community food and health (scotland)

Making your case for funding and investment in community food work with older people - learning from the field

NHS Health Scotland

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NHS Health Scotland is a WHO Collaborating Centre for Health Promotion and Public Health Development.

About us

Our overriding aim is to improve Scotland's food and health.

We do this by supporting work that improves access to and take-up of a healthy diet within low-income communities.

Major obstacles being addressed by community-based initiatives are:

Availability
Increasing access to fruit and vegetables of an acceptable quality and cost

Affordability
Tackling not only the cost of shopping but getting to shops

Skills
Improving confidence and skills in cooking and shopping

Culture
Overcoming ingrained habits

We help support low-income communities to identify barriers to a healthy balanced diet, develop local responses to addressing these barriers and highlight where actions at other levels, or in other sections, are required.

We value the experience, understanding, skills and knowledge within Scotland's communities and their unique contribution to developing and delivering policy and practice at all levels.

CFHS is funded by the Scottish Government and is now part of NHS Health Scotland.

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Theory of change models

These are available to download from
www.communityfoodandhealth.org.uk/wp-content/uploads/2014/07/MakingYourCaseAppendices.pdf

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Edinburgh Community Food
Mearns and Coastal Healthy Living Network
Moray Handyperson Service
Orbiston Neighbourhood Centre
Pilmeny Development Association
Silver Darlings
The Food Train

Introduction

A focus on older people

Statistics show that we are generally living longer, and the Scottish Government has established a national outcome that the extra years we enjoy should be healthy extra years – 'we will live longer, healthier lives'. Food plays an important role in maintaining good health and we know that, as people get older, access to affordable, acceptable food can become a major issue. This can be the result of limited resources, reduced access to shops and shopping, changes in motivation and skills in preparing meals, and the cost and availability of services which provide support in this area when it is needed. This may compound existing health inequalities that people have experienced throughout their lives.

Scotland has a strong tradition of community food initiatives, in which older people have always engaged both as providers and recipients of services. Many of these are located in low-income communities and look to support older people in their community to eat well.

Why this publication?

Despite evidence of the importance of food in maintaining health and wellbeing for older people, community food initiatives often struggle to attract longer-term funding and investment. This can be especially difficult when potential funders are facing the twin pressures of increasing demand and diminishing resources.

This publication aims to support community food initiatives as they make their case for funding and investment. It should help in two main areas:

1. How to describe what it is that you do – the strategies you adopt and the range of outcomes that work involving food can achieve.
2. How to identify the contribution you make in terms of 'preventative spend' – the longer-term outcomes, economic benefits and cost savings that can arise for your work.

The information in this publication comes from two separate pieces of research that CFHS commissioned in 2012. The first was a study of available evidence in relation to preventative spend and community food initiatives working with older people. This built on previous work that looked at the role that economic evidence can play in building support for the work of community food projects.

The second was a piece of work to develop a model of the 'theory of change' that underpins community-based food work involving older people. This was built from the work of eight different initiatives that very generously agreed to share their knowledge and experience and gave their time to work with us on this.

Thanks

This publication would not have been possible without the input of the following people who generously shared their time, knowledge and expertise to develop the material: Jane Cotton, Moray Handyperson Service; Irene Gibson and Robert Piper, Orbiston Neighbourhood Centre; Nikki Lorimer, Mearns and Coastal Healthy Living Network; Polly Mark and Linda Tod, Alzheimer Scotland; Michelle McCrindle, the Food Train; Emma Pattinson and Lyndsey McLellan, Edinburgh Community Food; Anne Munro, Pilmeny Development Project; and Ingrid Penny, NHS Grampian/Silver Darlings.

Marion Lacey of Rock Solid Social Research provided expert consultancy and wrote much of the material that appears within.

Thanks to all.

