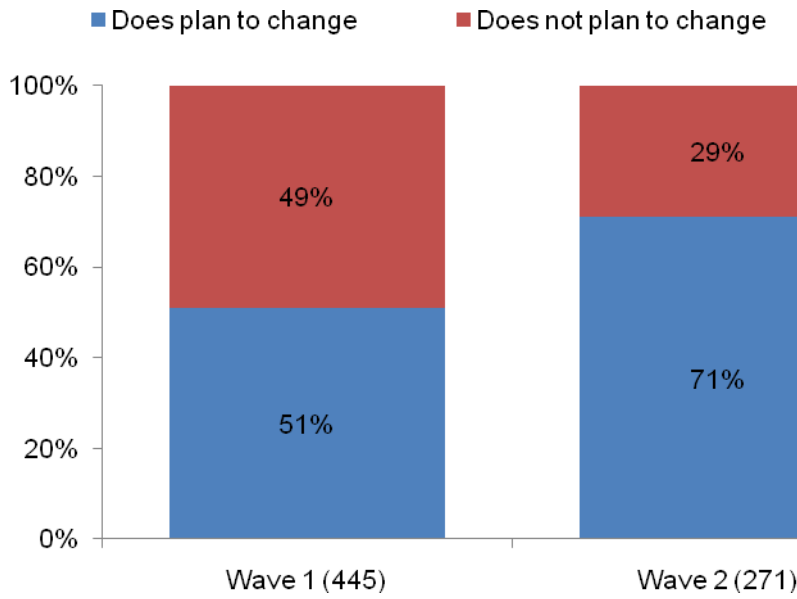
**Figure A7 Q20. Have you changed what you eat in any way recently / since you have been on this course?**



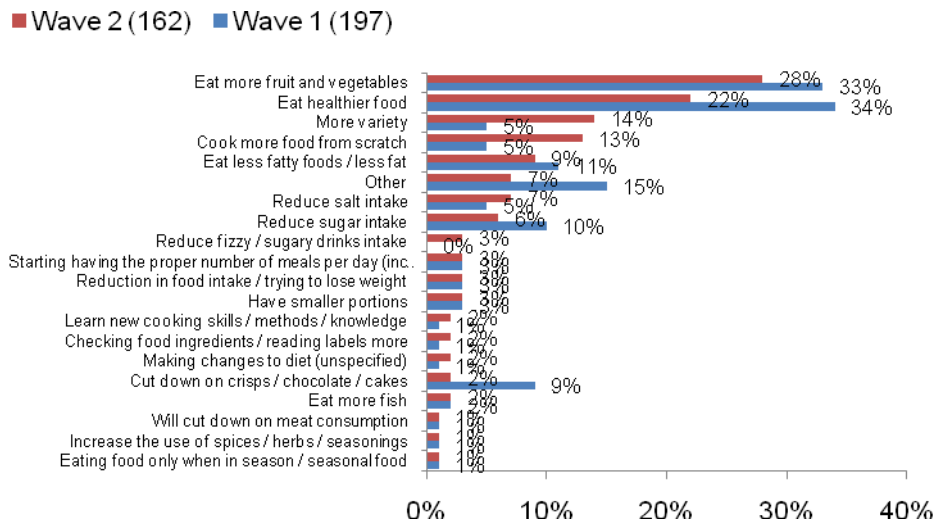
**Figure A8 ALL PILOTS - Q20A. How have you have changed what you eat?**



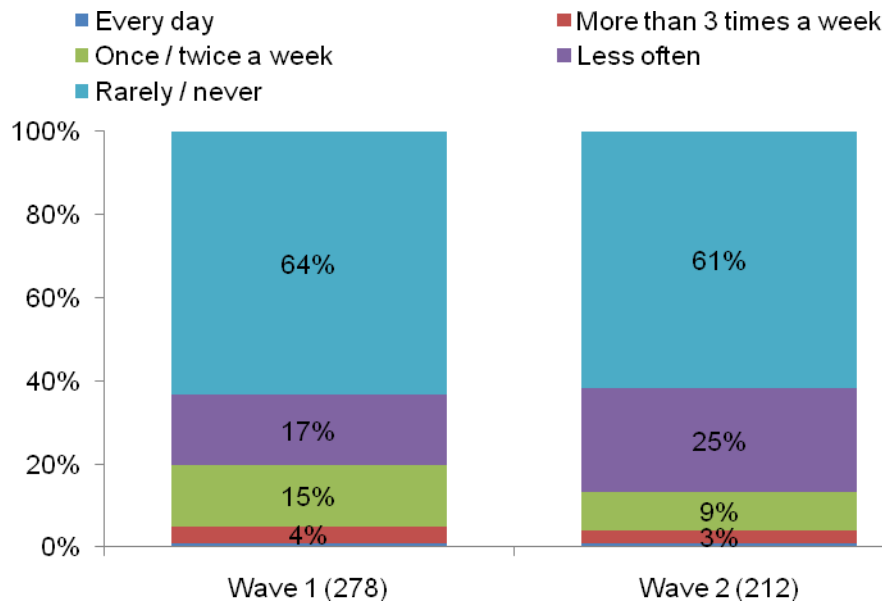
**Figure A9 Q21. Do you plan to change what you eat in any way in the future?**



