

**Option appraisal of a centrally based  
community kitchen**

**Aberdeen City 2010**

Report prepared by Mary McCallum on behalf of

Public Health Team  
Aberdeen City Community Health Partnership

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# Executive Summary

The Aberdeen City Food in Focus Steering Group consisting of representatives from NHS Grampian, Aberdeen City Council and the voluntary sector identified the need to carry out an option appraisal study to consider the way forward for the community kitchen located at Summerhill Community Centre in Aberdeen. The option appraisal was prompted in 2010 by concerns for the future of this successful partnership initiative that arose as a result of the planned closure of Summerhill Community Centre.

The aim of the option appraisal was to gather the information needed to make recommendations that will enable an informed and transparent decision about the future and long term sustainability of the Confidence to Cook (C2Cook) initiative (see note on page iv) within Aberdeen City.

## **The objectives of the option appraisal were to:**

- Provide a literature review of the evidence of the effectiveness of practical food skills initiatives for improved health and well being within the context of current public health priorities and lifelong learning.
- Review the use of the kitchen from it's opening to date (If available - no's attending; no. groups each year; age range in groups; purpose of groups - eg teenage mothers; postcodes of individuals/groups using the kitchen and possible outcomes/outputs from groups using the kitchen)
- Identify the impact of the loss of the facility from its existing location as a central resource.
- Generate a range of options for the future of the initiative.
- Assess the costs and benefits of these options (cost effectiveness).
- Identify the advantages and challenges of the options, quantifying and valuing them where possible (including the extent to which the options align with strategic NHS priorities for Healthy Eating and Active Living and SOA outcomes. This will involve looking into options available locally, e.g. in local schools and will take cognisance of emerging/final LA structures in Aberdeen City.
- Assess the risks of these options.
- Make recommendations for what represents the most appropriate option/s and best value use of resources (not simply focussing on the lowest initial costs).

## **The study involved the following key stages:**

- Researching the strategic context for, and background of, the community kitchen in Grampian
- Reviewing the literature on the evidence of effectiveness of practical food skills initiatives
- Collating examples of good practice of practical food skills work across Scotland; analysis of the use of the kitchen
- Semi-structured interviews with clients, steering group members, academics and staff involved in the original funding application for the community kitchen
- Workshop with key stakeholders to discuss and consider the pros and cons
- Risks and sensitivities of the options proposed

- Interim report and ranking exercise by key stakeholders
- Development of final report recommending the most appropriate and best value use of resources for further consideration by management

## **Context**

Since the 1990s food and health has been high on the agenda at the national and local level. Policy has developed substantially from the Scottish Diet Action Plan in 1996 to now be encompassed in the Healthy Eating Active Living Action Plan (2008) and Preventing Overweight and Obesity in Scotland: A route map towards healthy weight (2010). More recently, child healthy weight (HEAT target, 2008 - 2011) and infant and maternal nutrition (Improving infant and maternal nutrition, 2011) have become priority areas for action. However despite these strategic developments, a review of the Scottish Diet Action Plan (2007) highlighted little change in overall diet in the past decade. People are increasingly unaware of where their food comes from, how it is produced, and lack the skills to prepare healthy food for themselves.

Overall the Scottish population is still eating too much saturated fat and not enough fruit and vegetables, bread, oil rich fish and wholegrains. Scotland has one of the highest levels of obesity in the Organisation for Economic Co-operation and Development (OECD) countries. There is increasing concern about maternal and infant nutrition and the rise of childhood obesity and the implications of such obesity persisting into adulthood. There is a clear linear pattern of increasing obesity with increasing deprivation in adult women in Scotland (Scottish Government, 2010). In Grampian, it is estimated that, 22.8% of all adults are obese (<http://www.scotpho.org.uk> 2010). NICE guidance (2006) states that local authorities and health boards should ensure that preventing and managing obesity is a priority for action, dedicated resources should be allocated – at both strategic and delivery levels – through community interventions, policies and objectives.

## **Background**

The community kitchen was developed as a result of a needs assessment, conducted by NHS Grampian's Dietetic Service in 2003, which highlighted the need for practical cooking skills provision in Grampian. The community kitchen was built at a capital cost of £25,000 funded by NHS Grampian's health improvement fund. The community kitchen consists of five workstations with cooking areas and an area with a table for eating food prepared. It has been hosted by Aberdeen City Council in Summerhill Community Centre. Aberdeen City Council also covered day to day running costs and administrative support. Seven hours per week of a development workers time to facilitate the community kitchen was initially covered by NHS Grampian and latterly by Aberdeen City Council (through funds raised via income generation work). NHS Grampian has supported development and training courses through the dedicated staff time of health improvement assistants, catering advisor, community dietetics and public health staff.

Aberdeen City Council community learning and development staff and NHS Grampian staff have provided ongoing input to the community kitchen steering group.

Since 2004, the community kitchen has provided a 'one stop shop' for training in food and health for people from some of the most disadvantaged communities in Aberdeen City and across Grampian. Training and cooking skills courses address barriers to healthy eating such as declining cooking skills, menu planning on a low disposable income, taste preference.

The evidence on the effectiveness of practical food skills work is limited. Wrieden et al (2007) concluded that "*cooking skills are but one part in the healthy eating jigsaw but*

*may be a useful starting point for initiating dietary change and behaviour in the shorter term*". Confidence in ability to change behaviour in one aspect of life can be used as a stepping stone to bridge the 'intention-behaviour gap' (Schüz et al 2009). However, there are a wide range of examples of good practice in practical food skills work happening in communities across Scotland. Most of which highlight wider health benefits e.g. improved self esteem, confidence, emotional well being and community capacity.

C2Cook has been successful in attracting people to use the facility and encouraging facilitators from groups to get trained to deliver healthy eating and cooking sessions since it opened in 2004. Over three hundred people accessed the kitchen and crèche for a C2Cook session, training the trainer or training workers in 2009.

### **Conclusions and results**

From a number of interviews held over a time period of eight months with stakeholders involved in the community kitchen, key areas of achievement highlighted include:

- The range of good work achieved since 2004 in terms of tackling inequalities and the focus on disadvantaged groups e.g. homeless, people with mental health problems, substance misuse issues, young mothers, single parents.
- Strong support for continuation of C2Cook/practical food skills work in Aberdeen City.
- The usage figures of the community kitchen from across Aberdeen City and Grampian which have increased year on year since it opened in 2004.
- The partnerships developed and the wider outcomes of involvement in the community kitchen e.g. building transferable work place skills.

### **Areas for improvement highlighted include:**

- Better strategic linkage and accountability/reporting mechanisms for practical food skills work through appropriate reporting lines to partners.
- Opportunities to do more direct work such as setting up GP referral to schemes for practical food skills work.
- More development time spent on future planning, grant application, audit. Facilitating the use of C2Cook and proactively engaging with individuals, groups and services and co-ordinating usage via strategic themes.
- Learning from examples of good practice elsewhere in Scotland and the UK and developing further to become an independent and self-sustaining project.
- More of a focus on evaluation and capturing wider outcomes of involvement in C2Cook e.g. the mental health/self confidence benefits as well as any dietary change.

Due to the closure of the building where the community kitchen was based, the options listed below are recommended for further consideration:

1. **Do nothing.**
2. **Outsource the 'C2Cook' model** and rebuild a new community kitchen as a social enterprise.

Support a multi agency partnership proposal to rebuild a new community kitchen, which can operate as an independent and flexible 'social enterprise' funded by charity/income generation/lottery grant with NHS Grampian and Aberdeen City Council as key partners. (See Appendix 1 for examples of income generated by

C2Cook and section 3.3 for an example of a community food and health social enterprise programme in Edinburgh).

3. **Seek finance for relocation** of a centrally based community kitchen from within NHS/Aberdeen City Council budgets (approx capital cost £26,000). The Edinburgh Food Health Training Hub study (2009) concluded from a range of best practice investigated that having a central base that included outreach provision was the preferred option for developing a coordinated approach to food and health training.

Proposed opportunities for a replacement community kitchen include: Mither Kirk project; Dobbies/Hazelhead learning disabilities project, Intensive Community Support and Learning Project (MCMC) Westburn Road.

4. **Use existing community based facilities** available e.g. use the 'Cookwell programme developed and evaluated by a team based at Dundee University as the model (further details Appendix 2).

Improve kitchen facilities in existing community centres across Aberdeen e.g. provide 'Cookit kits'<sup>1</sup> to all suitable community centres (maximum of six) at a cost of (£881 per centre) and three table top 'baby belling' type ovens per centre (£200 each). Provide basic cooking skills targeting vulnerable groups and utilising network of locally based trainers.

Access home economic classroom/kitchen facilities in schools during evenings and weekends to provide training for larger groups (approximate costs £17.16 per hour – August 2007). Also there is the opportunity to access Robert Gordon University food handling facility (at a negotiated fee) to provide training for larger groups and to run income generation training sessions.

**Note:**

**Confidence 2 Cook (C2Cook)**

**C2Cook is a resource package developed in partnership with Aberdeen City Council and NHS Grampian to bring cooking skills into the community with emphasis on areas of inequality. Although the initiative was based in Aberdeen, at the community kitchen in Summerhill Community Centre, the resource is utilised across Grampian. C2Cook is much more than a mere training facility for the people of Grampian. The project has evolved to meet the needs of the wider community through sharing of best practice, training and development of resources.**

**Throughout the document C2Cook is the branding used to describe foodskills activities and training which take place in the kitchen and wider community.**

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<sup>1</sup> More information about Cookit Kits available from <http://www.focusonfood.org/resources.html>

# 1. Introduction

## 1.1 Background of the study

The Aberdeen City Food in Focus Steering Group consisting of representatives from NHS Grampian, Aberdeen City Council and the voluntary sector identified the need to carry out an option appraisal study to consider the way forward for the community kitchen located at Summerhill Community Centre in Aberdeen. The option appraisal was prompted in 2010 by concerns for the future of this successful partnership initiative that arose as a result of the planned closure of Summerhill Community Centre.