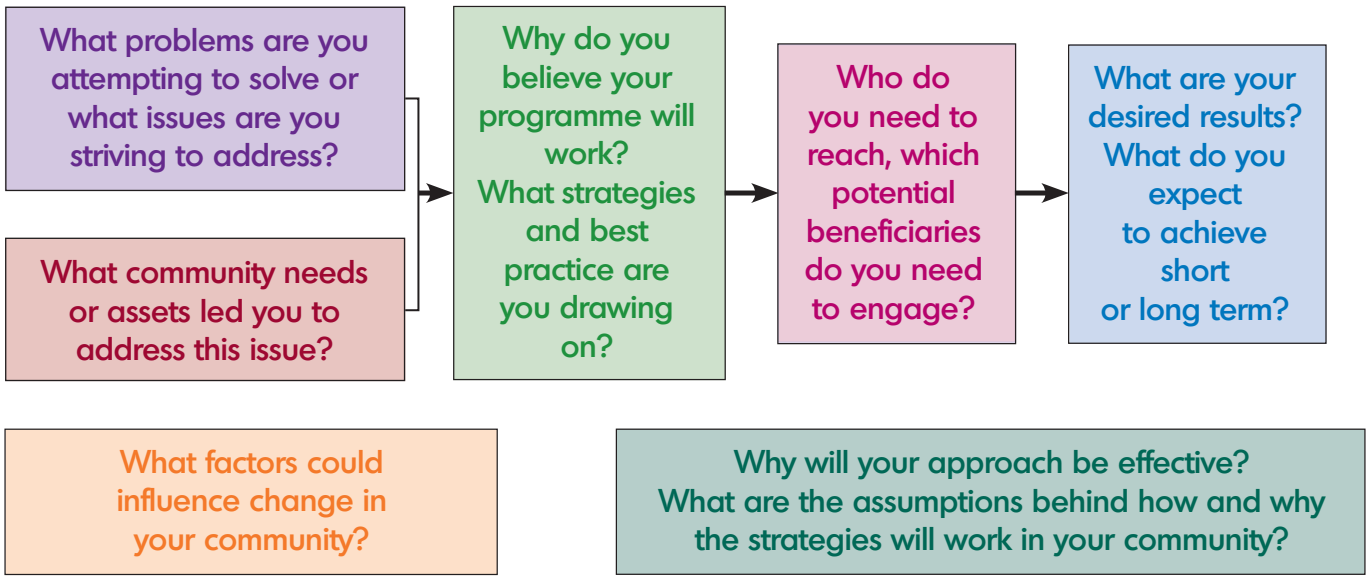
Section 1

Theory of change

What is a 'theory of change'?

A theory of change lays out the thinking behind how and why a particular programme of work is being developed. It can be a useful tool in planning and developing pieces of work, as well as describing to others why you are adopting particular approaches and how you think they will have an impact. We thought this could be a helpful way of building a picture of the logic that underpins community food work with older people and the ways in which it can contribute to a range of different outcomes.

There are a number of different models that you can use. For this work we used the template developed by the W. K. Kellogg Foundation, which encourages organisations to work through a series of questions. We adapted this to align with current logic modelling practice in Scotland, added a category on reach and presented the findings as illustrated below.



Eight organisations shared their thinking and learning to build this work. You will find their individual models, expressed in their own language, in the appendices. These provide detailed worked examples for a range of different community food initiatives and are available here to inform your thinking. From these individual models we worked on a generic model that draws together the key elements from all the individual models and then reduced this further into a one-sheet summary model. This final model attempts to synthesise the logic behind work in this area.

This is very much a work in progress and feedback on how useful the models are is very welcome.

Theory of change – general model (summary)

Problem or issue

- Barriers in terms of food access impact on the ability of older people in the community to live healthier lives.
- Malnutrition among older people.
- Older people themselves and their carers need more information about the warning signs and how to prevent malnutrition.
- Social isolation and the desire to remain independent may mean that early warning signs of malnutrition are not picked up.
- Specific groups of older people are likely to face particular barriers in terms of food access, e.g. older men and those in remote rural areas.

Community needs/assets

- Developing evidence base being produced by community food initiatives.
- The skills and expertise that older people in the community are able to offer.
- People – staff and volunteers.
- Community transport/access to transport.
- Premises, facilities and equipment.
- Local partnership arrangements and the quality of personal relationships within them.

Strategies

- Improve food access for older people via existing and new community food initiatives.
- Design and deliver initiatives with older people – co-production.
- Food at the core of activities that are designed to
  - promote independence, choice and personalisation;
  - share learning and skills development with other older people;
  - be affordable through delivery of services provided by volunteers; and
  - provide a safety net in terms of advice on nutrition and referral support.
- Food-based activities can provide social outlets with other older people, intergenerational contacts, support from befrienders, support for household jobs, and support for carers.
- The approach by community food and health initiatives avoids stigma by opening facilities to other members of the community. It is non-clinical and non-judgmental owing to the input of motivated volunteers experienced in listening skills.
- Volunteers and workers are supported in developing skills relating to the importance of food and the nutritional needs of older people.
- Partnership working is promoted with public, voluntary and private sector service providers in order to get the best deal for service users.