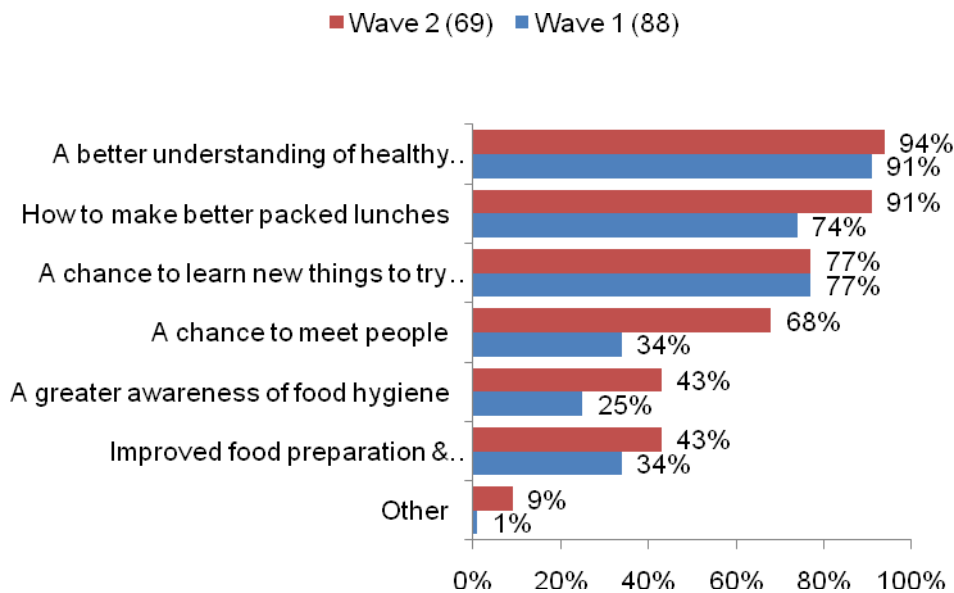
**Figure A10 Q21A. What do you plan to change about your diet in future?**