## 1.2 Aims and objectives of the study

The aim of the study was to gather the information needed to make recommendations that will enable an informed and transparent decision about the future and long-term sustainability of practical food skills work in Aberdeen City.

The objectives of the study included:

- Conduct a literature review of the evidence of the effectiveness of practical food skills initiatives for improved health and well being within the context of current public health priorities and lifelong learning
- Review the use of the kitchen from it's opening to date (no's attending; no. groups each year; age range in groups; purpose of groups - e.g. teenage mothers; postcodes of individuals/groups using the kitchen and possible outcomes/outputs, if available, from groups using the kitchen)
- Identify the impact of the loss of the facility from its existing location as a central resource
- Generate a range of options for the future of the initiative
- Assess the costs and benefits of these options (cost effectiveness)
- Identify the advantages and challenges of the options, quantifying and valuing them where possible including the extent to which the options align with strategic NHS priorities for healthy eating and active living and SOA outcomes. This will involve looking into options available locally, e.g. in local schools and will take cognisance of emerging/final structures in Aberdeen City
- Assess the risks of these options
- Make recommendations for what represents the most appropriate option/s and best value use of resources (not simply focusing on the lowest initial costs)

## 1.3 Method

The study involved the following key stages:

- Researching the context for and background of, the community kitchen.
- Meetings were held and documents were sourced from NHS Grampian and Aberdeen City Council staff involved in the initial needs assessment, funding application and evaluation of the pilot of Confidence to Cook (2003- to 2004).
- Reviewing the literature on the evidence of effectiveness of practical food skills initiatives.

- A senior lecturer in public health nutrition at Robert Gordon University and lead author of the evaluation of the Cookwell programme at Dundee University<sup>1</sup> was consulted.
- The Scottish Community Diet Project was contacted for information about food skills initiatives ongoing across Scotland and the UK.
- Analysis of the use of the kitchen - annual reports from the community kitchen were scrutinised and meetings held with the development worker and catering advisor closely involved in the day to day running of C2Cook.
- Semi-structured interviews with key stakeholders, representing the NHS, Community Learning and Development; the voluntary sector and clients took place over the course of eight months<sup>2</sup>. During these interviews a range of options for the future of the initiative were proposed by the interviewees.
- A workshop with key stakeholders was held to discuss and consider the pros and cons, risks and sensitivities of the options proposed.
- An interim report detailing the most practical future options was circulated. Key stakeholders were asked to rank their preferred option and provide comments.
- Final report written detailing recommendations for the future of the Community Kitchen and practical food skills work in Aberdeen City.

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<sup>1</sup> The impact of a community based food skills intervention on cooking confidence, food preparation methods and dietary choices- an exploratory trial

<sup>2</sup> See appendix 3 for list of key stakeholders interviewed

## 2. Strategic context and background of the community kitchen (C2Cook)

### 2.1 Strategic context of practical food skills work

Food and health is high on the agenda at a national level. Policy on food and health in Scotland has developed substantially since the early 1990s. Key documents and targets have included:

- The Scottish Diet Action Plan (1996)
- Improving Health in Scotland: The Challenge (Scottish Executive 2003)
- Eating for Health: Meeting the Challenge (Scottish Executive 2004)
- Review of the Scottish Diet Action Plan (Scottish Government 2007)
- Better Health Better Care (Scottish Government 2007)
- Equally Well: Report of the Ministerial Task Force on Health Inequalities (Scottish Government 2008)
- Foresight Tackling Obesities: Future Choices – project report (2007)
- Healthy Eating, Active Living HEAL (Scottish Government 2008)
- Preventing Overweight and Obesity in Scotland: A Route Map Towards Healthy Weight (2010)
- Completion rates for child healthy weight interventions (HEAT 3)
- CEL 36 (infant and maternal nutrition)

As outlined in the raft of strategic documents listed above community food initiatives are seen as a key contributor to health<sup>1</sup> which supports the delivery of the Scottish Government agenda on improving health and reducing inequalities.

However, despite much progress, Scotland still one of the highest levels of obesity in OECD countries, with low life expectancy rates across disadvantaged areas and an uphill battle in terms of dietary behaviour change and provision of infrastructure to support change.

At a local level within Aberdeen City and NHS Grampian health improvement work with a focus on tackling health inequalities and working with vulnerable groups is also prioritised in a range of documents including:

- Aberdeen City Community Plan and Single Outcome Agreement (2008-2011) and SOA (2009 - 10)
- NHS Grampian Health Plan (2010-2013)
- CHP Delivery Plan (2010/11)

### 2.2 Background of the community kitchen

The community kitchen was developed from a proposal by the NHS Grampian Community Dietetic Department in 2003 based on a needs assessment undertaken throughout 35 community education centres in Aberdeen City. Both local and national health improvement plans<sup>2</sup> noted the need for community based practical food skills initiatives. The proposal highlighted a huge unmet need for 'hands on' cooking skills due to a lack of suitable, accessible facilities within communities.

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<sup>1</sup> Scottish Government, CFHS Annual Networking Conference 2009

<sup>2</sup> Improving Health In Scotland: The Challenge and Eating For Health: Meeting the Challenge 2004

A preliminary community consultation and short life-working group guided the initial development of the project, highlighting the need for:

- A single venue
- A cooking facility rather than a community café
- Links with existing cooking skills provision
- An accessible site
- Grampian wide access

A project steering group was established to plan, manage and oversee implementation of the project. This steering group has remained relatively stable over the past seven years. It consists of a community dietitian, catering advisor<sup>1</sup>, two community learning and development Workers and a development worker<sup>2</sup>.

### **Capital cost of the community kitchen**

The capital cost of refurbishing a room in Summerhill Community Centre into a community kitchen with five purpose built work stations and an area for eating/ training in 2003 was £25,000. The capital cost was provided by NHS Grampian health improvement funds.

## **2.3 Support for the community kitchen**

Summerhill Community Centre (run by Aberdeen City Council) has hosted the community kitchen since it opened in 2004. Aberdeen City Council provided day to day running costs, heating/lighting, rates, maintenance and janitorial services. Administrative support was provided by Aberdeen City Council through clerical staff based at the centre. A development worker employed by Aberdeen City Council gave seven hours per week of their time and expertise to develop and manage the community kitchen. Community learning and development staff were members of the steering group for the kitchen.

A similar undertaking was given by NHS Grampian that a number of health professionals could devote time to the project. The lead dietitian for NHS Grampian was involved in the initial needs assessment and funding bid. Aberdeen City CHP public health dietitian provided time, skills and nutritional expertise and was a member of the steering group. NHS Grampian catering advisor provided ongoing training and expertise in evaluation and catering. NHS Grampian nutrition co-ordinator provided skills, evaluation and funding expertise.

## **2.4 Aim and objectives of C2Cook**

The original aim of the project was to address issues of confidence and skills in food preparation with an emphasis on health inequality and on building community capacity.<sup>3</sup> The project has evolved over the years. Whilst the aim remains consistent the objectives have changed to reflect the needs of client groups. Training courses (C2Cook training for trainers, REHIS - hygiene) have seen the biggest growth in the project over the past two years and play a key role in building capacity within the wider community.

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1 Community dietitian and catering advisor both employed by NHS Grampian

2 Employed by Aberdeen City Council

3 Project developed in partnership with Aberdeen City Council and NHS Grampian in 2004

## **2004**

- To develop and foster positive relationships with all stakeholders with the potential to influence community food and health improvement
- To establish a community based training facility offering experience in food handling and preparation which provides a safe environment for eating and learning
- To make a training kitchen facility available to the community creating opportunity for individuals to develop confidence around cookery skills, food and health knowledge and to encourage personal well-being
- To identify steps to ensure long term sustainability of project

## **2005**

- To develop a framework for training for trainers in house and accredited Food for Health course across Grampian
- To appoint a development worker for the project
- Continue to source funding to ensure sustainability of the project
- Continue to promote facility to vulnerable groups
- Continue to evaluate and produce relevant reports to support funding applications

## **2006**

- To increase the number of professionals accessing training, resources and relevant accredited training in food and health, nutrition and hygiene
- Continue to promote and market facility to vulnerable groups, the wider community and nationally
- Continue to source funding to ensure sustainability of the project
- Ensure the project is fully monitored and evaluated
- Ensure the kitchen operates to relevant food and hygiene standards
- Support relevant food and health initiatives

## **2007- 2009**

- Increase the number of professionals accessing training and resources
- Increase the number of professionals accessing relevant accredited training both in house and outreach
- Increase the number of community groups accessing the kitchen
- Continue to promote and market the facility locally and nationally
- Promote training for trainers to healthy living co-ordinators
- Continue to source funding to ensure sustainability of the project
- Support relevant food and health initiatives

## 3. Literature review

### 3.1 Definition of community kitchens

Community kitchens have been described as; ‘enhancing self-help and social support, while enabling participants to manage more effectively within existing social and economic structures by emphasizing food skills and alternative means of food acquisition<sup>1</sup>.’ In general, community kitchen initiatives are diverse in their goals – social support, community development, nutrition education, food security, or all of the above (Rouffignat et al., 2001; Tarasuk, 2001a; Tarasuk & Reynolds, 1999).

The C2Cook model aims to help increase people’s confidence in their ability to cook because of ‘hands on experience’ in preparation of healthy meals.

### 3.2 The public health challenge of improving nutrition, healthy eating, obesity and health inequalities

The last ten years have seen increasing recognition of the importance of obesity in the UK adult population and its association with a range of significant health problems, including type 2 diabetes<sup>2</sup>. There has also been increasing concern about the rise of childhood obesity and the implications of such obesity persisting into adulthood. Scotland has one of the highest levels of obesity in OECD countries; only the USA and Mexico having higher levels. The most recent Scottish Health Survey showed that nearly 27% of adults and more than 15% of children were obese and more than 65% of adults and nearly 32% of children were overweight and obese combined. In Grampian 20.1% of males; 25.6% of females and 22.8% of all adults are obese (<http://www.scotpho.org.uk> 2010).