Influential factors

Support

- National and local government outcome-focused commissioning, grants and investment.
- New partnerships with private sector suppliers and public sector service providers.
- Social enterprise activities (e.g. community cafés) that can cross-subsidise activities.
- Employment/training providers as a source of volunteers.

Barriers

- Limited public understanding of ageing as a process, requiring flexible support depending on changing circumstances.
- Potential levels of malnutrition among older people in the community not recognised.
- Financial constraints can lead to prioritisation of immediate needs over preventative activities.
- Funding is often only for projects/new work.

Reach

- Older people and their carers.
- Volunteers.
- Service providers and strategic partners.
- The general public.

Desired results

- Older people are able to live in their community and eat well.
- Older people have access to a range of affordable food services that can be tailored to their particular needs.
- Older people are less socially isolated and more engaged in their community, e.g. building intergenerational and multicultural contacts.
- Specific support needs of particular groups, including older men, are met.
- Improved skills and knowledge relating to the nutritional needs of older people.
- Influence on approaches adopted by other service providers.
- Influence on local planning and national policy towards older people and their nutritional needs.
- Positive outcomes for volunteers regarding transferable confidence-building skills.

Assumptions

- Growing older is a process and support needs to be tailored to changing needs as defined by older people themselves.
- Nutritional health and malnutrition among older people does not receive sufficient attention.
- Older people who are not attached to 'traditional' groups and clubs may need particular targeted approaches to reach them.
- Volunteers and workers from support services, and the general public as a whole, need to be better informed about the importance of nutrition for older people's physical and mental health.
- Home delivery shopping projects, which support older people in preparing their own meals, can provide welcome alternatives to frozen meals.
- Social capital can be developed by bringing older people and volunteers together with partner agencies through food and health issues.
- Co-production of food and health initiatives means involving older people in their design and planning.
- Food and health initiatives for older people require long-term investment by the public sector on a partnership basis to ensure sustainability, as continuity of provision is crucial for older people.

Theory of change – general model (detailed)

1. Problem or issue

- Food access is an issue that impacts on older people's ability to remain at home and healthy in their community.
- The availability of support in relation to food access varies across Scotland.
- Malnutrition can be an issue for older people in the community. Some may be malnourished although not undernourished. The health messages for older people are complex, as eating regularly is more important, especially if appetite is low, than being concerned about eating healthily. Access to affordable, but nutritious, food may be preferable to reliance on frozen meals long term by extending the time that older people can cook for themselves.
- The causes of malnourishment are complex. As well as food access barriers, lack of appetite related to poor mental health, lack of cooking skills or knowledge of nutritious recipes, and lack of awareness on the part of older people of risks and symptoms may result in a deterioration in health and wellbeing, and in some cases malnutrition.
- Social isolation, or the desire to be independent and not rely on family or charity, can lead to a deterioration in physical or mental health resulting from poor nutrition that goes unrecognised.
- Early problems related to poor nutrition and other health risks requiring attention, such as chiropody or physiotherapy, are often not picked up soon enough. Then an apparently unrelated event such as a bereavement, a small fall, being nervous about using a bus or being unable to drive, can result in food access and malnutrition issues.
- For particular groups of older people there are specific issues, for example:
  - Younger older people tend to consider lunch clubs as being only for frail elderly people with advanced health problems. They may be failing to consider the importance of good nutrition, which, if not addressed early enough, may result in malnourishment and deterioration in their health.
  - Older men, especially those with mental health issues, can miss out on nutrition support services because they do not tend to join groups and are therefore hard to reach. In particular, they miss out on activities involving the provision of nutritious meals (e.g. lunch clubs) and cooking classes.
  - In many rural areas shops are limited in what they sell, and there are no home delivery services or cafés for people to eat in outside the home.