**Figure A11 Q22 (P1). Overall, how often do you use each of the following ways of cooking... : Deep frying**

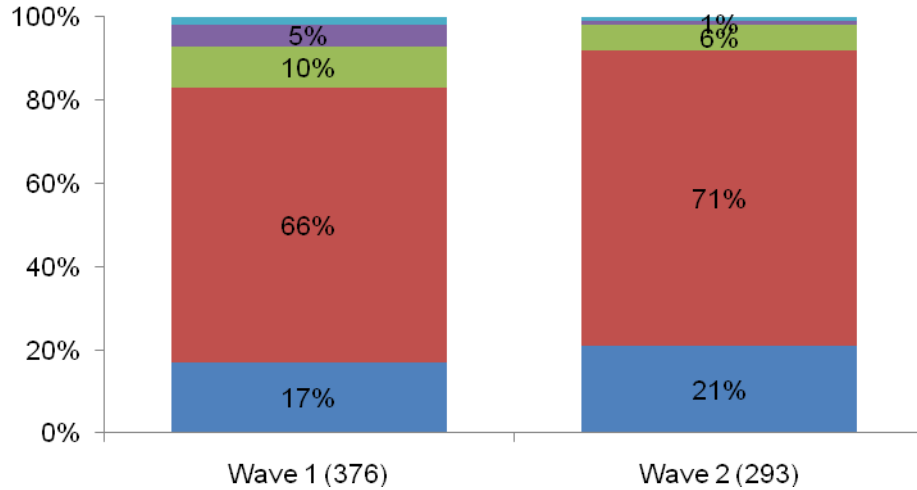


**Figure A12 Q23 (P3). What are you hoping to achieve / have you achieved from the course? (PSAs only)**



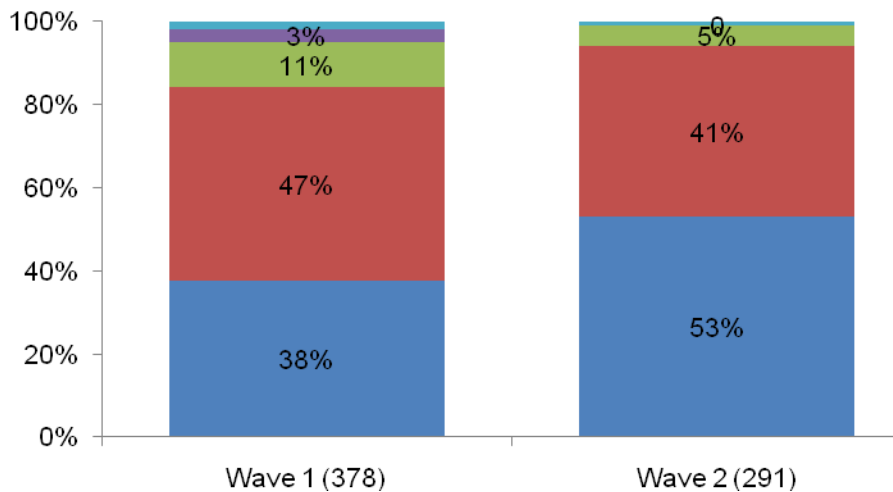
**Figure A13 Q23 (P1) & (P3,V2) / Q24 (P3,V1). How would you rate you current cooking skills when cooking at home?**