There is a clear linear pattern of increasing obesity with increasing deprivation in adult women in Scotland, and it is predicted that such a correlation between deprivation and obesity may soon become apparent for adult men and children. Being obese or overweight and having a poor diet continues to contribute to high rates of chronic diseases such as heart disease, type 2 diabetes, high blood pressure, stroke and certain types of cancer.<sup>3</sup>

A review of progress towards the Scottish Dietary Targets (2007)<sup>4</sup> indicated that there has been little change in overall diet since The Scottish Diet Action Plan (1996)<sup>5</sup>. Whilst some improvement has been made towards reducing total fat, there has been no change in the intake of saturated fat, fruit and vegetables, bread, oil-rich fish and breakfast cereals.

There are marked differences in the types of foods consumed between affluent and deprived areas. Deprived households consume significantly less fruit and vegetables,

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1 A Critical Examination of Community-Based Responses to Household Food Insecurity in Canada, Valerie Tarasuk, PhD Department of Nutritional Sciences, Faculty of Medicine, University of Toronto

2 NICE GUIDANCE (2006) Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children

3 Healthy Eating, Active Living: An action plan to improve diet, increase physical activity and tackle obesity (2008-2011) [www.scotland.gov.uk/Publications/2008/06/20155902/3](http://www.scotland.gov.uk/Publications/2008/06/20155902/3)

4 Review of the Scottish Diet Action Plan (2007) [www.healthscotland.com/scotlands-health/evaluation/policy-reviews/review-diet-action.aspx](http://www.healthscotland.com/scotlands-health/evaluation/policy-reviews/review-diet-action.aspx)

5 Eating for Health: A Diet Action Plan for Scotland. (Scottish Office 1996)

brown/wholemeal bread, breakfast cereals (all types and wholegrain/high fibre) than those in affluent households. Similar trends were found in a recent UK survey of low income groups<sup>1</sup>. A National Food Policy discussion document 'Choosing the Right Ingredients'<sup>2</sup> has carried forward themes highlighted in the Review of the Scottish Diet Action Plan<sup>3</sup> about closer integration between the policy goals of improving Scotland's diet-related ill-health and those of social justice and sustainable development. The Scottish Government's report Equally Well (2008) also highlights the importance of social justice and tackling health inequalities. Large socio-economic inequalities exist in relation to the prevalence of chronic disease in Scotland.<sup>4</sup>

In 2008 The Scottish Government published an action plan to tackle issues of poor nutrition, diet and physical inactivity (HEAL 2008).<sup>5</sup> This action plan re-affirms the Government's commitment to the underlying principles and goals established in the Scottish Diet Action Plan (1996) to improve diet, increase physical activity and tackle obesity. It seeks to achieve influence in five main areas: early years, schools and school age children, adults and workplaces, older people and communities. In 2010 Preventing Overweight and Obesity in Scotland: A Route Map Towards Healthy Weight was published setting out the direction of national and local government decision-making in the short and medium term with the aim of ensuring that the majority of Scotland's population will be in a normal weight range throughout adult life thus avoiding the adverse consequences of overweight/obesity

In addition to the rising rates of obesity, importance has more recently been placed on achieving the best possible start of life, through improving maternal and infant nutrition. The diet and nutritional status of mothers before conception and during pregnancy, the feeding received by the infant in the first few months of life, the process of weaning onto solid foods and the diet and nutrition status of the growing infant all contribute significantly to the long term health of the population. "While there are gaps in the evidence about the long-term consequences of poor maternal and infant nutrition, and we do not as yet understand the mechanisms fully, it is clear that steps need to be taken to promote healthy diets in young women and their families, to encourage breastfeeding and the use of appropriate complementary foods."<sup>6</sup>

Although there has been national and international recognition of the need to promote and support breastfeeding for a number of years, resulting in positive action across many agencies, there has not always been the same focus on improving the nutrition of pregnant women, nor on the nutrition of young children beyond milk feeding.

A multi-sectoral approach is required to address the wide range of individual and environmental barriers to healthy eating/physical activity such as low disposable income, limited access to good-quality food at affordable prices, declining cooking skills, taste preference, social network factors (e.g., family, friends) food marketing (Stead et al 2004, Story et al., 2008).

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1 Nelson M, et al., (2007). Low income diet and nutrition survey. Food Standards Agency, London

2 Choosing the right ingredients 2008: The Future for Food in Scotland: Discussion Paper . Scottish Government  
<http://www.scotland.gov.uk/Publications/2008/01/23111646/0>

3 Review of the Scottish Diet Action Plan. NHS Health Scotland (2006) Edinburgh

4 Scottish Government's Task force on tackling inequalities: Equally Well Report of the Ministerial Task Force on Health Inequalities June 2008 (<http://www.scotland.gov.uk/Publications/2008/06/09160103/0>)

5 Healthy Eating, Active Living: An action plan to improve diet, increase physical activity and tackle obesity (2008-2011)  
<http://www.scotland.gov.uk/Publications/2008/06/20155902/0>

6 Early life nutrition and lifelong health, British Medical Association, February 2009

The evidence suggests that the “provision of health information, although important, is not sufficient and that to make the changes necessary we have to reshape our living environment from one that promotes weight gain to one that supports healthy choices”.<sup>1</sup>

### 3.3. Summary of evidence on practical cooking skills projects

In reviewing the literature for this report it was apparent that the evidence base on effectiveness of practical food skills interventions in changing behaviour is limited. Researchers from the University of Dundee Public Health Nutrition Centre concluded, “...the overall impact of practical food skills interventions on food preparation habits and dietary intake has not been systematically assessed to present an evidence base for cost-effective and efficient work in this arena”. (Wrieden et al 2007). However they did highlight that “A food skills intervention is likely to have a small but positive effect on food choice and confidence in food preparation. Cooking skills interventions are but one link in the ‘healthy eating jigsaw’ however pilot studies suggest they may be a useful starting point for initiating dietary change and influencing behaviour in the short term”. (Wrieden et al 2007). Healthy food choice is not solely due to lack of information about what constitutes a healthy diet. Research conducted by the FSA (2007) found that people on low incomes can describe a healthy diet as well as those on higher incomes. Lobstein (1997) stated “Food consumption should be examined within the context of individual’s daily lives. Improving knowledge alone is ineffective in improving people’s diets”.

People are increasingly unaware of where their food comes from and how it is produced, what constitutes a balanced diet, and are unable to prepare healthy food for themselves. “Since the second world war, the British have altered what they eat to a remarkable degree. A previously unimaginable range of foods and ingredients, from pizzas to yoghurts to muesli, are now mass market items” (Caraher et al. 1999). Millstone and Lang (2003) state Britons have the “fastest” food habits in Europe and eating “on the hoof” is a growing feature.

The Cookwell project (2002) was a research project that aimed to increase consumption of ‘healthy foods’ amongst participants attending cookery courses in low-income communities across Scotland. Participants did improve their diet slightly after completing a cookery course. Unfortunately, this improvement was not sustained six months after the course had finished. They did find however, that former participants were eating or tasting a wider variety of foods, were preparing meals from basic ingredients and were experimenting more with their cooking. The former participants reported that they had more confidence and a sense of pride about their skills. They also said that the barriers to cooking more often were because of family tastes and preferences and because of caring responsibilities (Wrieden et al 2007) (See Appendix 2 for more details).

Key principles for interventions aimed at changing health related behaviours have been outlined by NICE (2007). These include creating an environment where social support is provided by peers; helping clients to develop and maintain supportive social networks; promoting resilience by building skills and providing access to financial/ material resources to help facilitate behaviour change; providing training and support for those involved in changing peoples health related behaviour.

There has been a gradual decline in cooking skills in the UK. Acquiring good cooking skills is viewed as old-fashioned and no longer necessary in an increasingly technology based world. Young people rated cooking food in a microwave rated higher than cooking from scratch (Caraher et al 1999).

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<sup>1</sup> Preventing Overweight and Obesity: A Route Map Towards Healthy Weight (2010)

Conversely while cooking skills and confidence have been in decline, public interest in food has soared, influenced by increased choice, TV programmes and commercialisation (In 2008 Jamie Oliver claimed “This is the first time in British history that we have a large number of people who cannot cook.” He called on the government to invest £6.5bn in food education over the next decade and called for controls on the fast food industry to counter the commercial influences pushing people to eat unhealthily).

The C2Cook model provides an excellent example of these principles in action e.g. training and support for those involved in changing peoples health related behaviour is provided via Training for Trainers and REHIS courses; material resources to help facilitate behaviour change are provided via C2Cook packs. Over 6 years of evaluation and testimonials from clients using the community kitchen have highlighted increases in self-efficacy/ self confidence.

### 3.4. Examples of practice

A large number of community diet projects in Scotland have sought to improve confidence and skills in cooking and shopping. A wide range of community food and health initiatives were explored for this study. The key terms for inclusion in the review where practical food skills, and working with low income/vulnerable groups.

Some alternative food and health projects and examples of practice in other areas highlighted during interviews with stakeholders and a review of the Community Food and Health Directory<sup>1</sup> of the Scottish Community Food and Health Organisation include:

- ‘Get Cooking’ (West Lothian 2003-ongoing)
- Huntly Food and Health Project (2005-ongoing)
- Fife Learning Disability Healthy Living Initiative (ongoing)
- Edinburgh Cyrenians -Good Food in Tackling Homelessness Programme (an example of a community food initiative which has become a social enterprise)

#### **Get Cooking**

The ‘Get Cooking’ programme has two elements. The first is practical cooking skills courses delivered in identified areas of deprivation and with specific vulnerable groups e.g. the homeless. Courses include budgeting skills and how to eat healthily on a low income. The second element is a nutrition skills course, which teaches others to deliver ‘Get Cooking’ thus building capacity across West Lothian. The nutrition skills course consists of eight units. Unit one covers the key areas of diet and nutrition and after completion of this unit participants are able to deliver ‘Get Cooking’ sessions in their own place of work and register with the ‘Get Cooking’ tutor network; find out about related projects and get access to various resources, such as equipment, promotional materials and teaching aids. Units two to eight offer a range of individual modules, delivered over a period of one year, and cover more specific training in nutritional age groups, other areas related to nutrition and health and further teaching and community development skills.

A ‘Certificate in Community Food and Nutrition Skills’ is awarded upon completion of all eight modules. ‘Get Cooking’ was originally funded as a three-year Big Lottery initiative, but since April 2007 it has been mainstreamed into the work of the West Lothian Council Social Policy (Rijsdijk 2009).

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<sup>1</sup> <http://www.communityfoodandhealth.org.uk>

## **Huntly Food and Health Project**

The Huntly Food and Health Project<sup>1</sup> was established in November 2005 in response to identified issues relating to the diet and lifestyle of the community where there is considerable deprivation. This multi agency project was set up to tackle poor eating habits and to promote the health and wellbeing of the people living in the Huntly area of Aberdeenshire. The project developed a central community kitchen in Huntly which is run by Aberdeenshire Council.

The cost of the kitchen fitting was £26,000. The resource is supported by a development worker and NHS Grampian's catering advisor. Partnership working in the planning and delivery of projects was established from the outset which has enabled the kitchen to be utilised as an engagement tool to work with a variety of vulnerable groups including, confidence and life skills courses with parents, 'alternatives to exclusion', tailored work with young people who have additional needs; harder to reach parts of the community.

REHIS Food Hygiene, Nutrition and Training for Trainers courses are provided so that participants can form groups of their own or be up skilled to support other community groups they may be involved with. A crèche is available in the centre so young parents can attend.

## **Fife Learning Disability Healthy Living Initiative**

Fife Learning Disability Healthy Living Initiative was established in September 2008 by a partnership between Fife Council, NHS Fife and Fife Community Food Project. It was developed for a small group of women with learning disabilities living in the Glenrothes and Kirkcaldy areas in Fife. The project received funding through Fife Community Food Project.

The aim of the project was to empower people with learning disabilities to improve their health by providing education around what constitutes a healthy lifestyle and to increase opportunities to improve social and interpersonal skills and overall self esteem. The main objectives were to provide opportunities to develop skills in menu planning, shopping, cooking, food tasting sessions and basic food hygiene achieved by:

- Food tasting sessions
- Information on healthy eating
- Practical cookery classes

## **Edinburgh Cyrenians - Good Food in Tackling Homelessness Programme, an example of a community food initiative which has become a social enterprise<sup>2</sup>**

The 'Good Food in Tackling Homelessness' programme was launched in 1999. The programme is based within a depot in Leith in Edinburgh. In addition to an operating area which can accommodate two refrigerated vans and a forklift truck, the premises include a commercial refrigeration plant, a training kitchen, training room and offices. The project has four members of staff and a team of 70 trainees and volunteers. The programme has four distinct food and health components:

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<sup>1</sup> The Huntly Food and Health Group, report October 2007 – March 2010

[www.hi-netgrampian.org/hinet/file/5891/HFHGReport2010.pdf](http://www.hi-netgrampian.org/hinet/file/5891/HFHGReport2010.pdf)

<sup>2</sup> Social Enterprises can be identified through three common characteristics: enterprise orientation, explicit social aims and some form of social ownership. Social Enterprise Institute, 2005

1. Food redistribution - A Fare Share<sup>1</sup> project that delivers good quality surplus food to projects working in the fields of homelessness and social exclusion. Around nine tonnes of food is delivered each week providing greater choice and nutritional value for some of the most vulnerable groups in the community.

2. Traineeships and volunteering - The project has around 70 volunteers. In 2008, 84% of the 11,000 hours of volunteering completed was contributed by individuals who have issues around homelessness, mental health and other complex needs.

3. Cooking classes - Cooking classes are provided aimed at people who have little or no cooking experience, and provide inspiration on how to eat well on a budget in a supportive teaching environment. At the end of each class the participants eat together, enjoying the social benefits that good food can bring. Last year 126 small group classes were run.

4. Improving provision and practice - Learning is shared with organisations working with people who are experiencing homelessness and complex needs issues. A handbook has been produced that is used by organisations seeking to improve awareness of healthy eating and teach basic cooking skills. In addition, an annual Food Conference, is held, which provides a chance for organisations to find out how good food can be used creatively to support people overcoming homelessness.

### 3.5 Lifelong learning priorities and summary of evidence

The social benefits of cooking skills interventions are consistently highlighted in the literature e.g. social support networks; enhancing community capacity; emotional and tangible support; decreased isolation and increased cultural integration; improved personal health practices and coping skills; healthy childhood development (Dobson et al., 2000; Fano et al., 2004; Racine & St-Onge, 2000; Tarasuk & Reynolds, 1999).

Literacy and numeracy are embedded within the courses provided in cooking skills interventions, reading and understanding recipes and measuring ingredients being two obvious examples, e.g. Healthwise. Like other classes run under the auspices of community learning and development the personal development of the participants and workers is also paramount. (See Appendix 4 for case studies of involvement in the community kitchen).

The main disadvantages of community kitchens are seen to be in relation to short term funding and in bringing about behaviour change. Laverack and Labonte (2000) suggest that “too short a programme time frame runs the real risk of initiating healthy community changes, only to end before such changes have reached some degree of sustainability”

The literature on health promotion emphasizes that a key determinant of health is social support networks (Labonte et al. 2005). Research on community kitchen and community garden projects highlight the social importance of the projects, and suggest that this is a key area where cooking skills interventions succeed as a health promotion project. (Engler-Stringer 2005; Tarasuk 2001). The impact of the project extends beyond the confines of the project itself, various financial, material, human and knowledge resources become available to community members that help to enhance their capacity (Laverack and Labonte 2000).

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<sup>1</sup> FareShare is a UK charity that supports communities to relieve poverty by promoting, developing and supporting the redistribution of quality food that is surplus and fit-for-purpose, and by providing training and education [www.fareshare.org.uk](http://www.fareshare.org.uk)

## 4. Analysis of the use of the community kitchen

### 4.1 Summary of usage

Since opening the number of cooking sessions delivered in the community kitchen has increased from 90 in 2004 to over 300 in 2009/10. See tables below.

#### **Disadvantaged and vulnerable adults**

Much of the work C2Cook does is with disadvantaged and vulnerable adults across Grampian. Participants have included those in supported housing, agencies who work with people with mental health problems, adults with learning difficulties, people with alcohol dependency, young parents and women's groups. The focus of the work in Aberdeen City is with clients/groups based in the priority neighbourhoods identified in the Community Regeneration Strategy which include Torry, Tillydrone, Middlefield, Woodside, Seaton, Cummings Park, Northfield, Stockethill, George Street and Mastrick.

#### **Early years and young people**

Developing cooking skills and healthy eating messages for early years and young people are a key focus of C2Cook. Cooking classes for parents of young children and young people are delivered by C2Cook with the goal of increasing vegetable and fruit consumption, reducing the risk of chronic illness, and helping children establish lifelong healthy eating habits at an early age. Work with children and young people has involved play-schemes, primary schools, youth groups from both community learning and development centres and the voluntary sector, secondary schools (both local authority and private), young carers, looked after children, young people with substance misuse problems and young people from the Gypsy Traveller Community.

#### **Building capacity**

Building capacity of local people and other agencies to deliver cooking skills and food and health/hygiene messages to communities across Grampian has been a growth area for C2Cook. Staff from a wide range of agencies have attended Training for trainers e.g. from family centres; residential units; supported housing units, mental health teams; schools and youth groups. Training for trainers and the accredited health & hygiene training REHIS course proved a very popular addition to the initiative, not only enabling workers to cascade their training through their organisations but providing income generation and marketing for C2Cook.

#### **Community kitchen activity 2004 - 2009**

<b>Activity</b>	<b>04/05</b>	<b>05/06</b>	<b>06/07</b>	<b>07/08</b>	<b>08/09</b>
Number of groups	96	163	240	251	279
C2Cook training for trainers	1	4	4	5	5
Income generating sessions	1	34	68	43	54
REHIS courses		2	10	10	25
Number of participants on accredited 'Food for Health' course	1	1	5	0	0

### Kitchen usage by number of sessions (City, Aberdeenshire and Moray) 06 - 09

Group	Number of Sessions			Group	Number of sessions		
	06/07	07/08	08/09		06/07	07/08	08/09
Aberdeen Foyer	19	31	21	St Fitticks House			2
Aberdeenshire C2Cook T4T		3		North East Community Care		6	24
Acorn Project - Craigielea	3	5	5	Portlethan Teenagers	2		
Adult learning		1	2	Mastrick Young People's Project	5	14	24
Albyn House	12	7		Momentum	21	12	15
Bervie School	1	1		REHIS Courses *food and health	11	9 2	13 4
Bramble Brae School	10			Richmondhill	5	9	
Bread Maker*	3			Quarryhill Parent and Child Group			18
Childrens cook classes	7			Powis cooking group Give kids a chance	4	1	
CL&D Mental Health Team	4	8	12	Tilly Youth Project		8	1
Connections women's group	1			Robert Gordon College*	40	32	37
Cornhill Outreach	9	12	25	Residential Weekend			1
Cummings Park	2			Pathways	7	2	
Deafinitely cooking *	14			Pillar	1	7	4
Fairshare		1		NHSG		2	5
Feeling Great	1	1		Weight management review		2	10
Fernielea School		5		St Machar Parent Support	2	2	1
Fersands Project	10	2	10	Smithfield School	9		
Marchburn		1		Springvale School	3		
Northfield Christmas leavers	2	8	12	Tillydrone flats Heathryfold flats		12	3 1
Healthwise	6			Newhills CG	2		
Home support	10	2	2	Elderly cooking classes			5
Inverurie Job Club	1			Supported Housing	4		
Kincorth Academy		1	1	Bankhead Academy		1	
Mastrick Sup up Club		1		Ashgrove Dads Group		7	8
Middlefield		3		Travellers		6	
Training for Trainers	3	10	10	WEA Reach Out		5	1
Turning Point	1	5		Play schemes	5	4	