■ Very good ■ Fairly good ■ Fairly poor ■ Very poor ■ I never cook at home

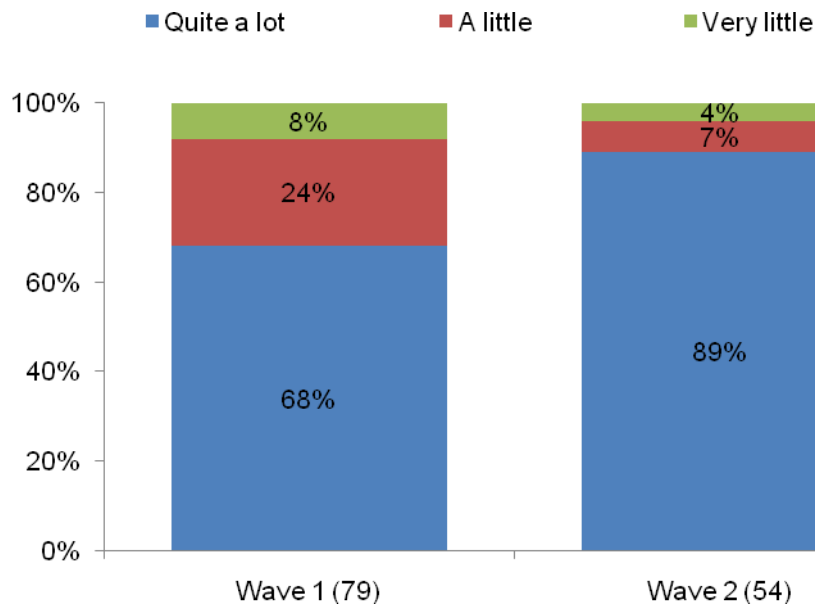


**Figure A14 Q24 (P1) & (P3,V2) / Q25 (P3,V1). How confident are you when preparing raw ingredients at home?**

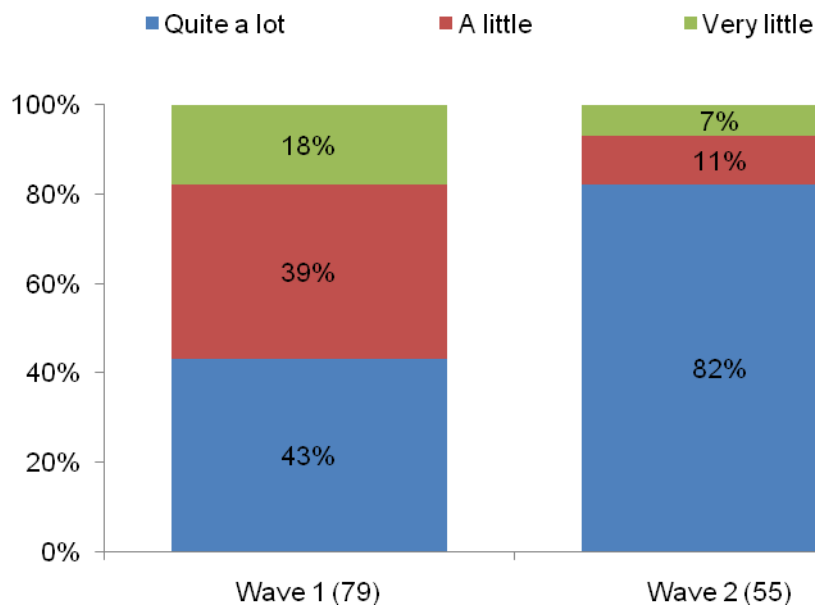
■ Very confident ■ Fairly confident ■ Not very confident  
 ■ Not at all confident ■ I never cook at home



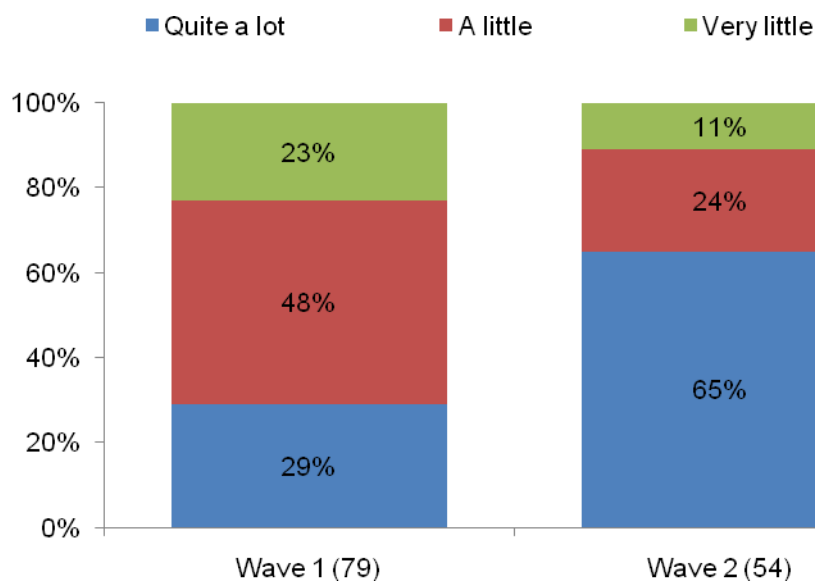
**Figure A15 Q24 (P3). Overall, how much do you know about what is considered a healthy diet for the following groups of people... : Pregnant Women**



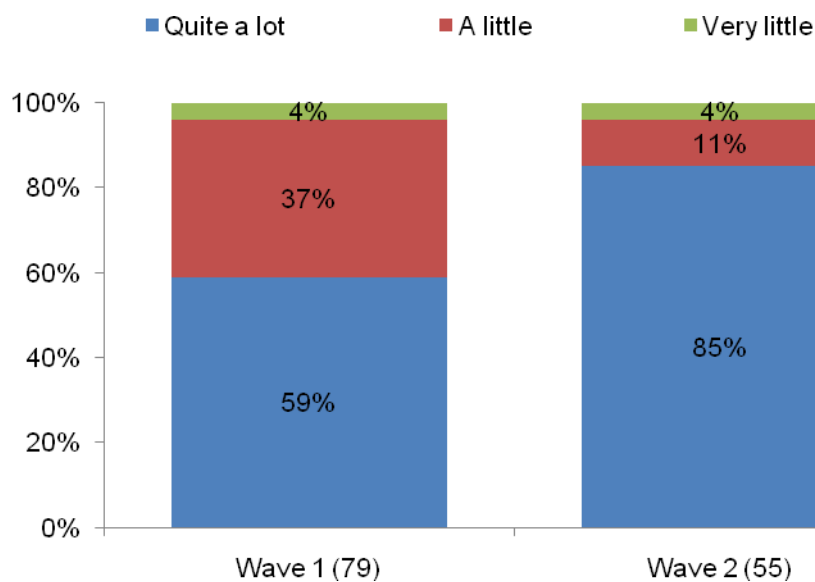
**Figure A16 Q24 (P3). Overall, how much do you know about what is considered a healthy diet for the following groups of people... : Babies**