**Sources:**

**C2Cook Progress Report: October 2004 – March 2007**

**C2Cook Progress Report: April 2007 – March 2009**

**\*Indicates income generation**

## Examples of C2Cook sessions delivered in the kitchen

Aberdeen		
Health Literacy Group Cummings Park	Adults with literacy problems (approx 6)	8 sessions
Foyer Life Shapers	6-10 young adults	2 sessions
Quarry Family Centre	6 parents	2 sessions to support worker following training for trainers
Tilly Youth Project	6 Single mums	3 sessions
Foyer, Victoria Road	20-25 young people	1 healthy BBQ to celebrate launch of new gardening project
Cornhill Community Centre	6-10 Young mums 6 Vulnerable adults 6 Mums with primary school aged children	4 sessions 6 sessions 6 sessions
Disabled Young Mum	With a 2 year old child	4 sessions, delivered in her own home due to lack of disabled access facilities
Momentum	3 x 6 Mental Health Clients	6 sessions per group
VSA Mastrick	2 x 16-25 year olds with learning difficulties	6 sessions
Outreach Cornhill	6 adults recovering from severe mental health problems	8 sessions
Fulton Clinic, Cornhill	5 mental health clients 6 adults, part of rehab programme, group to make own cookery book in literacy class	6 sessions 8 sessions
Sunnybank Community Centre	6 Young mums	4 sessions
Powis Community Centre	6 Young mums 6 Young mums	4 sessions 5 sessions
Ready Steady Cook	10 Young women, part of Feeling Great Event	2 sessions
Robert Gordon's College	4 x 6 <sup>th</sup> Year pupils – part of independent living programme	10 sessions per group
Seaton Project	26 primary pupils	3 sessions
Supported Housing	2 x 6 Mental Health Clients	4 sessions per group

## 4.2 Reported outcomes

Evaluation of C2Cook sessions is completed by participants or facilitators after each session. The feedback forms have evolved over the course of the project to capture more information. There are gaps in capturing this data as some clients have literacy issues and not all facilitators complete the necessary paperwork. However from available feedback participants reported that:

- Taking part in C2Cook has had a positive effect on their confidence and health and well being. Knowledge gained by participants on courses is shared with family, friends and others.
- Professionals report they use the experience to develop the skills of their own clients and staff and have a better understanding of the potential for using the development of cooking skills as a vehicle for building confidence and self esteem.

- The outcomes that participants, professionals and steering group members most often associated with C2Cook were improved self esteem/confidence; cooking skills/enjoyment of food and relationship building.

### **Self esteem/confidence**

When trying to explain the purpose of the project, a key stakeholder (during interview) highlighted:

*“Food work and cooking skills is positive health promotion, you are not saying ‘do not do’ you are saying ‘this is how to’. It can be an excellent vehicle for developing a range of life skills, particularly social skills and confidence. Food activities can be useful as a way of engaging with vulnerable participants, or as a way of encouraging them to participate in other activities.*

Another key stakeholder working with ex drug users in the community kitchen reiterated the positive focus of C2Cook:

*“It promotes healthy cooking and eating to the most vulnerable in the community. It’s fundamental ‘ill health prevention work’. Particularly useful for people who have had long term drug misuse and are trying to get off drugs. One thing that affects them is their health, having a good cooking and eating regime in place really helps and boosts self confidence. You can discuss difficult topics issues in a casual way while the dads are cooking. Actively doing something is a real confidence booster. I have now got four dads ready to be trained as facilitators this is a great step forward from where they started.”*

Another key stakeholder highlighted:

*“Helping people to gain or regain skills around cooking food can be a powerful way to help people change their behaviour in other spheres of life, gaining confidence around one aspect of life can lead to positive health behaviours in other areas of life.”*

It was reported that participants’ often have had negative experiences in previous learning environments. An important theme that came up with participants about C2Cook was the relaxed atmosphere of the kitchen, the fact that it was a large dedicated space with no stigma attached to being there.

### **Cooking skills and enjoyment of food**

A common theme highlighted by participants and workers was increased confidence around food skills and experimenting with food as a result of C2Cook:

*“It’s given me more confidence, I read food labels now and know about what fruit and vegetables to eat, I tried marrow the other week. Something I’ve never tried before”*

*“The thing is people who come into the kitchen whether its young mums or carers are people who don’t know-how to cook or prepare a meal it gives them a kick start and knowledge about menu planning and confidence that they can do it, use ingredients and experiment.”*

### **Relationship building**

Building relationships was a further theme highlighted by participants.

*“You get to meet people of all ages and meet friends”.*

*“Cooking helps breaks down barriers to communication, people feel more relaxed to talk with their hands covered in flour.”*

*“Training with other carers is really useful. Usually this is quite an isolated job nice to get together and share experiences and ideas.”*

What was notable was that the perceived outcomes of the C2Cook were not limited to physical health. While participants saw physical health benefits, they also saw broader mental and emotional health benefits as a result of participation.

## 5. Interviews with key stakeholders

### 5.1 Main themes

Semi-structured interviews with 14 key stakeholders, representing the NHS, community learning and development, the voluntary sector and clients took place over the course of eight months. During these interviews key areas of achievement; areas for improvement and ideas for the way forward were highlighted and a range of options for the future of the initiative were proposed. For a list of all those interviewed and interview guides see Appendix 3 and 5.

#### **Key areas of achievement**

Strong support for the continuation of practical food skills work in Grampian.

The services provided by the community kitchen are well placed to deliver interventions which will help meet NHS national policy outcomes on improving diet and tackling obesity<sup>1</sup>. Much of the focus of the work in community kitchen has been working with vulnerable families to try and establish life-long habits and skills for positive health behaviour.

The community kitchen has been very well used by groups and individuals across Aberdeen City and wider Grampian area. In 2009 over 300 individuals accessed the kitchen including: children and young people; carers; homeless, people with substance misuse problems, adults with learning difficulties; young parents and women's groups. (See Appendix 4 on case studies for further details).

The outcomes achieved by involvement in practical food skills work have been wider than healthy eating. For example, building transferable work place skills has been a key focus area. In 2007 "Pathways to Catering" was launched - a six week course designed specifically for Christmas school leavers with few qualifications and limited career prospects. This initiative targets young people who, for a variety of reasons, are disengaged from school education. The programme aims to provide skills relevant for work in the care or hospitality sector. Participants attend the kitchen for one day each week and progress through REHIS courses in food and health and food and hygiene course. The progress made by the young people taking part in the programme in terms of self-esteem, confidence and personal development has been tangible and many have gained accredited qualifications that they can take into the job market.

#### **Quotes from key stakeholders, clients and workers involved in the community kitchen about its key achievements**

*"It promotes healthy cooking and eating to the most vulnerable in the community. It's fundamental ill health prevention work".*

*"We deliver a really wide range of courses to groups who really need it e.g. ex drug addict single parent/career dads, careers of people with dementia, to Gordon's school kids ....and do a lot of outreach work in Aberdeenshire and Moray especially REHS training."*

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<sup>1</sup> Healthy Eating, Active Living (2008) CEL 36 and HEAT 3.

### **Key areas for improvement**

Practical food skills work needs to be better linked strategically and organisationally into e.g. infant and maternal nutrition and child healthy weight current work programmes for NHS Grampian. Appropriate reporting mechanisms should be established.

More time should be devoted to development to help with future planning/grant application; income generation; to ensure that key priority groups are using the kitchen; progression in cooking skills is taking place and demand for use of the kitchen is met.

At present practical food skills work in Aberdeen City is not evaluated well. Links should be further developed with local universities to focus on evaluation and measurement of meaningful outcomes e.g. mental health benefits of involvement in the community kitchen; cost effectiveness measures; linkages with existing service provision.

The number of requests for practical food skills interventions has increased over the years but is restricted by funding streams available in the current climate, lack of income generation and uncertainty about the future. See Appendix 6 for quotes from key stakeholders, clients and workers involved in the community kitchen about key areas for improvement.

### **Ideas for the way forward**

Closure of Summerhill was seen as an opportunity for C2Cook to become a more community based, flexible and innovative project. Moving towards a social enterprise model, (See 7.2).

One size might not fit all with future development of C2Cook. Different models of provision of practical food skills work in Aberdeen City were highlighted e.g. outreach provision in community centres and schools (See 7.2).

The preference for a central facility for provision of practical food skills work was a common theme. The interactive element and social aspect of C2Cook was seen as an important feature.

The potential for more direct service provision was highlighted e.g. GP referral for practical food skills interventions and access to community kitchen. This is being established in Huntly community kitchen. In 2007 C2Cook piloted a weight management programme encompassing practical food skills delivered in the kitchen. This initial course was for people with cardiovascular disease, the evaluation was very positive.

See Appendix 6 for quotes from discussions about the way forward for practical food skills work.

## 6. An appraisal of the range of options for the future practical food skills work

### 6.1 Discussions with key stakeholders

Discussions took place with a wide range of key stakeholders (see Appendices 3 and 4) to consider the possible options for the future of the community kitchen and practical food skills work. Those interviewed included representatives from NHS Grampian public health and dietetics service; community kitchen staff and users; Aberdeen City Council community learning and development and social work; researchers from Robert Gordon University and the voluntary sector. Interviewees were selected because they were involved in the set up, day to running, evaluation and support of the community kitchen.

The aim of the initial discussions was to generate as wide a list of options as possible without constraint or limit. Options presented were:

- Complete relocation of the community kitchen linking in with existing projects e.g. the Mither Kirk development project
- Complete relocation of the community kitchen in a city council/NHS Grampian funded site
- The development of the community kitchen as a social enterprise
- The improvement of existing community centre kitchens across Aberdeen City
- The use of existing food handling facilities in Robert Gordon University
- The use of home economics kitchens in schools across Aberdeen City

A workshop was then held to discuss the suggestions made by key stakeholders (See Appendix 3 for list of attendees). As much information as possible was gathered about each option. The risks, benefits and dependencies of each option were considered.

### 6.2 The options

Six options were put forward at the workshop for full appraisal:

1. Do nothing.
2. Improve kitchen facilities in existing community centres across Aberdeen e.g. Williamson Family Centre; Northfield Community Centre; Bucksburn Beacon Centre; Deeside Family Centre; Oscar Road Community Learning Centre.
3. Use existing kitchen facilities in schools during evenings and weekends to provide training for larger groups and to run income generation schemes to support the operational costs of C2Cook.
4. Develop links with RGU and use their food handling facility to provide training for larger groups and to run income generation schemes, again to fund the operational costs of the kitchen.
5. Develop the community kitchen as a social enterprise and apply for lottery funding with key partners e.g. CFINE /Aberdeen Foyer/Aberdeen Forward and 'Dadsworks' and replace community kitchen in Poynerook Road site or Marywell Street site.
6. Explore future opportunities for a replacement community kitchen e.g. Mither Kirk project; Dobbies/Hazelhead learning disabilities project; Intensive Community Support and Learning Project (MCMC) Westburn Road.

## 7. Advantages and challenges of the options

### 7.1 Identification of the risks, benefits and constraints of each option

Option	Benefits	Risks	Dependencies
1) Do Nothing	Cheap	<p>Lose central facility and focus on practical foodskills</p> <p>Lose client base</p> <p>Lose a project with national recognition</p> <p>Waste of all work that has gone into development of project</p> <p>Poorer health and social capital outcomes</p>	
<p>2) Improve kitchen facilities in existing community centres previously identified by CL&amp;D as potential sites with suitable kitchen areas e.g. Mastrick Community Centre; Williamson Family Centre; Northfield Community Centre; Deeside family Centre; Oscar Road Community Learning Centre</p>	<p>No major refurbishment costs</p> <p>Available across the City immediately allows for continuity of provision of basic practical food skills training</p> <p>Sustainable support built in via linking with community learning and development</p> <p>Wide base of local 'community based trainers' been through accredited Training for Trainers</p> <p>C2Cook manual developed to aid standardised provision across community centres</p> <p>Base in community centres provides a good first step for some of the most vulnerable client groups who may find it challenging to travel</p> <p>Crèches available in community centres</p> <p>With 'creative' use of space kitchens in community centres can be adapted for eating meals prepared together and for</p>	<p>Some development costs required e.g. <i>cooking equipment (Focus on Food Cookit sets (£881 each) Baby Belling Table Top ovens (£200 each)</i></p> <p>Lack of standardised provision including consistent quality control.</p> <p>Community centre and 'Reach out project' kitchens not suitable for training large groups or running income generation training/ courses (6 people maximum)</p> <p>Could be child protection issues if accessed by all clients</p> <p>Skills of staff running centres/courses</p> <p>Not all family centres willing/able to accommodate all clients e.g. ex drug users</p> <p>Loose advantage of large dedicated space with crèche attached</p>	<p>Administration/ support would need to be in place to ensure right people are using the community based kitchens and C2Cook standards are being adhered to</p> <p>Cover for breakages, wear and tear and vandalism</p> <p>Janitors and community centre managers' time for dealing with administration /access issues</p>

	training smaller groups in basic skills e.g. chopping, peeling, menu planning.		
3) Make use of home economic classrooms/kitchens in schools particularly in 3Rs campuses (project to upgrade/rebuild schools) where the council is committed to "ensuring wider community access to council services for the benefit of everyone"	<p>Would help achieve aspiration of Aberdeen City 3R;s project to "make the school part of the community and maximise the use of facilities" Aberdeen City Council Revision of School Capacities report number: ECS/09/083</p> <p>Purpose built training facilities available across the City</p> <p>Suitable for providing training for larger groups and income generation schemes</p> <p>No capital expenditure or refurbishment costs</p> <p>Janitorial support available 8am - 10pm</p>	<p>Cost of venue hire and use of school facilities to be negotiated (Large Unit with 50% of participants resident in Aberdeen £17.16 (August 2007)</p> <p>Only available evenings/weekends and school holidays</p> <p>May be child protection issues if accessed by all client groups during the day</p> <p>School environment may be intimidating for some client groups</p> <p>Lack of crèche facilities</p>	<p>Administration/ support would need to be in place to ensure right people are using the school kitchens and C2Cook hygiene and nutrition standards are adhered to</p> <p>Cover for breakages, wear and tear and vandalism</p> <p>Staff time for dealing with administration /access issues</p>
4) Develop links with RGU and use their food handling facility	<p>Modern and spacious facility suitable for providing training for larger groups and income generation schemes</p> <p>University staff interested in working with community kitchen user groups and evaluating impact of service e.g. on self confidence, mental health</p> <p>No capital expenditure or refurbishment costs</p> <p>Kitchen available immediately allows for continuity of provision</p> <p>Kitchen not fully utilised during term time and empty during university holiday periods</p> <p>Ability to block book the kitchen for a number of sessions e.g. per week/month</p> <p>3 hour crèche available at Leaping Leopards</p>	<p>Travel arrangements to and from RGU for clients</p> <p>Cost of crèche at Leaping Leopards</p> <p>Parking facilities for trainers</p> <p>University environment may be intimidating for some client groups</p> <p>High operating/ongoing costs for 'renting the kitchen'</p> <p>May not be able to be as flexible in terms of service provision as kitchen also used by students during term time</p>	<p>Price per hour for hiring food handling facility at RGU quoted at £100 hour would have to be negotiated down</p> <p>Administration/ support would need to be in place to ensure right people are using the RGU kitchens and C2Cook hygiene and nutrition standards are adhered to</p>
5) Develop the community kitchen as	Sustainable way forward for community kitchen	Capital costs involved in developing suitable area for kitchen	Depends on sourcing funding

<p>an independent 'social enterprise' with key partners e.g. CFINE, Aberdeen Forward, The Foyer</p>	<p>Strong support for social enterprise partnership from wide range of partners Creates ability for C2Cook to be flexible and innovative in its approach Provides an exit strategy for NHS and LA funding Examples of good social enterprise models from other areas e.g. 'Food for Thought' training kitchen in Glasgow see Scottish Community Diet project toolkit 'Minding their own business too' (2009) which provides examples of community food initiatives that have become social enterprises Linking with existing organisation such as CFINE The Foyer, 'dadsworks' group ensures reach vulnerable target groups and link in with existing schemes e.g. Healthy Start vouchers and food co-ops, work with homeless Central locations on major bus routes</p>	<p>Poynerook Road not ideal in terms of ventilation and location Marywell Street not ideal in terms of size and works required Timescale (e.g. sourcing funding, development of kitchen)</p>	<p>Service Level Agreement would have to be drawn up specifying inputs from all partners Administration/ support would need to be in place to ensure right people are using the kitchen and C2Cook hygiene and nutrition are adhered to Partnership working with NHS and local authority to ensure strategic fit and delivery of outcomes specified in SLA</p>
<p>6) Explore options for a replacement community kitchen Mither Kirk Union Street project</p>	<p>Central location. On major bus routes. Parking for deliveries and disabled access available on site Architect has designed the kitchen around the floor plan for Summerhill Will include disabled access/lifts and raising/lowering workstations Work underway to develop the site. Part of a wider community facility Commitment to house a Community Kitchen Will provide 'blocks of time' in the kitchen for vulnerable groups at a discounted rate Crèche on site</p>	<p>Loss of lottery funding means project still not financially sound and will not be ready until at least 2012 Lose independence of C2Cook and ability to be flexible Timescale (e.g. sourcing funding, development of kitchen)</p>	<p>Big Lottery funding still to be secured Administration/ support would need to be in place to ensure right people are using the kitchen and C2Cook standards are being adhered to Staff time for dealing with administration /access issues</p>

## 7.2 Ranking of options

Using a 'virtual group', **six** key stakeholders were emailed the table above (7.1) and asked to rank each of the options for the future of practical food skills work with **1 being the preferred option** and **6 being the least preferred option**. (Suggested issues to consider when ranking the options were also emailed to the group and are detailed in Appendix 7).