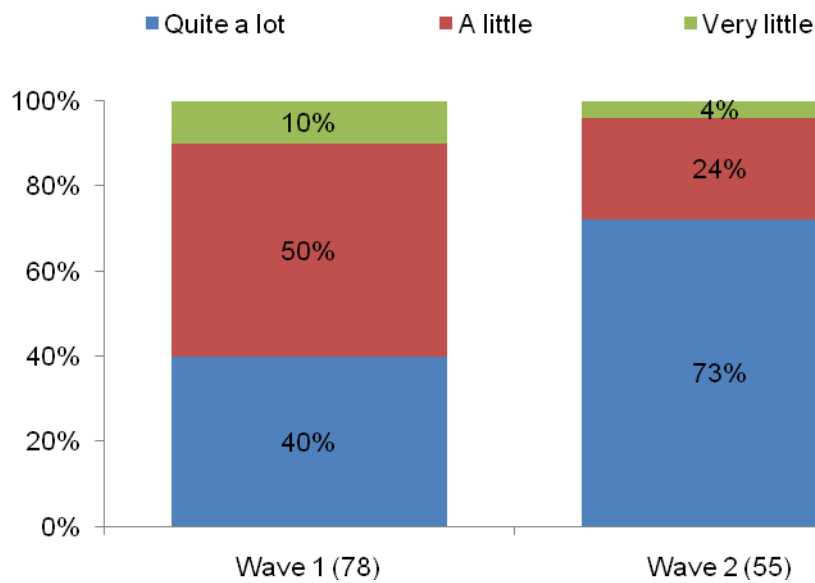
**Figure A17 Q24 (P3). Overall, how much do you know about what is considered a healthy diet for the following groups of people... : Toddlers**



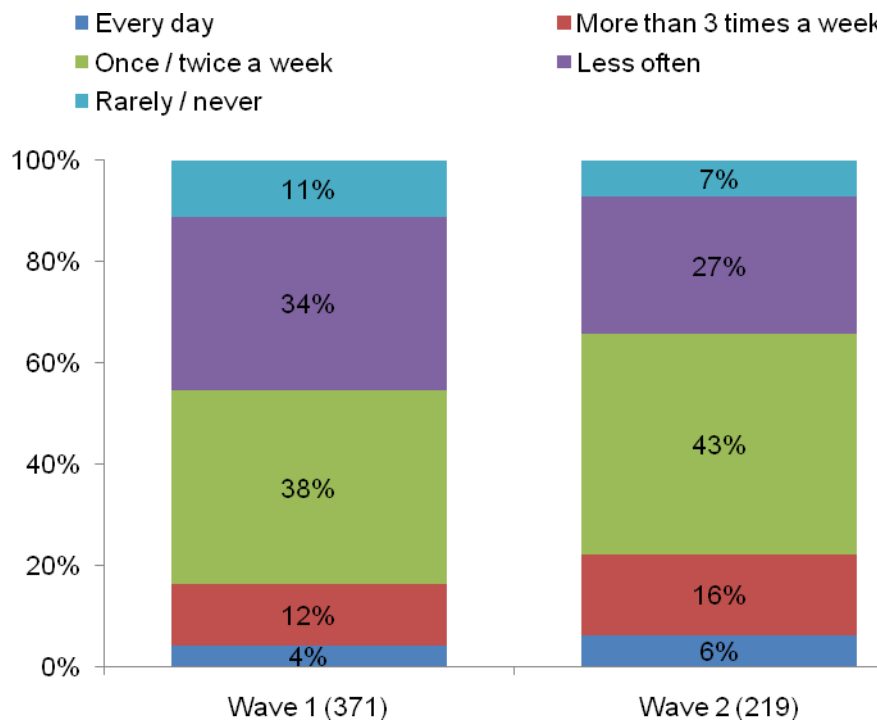
**Figure A18 Q24 (P3). Overall, how much do you know about what is considered a healthy diet for the following groups of people... : Adults**