The results from the ranking exercise:

Option 1 Do Nothing	Option 2 CLD	Option 3 Schools	Option 4 RGU	Option 5 Social Enterprise	Option 6 Mither Kirk
6	3	5	4	1	2
6	3	4	5	1	2
6	1	1	4	2	5
6	2	3	4	1	4
6	2	2	3	4	1
1	2	3	1	2	5
<b>5</b>	<b>2</b>	<b>3</b>	<b>3</b>	<b>1.8</b>	<b>3 *</b>

\* Figures in bold denote final average ranking

**The results from the ranking exercise reveal the following:**

Option	Average ranking	Comments
<p><b>Option1</b> Do Nothing</p>	<p><b>5</b></p>	<p><i>“Waste of all work that has started.”</i></p> <p><i>“Will widen the inequality gap, by not targeting those most in need.”</i></p> <p><i>“The good work over the last 6 years will be lost.”</i></p> <p><i>“Have to recognise it might be the no 1 depending on other priorities re funding.”</i></p>
<p><b>Option 2</b> Improve kitchen facilities in existing Community Centres</p>	<p><b>2</b></p>	<p><i>“Probably best as short term option but may need to be combined with option 3 and 4.”</i></p> <p><i>“But only for a small number of centres; logistics for some very problematic.”</i></p> <p><i>Would be hard for some ‘challenging’ groups to access these facilities.”</i></p> <p><i>“Family Centres ought to be targeting /catering for the target client groups already so query why they wouldn’t be happy to accommodate, clients however might not want to access”</i></p> <p><i>“Potentially inconsistent delivery of service.”</i></p> <p><i>“Would require investment to bring facilities up to scratch – hygiene, food safety.”</i></p> <p><i>“Would only be accessible for local people within that community.”</i></p>
<p><b>Option 3</b> Make use of home economic classrooms/ kitchens in schools particularly in 3R’s campuses</p>	<p><b>3</b></p>	<p><i>“In conjunction with option 2 and only as a short term solution.”</i></p> <p><i>“Probably best as short term option but may need to be combined with 2 and 4.”</i></p> <p><i>“Only available out with the school day.”</i></p> <p><i>“May not be accessible for more vulnerable clients &amp; they may not be comfortable attending sessions in schools nor may they be welcome.”</i></p> <p><i>Not friendly, user orientated or accessible for a majority of client groups.”</i></p>

<p><b>Option 4</b></p> <p>Develop links with RGU and use their food handling facility</p>	<p><b>3</b></p>	<p><i>“May be useful for a limited number of groups but more discussion required.”</i></p> <p><i>“But only as a training project to facilitate the training of workers to cascade the project out to the community.”</i></p> <p><i>Would be hard for some ‘challenging’ groups to access these facilities.”</i></p> <p><i>“Potentially inconsistent delivery of service.”</i></p> <p><i>“Too expensive.”</i></p> <p><i>“Crèche quite a distance away – parents tend to require their children to be in the same building &amp; if it’s an external venue the opportunity for the children to come &amp; eat the food is lost.”</i></p>
<p><b>Option 5</b></p> <p>Develop the community kitchen as an independent ‘social enterprise’ with key partners</p>	<p><b>1</b></p>	<p><i>“Key partners have existing strong links with client groups in need of support.”</i></p> <p><i>“Opportunity for partnership working with key organisations.”</i></p> <p><i>“Sustainability for community kitchen and health input for this client group.”</i></p> <p><i>“Existing locations not ideal but in partnership could apply for funding to access more appropriate venues e.g. shop front – follow the Jamie Oliver model.”</i></p> <p><i>“May lose the C2Cook identity.”</i></p> <p><i>“May lose the power to influence interventions to meet Govt targets e.g. CEL36, H3.”</i></p> <p><i>“Be able to tap in to other initiatives e.g. Fare Share &amp; CFINE – fruit &amp; vegs.”</i></p> <p><i>“This would be the best long term solution short of getting a new purpose built facility. C2C would have a permanent home if funding was available but there would be issues regarding independence and standards.”</i></p> <p><i>“Is there funding and can it be sustained?”</i></p>
<p><b>Option 6</b></p> <p>Explore options for a replacement community kitchen e.g. Mither Kirk Union Street project</p>	<p><b>3</b></p>	<p><i>“Set C2Cook up as a social enterprise in its own right with a professional advisory group to support.”</i></p> <p><i>“May not be a facility that vulnerable groups would feel welcome.”</i></p> <p><i>“Seems best term option but need short term options in the meantime.”</i></p> <p><i>“Centre of town – will clients from our areas of deprivation venture this far for cooking sessions?”</i></p> <p><i>“Will costs be too expensive for vulnerable groups?”</i></p> <p><i>“Timescales mean C2C would lose all momentum and there is no guarantee funding would be available.”</i></p>

## 8. Conclusions and recommendations

### 8.1 Options recommended

In the current financial climate with less resource available to the public sector and in view of the fact that Summerhill Community Centre has closed, service provision cannot continue as it is. The most likely scenario is that a range of options will have to be employed to allow for continuity of provision of practical food skills work in Aberdeen.

1. There was strong support amongst key stakeholders for a partnership proposal to rebuild a new community kitchen (with crèche) as an independent and flexible 'social enterprise' funded by charity/income generation/lottery grant.
2. In the immediate future there was support for improving kitchen facilities in existing community centres across Aberdeen to provide basic cooking skills targeting vulnerable groups and utilising network of locally based trainers. This work is already underway e.g. Williamson Family Centre; Northfield Community Centre; Bucksburn Beacon Centre; Deeside Family Centre; Oscar Road Community Learning Centre.
3. In the immediate future there was also support for utilising the partnership between Aberdeen City Council and NHS Grampian to access home economic classroom/kitchen facilities in 3R campuses during evenings and weekends to provide training for larger groups.
4. In the longer term, there was support for continuing to explore proposed opportunities for a replacement community kitchen e.g. Mither Kirk project. However lack of guaranteed funding for this project and any other new development is a key issue.
5. There was support for building upon research and evaluation links with Robert Gordon University. It was also highlighted that the food handling facility at RGU may be useful to utilise for a limited number of groups. (E.g. to facilitate the training of workers to cascade the project out to the community). More discussion would be required as at present it appears an expensive option.

#### **Key areas for improvement of practical food skills work include:**

- Better strategic linkage and accountability/reporting mechanisms for practical food skills work through appropriate reporting lines to partners.
- Opportunities to do more direct work such as setting up GP referral to schemes for practical food skills work.
- More development time spent on future planning, grant application, audit, proactively engaging with individuals, groups and services and co-ordinating usage via strategic themes.
- Continue to learn from examples of practice elsewhere in Scotland. Developing further to become an independent and self-sustaining project.
- More of a focus on evaluation and capturing wider outcomes of involvement in practical food skills work e.g. the mental health/self confidence benefits as well as any dietary change.

## Appendix 1: Examples of income generation projects run by C2Cook

*The number of paid staff (coming from a wide range of organisations) accessing training saw the largest growth in 2007.*

*Twelve accredited REHIS (Royal Environmental Health Institute of Scotland) courses in food and hygiene and Food and Health (Nutrition) and 4 training for trainers courses were delivered in the community kitchen.*

*Eight REHIS and six training the trainer courses were delivered on an outreach basis across the wider Grampian area, where a facilitator delivers sessions at the participants' own base using the C2Cook training pack.*

*Sale of C2Cook Training Packs, (containing nutritional information, quizzes, over 200 recipes) to external agencies, community groups and Health Boards.*

*Design and delivery of the '10 session' Independent Living programme for Robert Gordon's College, now incorporated into their curriculum as a sixth year elective subject (charged £35 per session April 2010).*

### **Potential for income generation in the community kitchen**

The standard charge for a C2Cook course in the community kitchen varies according to the level of tuition required. An average facilitated session costs a group of 8 -12 participants £87.50 in total:

- £20 for food/perishables
- £52.50 for staff costs health information assistants (HIAs) recharged at £17.50 per hour. One session is approx 2hrs + 1hr for prep and travel
- £15 for hire of the community kitchen per 2.5 hour session.

Although the facilitated sessions are aimed at vulnerable and disadvantaged groups, there is potential to increase income from facilitated sessions. As a point of comparison to the £15 fee per session for hire of the community kitchen, Robert Gordon University have proposed charging £100 per hour for hire of their food handling facility in St Andrews Street in Aberdeen. Costs, such as purchase of cooking equipment, wear and tear should be included in the charge per session. Staff costs should be higher to cover administration, evaluation, the full extent of preparation e.g. shopping and support staff costs e.g. cleaning, janitorial and crèche staff.

Groups could be encouraged to apply for funding to pay for facilitated sessions. For example the 'Dadsworks' group has recently received £6,500 funding from Fairer Scotland to use the community kitchen facilitated sessions.

The standard charge for a 1 day REHIS course is £60 per participant. On average ten participants attend per day. The REHIS facilitator is charged £50 per day for use of the community kitchen. There is potential to increase income from REHIS courses, charging more per participant and more per day for use of the community kitchen to cover the 'hidden' costs listed above.

Training for trainers (T4T) courses in the community kitchen do not currently generate income because they are seen as core public health work to build capacity and address health inequalities. (Staff costs are covered in core time by NHS Grampian's catering advisor who delivers the training as part of her role). The cost for running T4T courses for groups of ten participants in the community kitchen is approximately £330. This includes:

- Food costs £30 (for perishable food for 10 different dishes)
- C2Cook packs £30 each (are only given to those who complete the T4Ts, delegates get a copy of the printed recipes that they prepare). Funding is usually sourced to pay for the C2Cook packs.

There is scope to generate income from running T4T courses if disadvantaged groups can be encouraged to apply for funding to pay for the training.

## Appendix 2: Cookwell Programme

The Cookwell Project (2002) was a research project that aimed to increase consumption of 'healthy foods' amongst participants attending cookery courses in low-income communities across Scotland. (Wreiden et al 2007).

### **Aim**

- To encourage participants to increase their consumption of fruit, vegetables, fish and high fibre starchy foods and decrease their consumption of fat.

### **Objectives**

- To increase participants cooking skills and knowledge
- To increase participants confidence in their cooking skills
- To increase participant's awareness and understanding of healthy eating and cooking techniques and how to create healthy balanced meals
- To encourage participants and their families to eat a wider range of foods by giving the opportunity to cook and taste a wide range of foods
- To encourage home cooking by demonstrating that home cooked foods are tastier and in many cases cheaper than ready made meals.

### **Venue requirements**

A medium sized kitchen or kitchen area with easy access to another room for suitable food preparation; at least one ring cooker with oven; a large sink for food preparation and washing up; a separate sink for hand washing. This could be situated in a nearby toilet; work surfaces for food preparation must be in reasonable condition i.e. not chipped cracked or badly scored; cooking equipment; access to crèche is recommended, as many parents with pre school children attend cookery groups; if there is crèche a means of keeping children out of the kitchen is essential for their safety

### **Number of participants**

To a certain extent the number of participants will be determined by the size of the kitchen and the numbers of cookers available. Small baby belling ovens can be supplied so that more participants can be accommodated. Each participant should have access to adequate work top surface for preparation. An overcrowded kitchen is difficult and dangerous to work in. A maximum ten participants is recommended for a cookery group.

See Cookwell report prepared by L Porteous and K Valentine (for further information on setting up a Cookwell style group).

<http://www.food.gov.uk/multimedia/pdfs/cookwellmanualv2.pdf>

## Appendix 3: List of key stakeholders interviewed

Fiona Matthews	Catering Advisor	NHS Grampian
Caroline Comerford	Nutrition Coordinator	NHS Grampian
Janette Gascoine	Development Worker	Aberdeen City Council
Carol Gray	Principal Community Learning and Development Worker	Aberdeen City Council
Judith Hendry	Professional Head of Dietetics and Lead Dietitian	Aberdeen City CHP
Dr Wendy Wrieden	Lecturer	Robert Gordon University
Dave Simmers	Chief Executive	Community Food Initiatives North East
Lisa Duthie	Health Team Manager	Aberdeen Foyer
Jackie Thain	Principal Community Learning & Development Worker	Aberdeen City Council
Arthur Winfield	Project Leader	Mither Kirk Project
2 Community Learning & Development staff	Mastrick Community Centre	Aberdeen City Council
Ron Bird	Community Learning & Development Worker (working for Social Work)	Aberdeen City Council
Joanne Adamson	Public Health Co-ordinator	Aberdeen City CHP

## Appendix 4: Case studies of involvement with C2Cook

### Case study 1: Longer term results for 1 participant's involvement in C2Cook

One participant who received training in cooking skills via NHS Grampians "Now You are Cooking" project now trains others in Middlefield with a focus on working with children aged 8-12 years. She first started as a volunteer twelve years ago because she had young children and became interested in cooking skills when she was offered to attend a "Now You're Cooking" at RGU. She followed this up with a course at Moray College and has since continued to update her skills with REHIS courses.

*"Getting involved in things has got me where I am now..... I was really nervous at the course in Moray College because it was all professional people, head teachers, midwives you know...but I realised we were all there to learn the same thing."*

She was on one of the first courses run by C2Cook when it opened in 2004.

*"The community kitchen has given a lot of people confidence, regardless of whether its children or adults its about learning and being more aware of different types of food, what's in food, how to read labels, different tastes, getting over the fear of cooking ...its about enjoying food. I am learning all the time"*

*"I would never have had the confidence to stand up in front of people without Now You're Cooking. Before you can teach others you've got to know the background yourself. My confidence has improved by knowing about what I'm saying".*

*"Working with kids can be difficult you've got to know which ones need that extra bit of supervision. Its amazing some of the young ones don't even know how to hold a knife to chop a vegetable. But whether its kids or adults they all get something out of it, they enjoy it."*

### Case Study 2: Dadsworks group involvement in C2Cook

Dadsworks is a self help support group for single dads based in Aberdeen. A Dads Cooking group has been meeting in the community kitchen on Mondays between 9am and 12.30pm with use of the crèche for their children in the same building. Most of the Dads are current or ex substance misusers coming from 'chaotic backgrounds'. Transport is provided to and from the community kitchen and facilitators regularly phone or text the participants to ensure their attendance. This is a difficult group to engage with, they lack the confidence to attend groups without support.

The community kitchen can accommodate 12 dads although usually between 7 and 12 attend. The focus of the group is practical cooking skills and building a repertoire of recipes to use at home. The facilitator who runs the group highlighted the act of cooking breaks down barriers to communication and enables workers to quickly build relationships with those attending.

*“You can discuss difficult topics issues in a casual way while the Dads are cooking. Most of the Dads are either still using or recently off using drugs and on a methadone programme. This presents ongoing health problems, having a good cooking and eating regime in place really helps. Also actively doing something is a real confidence booster.”*

A crèche is provided and the men attending are expected to talk about and share the dishes they prepare.

The success of the Dads Work sessions in the community kitchen is difficult to quantify, however there is evidence to suggest that many of the men attending the group have gone on to take a more active, parenting role. There is also evidence that some of the Dads gain confidence, four of the Dads are now in a position to be trained up as C2Cook facilitators which is a huge step forward from where they were when they started. <http://www.dadswork.org.uk>

*“A participant in the dads cooking group, was a heavy user of Class A drugs. When he got on top of that and went on a methadone programme his drinking went out of control. He pulled himself together because he became the sole care of his son as his partner was still in chaos. No-one could believe what he was putting together in the kitchen it was real cordon bleu stuff, presentation was immaculate. Some of the dishes were amazing, it was obviously an innate talent that he had even though previously he had never bothered with food. This was a real confidence booster for him.”*

# Appendix 5: Interview guides

## Guide for semi-structured interviews with key stakeholders

1. How did you come to be involved in the community kitchen?
2. What, in your view, was the impetus behind starting the project?
3. What would be the impact of the loss of the community kitchen?
4. How do you see practical food skills work progressing in Aberdeen City
5. How does the community kitchen fit with strategic priorities e.g. CEL 36 and HEAT 3 (tackling childhood obesity); Single Outcome Agreement and lifelong learning priorities?
6. What is the best way forward for the community kitchen e.g. in your opinion is it ready to become financially independent?
7. What major strengths and weaknesses do you see in the project?
8. Without a central resource in Aberdeen City how would you further develop practical food skills work?

## Guide for semi-structured interviews with community kitchen users:

### Reasons for participation/background:

1. How did you first hear about the project?
2. Why did you want to become involved?
3. What experiences did you have with cooking your own food before involvement?
4. What relationship has food (cooking, eating) had to health in your life and the life of those around you?

### Experiences with the project:

1. Can you give me examples of any new recipes or cooking tricks that you've learned?
2. Who have you met through participation in the project? What do these relationships mean to you?
3. Of everything that you've experienced with the project, what has been most significant to you? Why?
4. Can you share with me ideas of what you might like to see change in the project?
5. How would you feel if the community kitchen was no longer available?
6. How do you think it should develop in the future?

### Influence of project on health and well being and lifelong learning

1. How do you feel the project has affected you?
  - a. Has what you eat at home changed at all?
  - b. Have you ever shared any of the things you learned with friends or family?
2. Do you see any relationship between your participation in the project and any aspect of your health and well being? If so, what has been most important to you?
  - a. The way you eat?
  - b. Connection to others?
  - c. Self confidence?
  - d. Learning new skills?

## Appendix 6: Quotes from key stakeholders

### Key areas for improvement

*“C2Cook needs to be better hooked in, linked into peoples work streams. It is undervalued for all the really good work it has achieved since 2004 especially in terms of tackling inequalities and the focus on disadvantaged groups.”*

*“The project at present has not developed as far along the lines of being self financing as was hoped.”*

*“C2Cook is not well integrated generally with strategic priorities and yet it could be as it is dealing with all main priority groups homeless, people with mental health problems, substance misuse issues, young mothers, single parents.”*

*“A strong administrator would be needed to keep it all together e.g. signpost users to where the ‘community kitchen’ was next going to be doing training and to co-ordinate users via various strategic themes e.g. H3 workshops for parents with obese children would need to be informed of when C2Cook session happening, diabetic patients informed of when next C2Cook session happening.”*

*“Don’t evaluate well, too much time spent doing and providing and planning session not enough time to evidence outcomes which would help future funding. Lack of focus on evaluation lets us down”.*

*“It would be good to look at cost effectiveness of C2Cook like in the Cookwell project, a breakdown of how much it costs to run a session”*

*“Need to capture the mental health benefits as well as the healthy eating benefits, might not change people diets but evidence accumulated over six years indicates it does make a difference to peoples self confidence and self esteem”*

*“May be useful to explore C2Cook in terms of a health psychology perspective and how food work in general is quite effective in terms of bridging the intention behavior gap. Also may be useful to do more case studies i.e. follow one person or people in different groups to see how the cooking skills have impacted on their confidence, life in general”.*

### The way forward for practical food skills work

*The need for training in cooking skills is still a key issue in why people are not eating healthily. The great thing about the C2Cook model is that it taps into peoples need for skills when they most need it e.g. when they have just become a mum or single parent or diagnosed with a health problem.” Makes a difference that we are doing it (cooking) not just sitting and listening nice that we get to eat what we have cooked its interactive less hard work than sitting down all day and listening”.*

*“I like the way it is interactive. Reading a book doesn’t work you have to do it taste and eat it to make sure you have that 3D experience”.*

*“There is great benefit in actually showing people how to cook its not just talking about it its doing it that makes the difference”*

*“Actively cooking is a real confidence booster, just watching someone else do it is too passive. Its helpful for the guys to be doing something, it means I can discuss difficult topics with them while they are focused on the task of cooking”*

*“There will always be work to be done on teaching people cooking skills while we have got young people totally disengaged from learning about how to cook at school and at home.”*

*“Food is an excellent vehicle for developing a range of life skills, particularly social skills and confidence. Food activities can be useful as a way of engaging with vulnerable participants, or as a way of encouraging them to participate in other activities (such as further education or volunteering)”.*

*“The closure of the community kitchen at Summerhill could really be the opportunity we need to do things differently, a central facility might be easier but we are not in a financial climate where we can replace like with like we have to explore the opportunities. Doing more work locally in community centres and schools could be a very positive way to actually involve and empower community groups... Food work is positive and often by its very nature gets people involved.*

*Could be more of a focus on getting groups together and teaching them how to be a self sustaining group e.g. a tool kit including group contact details, foods shopping list, pots and pans set, community centre opening times and janitorial access. We need to be moving towards models where people are less dependent not more. Also need to support CL&D staff to support ‘stand-alone’ groups and help them get back on track if they falter.”*

## Appendix 7: Suggested issues to consider during options ranking exercise

Sustainable in the longer term
Builds use of existing infrastructure e.g. contacts, facilities, groups engaged in community kitchen
Will help to address needs of vulnerable groups across Grampian in terms of cooking skills, building confidence and social capital
Is accessible for all key client groups
Ensures partnership with key organisations e.g. CFINE and voluntary sector
Allows for flexibility of approach
Will enable consistency in current high standard of community kitchen work
Ensures training for trainers and income generation schemes can continue

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