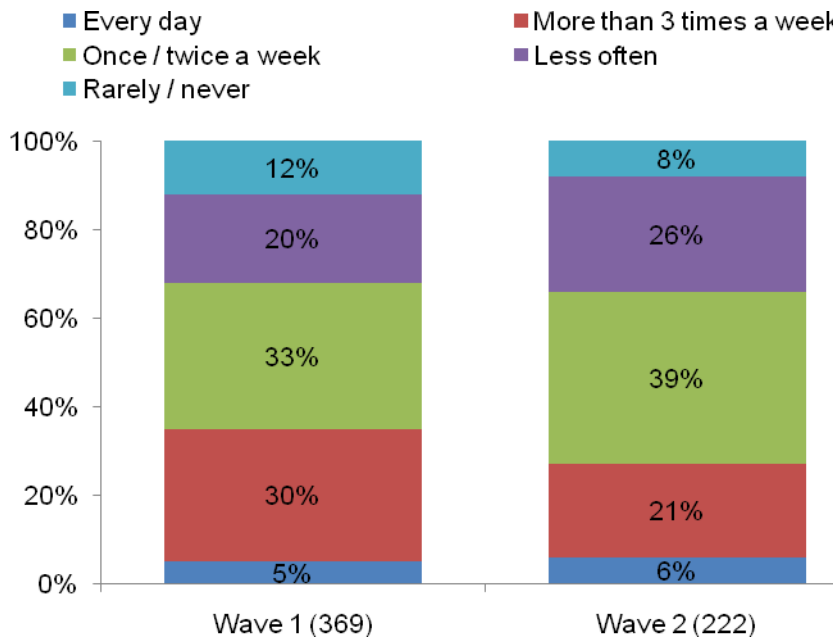
**Figure A19 Q24 (P3). Overall, how much do you know about what is considered a healthy diet for the following groups of people... : Children**



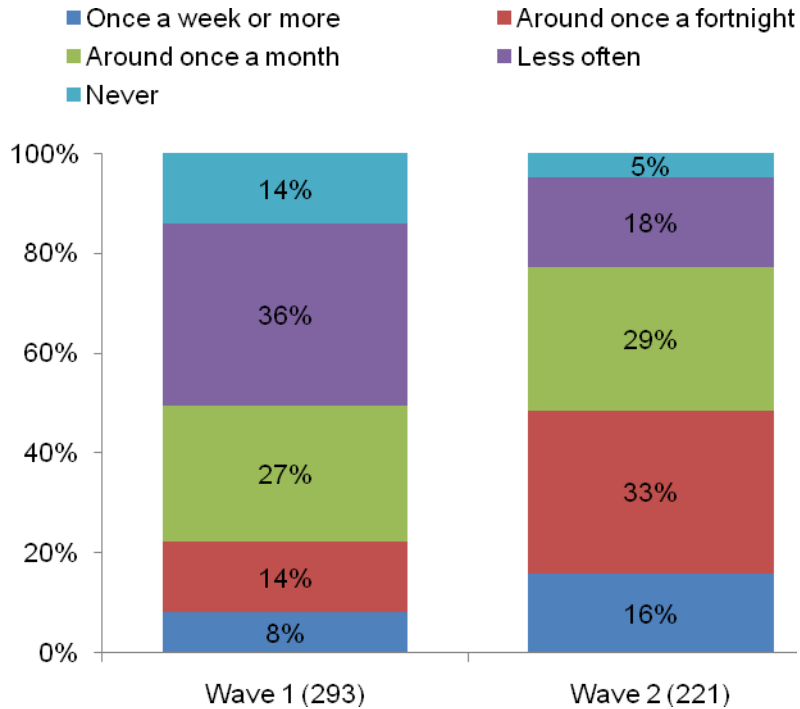
**Figure A20 Q25 (P1) / Q22 (P2). Overall, how often do you use the following type of food when cooking at home... : Fresh or frozen fish**



**Figure A21 Q25 (P1) / Q22 (P2). Overall, how often do you use the following type of food when cooking at home... : Packet mixes**



**Figure 5 Q26 (P1). How often do you try out a new recipe?**



## Because people matter, we listen.

With some 20 years' experience, BMG Research has established a strong reputation for delivering high quality research and consultancy.

Our business is about understanding people; because they matter. Finding out what they really need; from the type of information they use to the type of services they require. In short, finding out about the kind of world people want to live in tomorrow.

BMG serves both the social public sector and the commercial private sector, providing market and customer insight which is vital in the development of plans, the support of campaigns and the evaluation of performance.

Innovation and development is very much at the heart of our business, and considerable attention is paid to the utilisation of technologies such as portals and information systems to ensure that market and customer intelligence is widely shared.