2. Community needs/assets

- Evidence that informs the work of food and health projects with older people includes the following:
  - Consultation with older people themselves around their food issues, e.g. level of support for shopping; access to hot meals (Moray Older People's Survey on Food and Related Issues); older men's health needs (Evaluation of Pilmeny Development Project North East Edinburgh Older Men's Health and Wellbeing Project).
  - Mapping of local support services around food access, e.g. in Moray, WRVS meals on wheels, lunch clubs, community transport providers (Moray Older People's Survey on Food and Related Issues); in north-east Edinburgh, allotment community health projects, cooking classes, community cafés, food co-ops, services providing a meal as an add-on to the core service, lunch clubs, services for BME communities, frozen meals services (case study into quality, scope and nature of food services for older people in north-east Edinburgh).
  - Analysis of secondary data on: promotion of a healthy and active older age and improving community-based services; guidance on recommended dietary allowance and estimates of food poverty among older people; and food health risks (Moray Older People's Survey on Food and Related Issues).
  - Case studies from Scotland's lunch clubs; from food and health projects in Scotland including the Food Train's estimates of unmet needs based on its delivery of services in Dumfries and Galloway and other council areas of Scotland; and learning from specific services such as dementia support by Alzheimer Scotland.
- The community assets that food and health projects bring include:
  - Pools of committed and trained volunteers, including recently retired older people; in Moray an employer partner who promotes the involvement of their workforce in voluntary work.
  - Premises where cookery classes can be delivered or where lunch clubs or community cafés can provide fresh cooked meals, and food co-ops providing fresh fruit and vegetables.
  - Community transport that can be used for delivering shopping, or volunteer drivers to drive older people to the shops.
  - Partnership arrangements with other agencies from the public, voluntary and private sector committed to jointly delivering and promoting services for older people, and sharing of resources with the public sector.

3. Strategies

- Food is a major focus of initiatives involving older people, e.g. day service and activity-based clubs for older people, shopping delivery or accompanied shopping services, cooking groups and food co-ops.
- Initiatives are designed to address the following requirements:
  - Promote independence and self-determination among older people in the community through provision of services that are flexible to specific needs, which may vary from day to day and week to week owing to changing health and personal circumstances. For example, offering the option to stop and restart ordering fresh fruit and vegetables or using the shopping service if alternative options are available.
  - Be responsive (the personalisation agenda) by providing a type of service that is right for the individual older person and allows choice regarding level of support required. This might require provision of physical-based activities for older men or sale of small quantities of foodstuffs for people living alone, etc.
  - Promote shared learning among older people, e.g. around cooking and sharing food preparation tasks or gardening, or through peer support, e.g. older men supporting others dealing with bereavement issues.
  - Provide affordable services, e.g. nominal service charges, and reduce costs to older people through using volunteers.
  - Provide a safety net for older people by addressing risks in the home through pragmatic and common-sense responses by volunteers and staff.
- Initiatives are about more than food. They include one or more of the following:
  - Providing social outlets and engagement with other older people, e.g. shared learning through cooking together and sharing meals.
  - Providing social support from volunteer befrienders and befriending groups (for sheltered housing residents).
  - Providing a contact person, phone number or customer newsletter for information and advice.
  - Providing support with household tasks and small repairs.
  - Time out and support for carers.
- The approach that underpins community food and health projects:
  - Avoids stigma, e.g. opening services such as community cafés to the wider public; promoting intergenerational activities.
  - Removes barriers between provider and carer through promoting the contribution made by older people themselves by encouraging their input to the redesign of services.
  - Provides non-clinical and non-judgmental services supported by the dedicated contribution of volunteers.
  - Develops the skills base of volunteers and workers and their learning around the importance of food to older people.
  - Involves partnership working with other partners from the public, voluntary and private sectors.

4. Reach

- Socially isolated older people, including those living in rural communities.
- Older people in hard-to-reach groups, for example men affected by mental health issues and bereavement or older people with dementia.
- Older people who have relatives or friends nearby who want to feel less dependent on them.
- Younger older people or those not attracted to 'traditional' groups or clubs for older people.
- Carers of older people.
- Volunteers, including older people.
- Service providers and other decision makers or policy makers.
- The general public.

5. Desired results

- Supporting older people through delivery of services linked to that of voluntary and statutory providers, to live an independent and well-nourished way of life in their own home and as part of the community, without feeling dependent on anyone or on the system, and thereby preventing need for more intensive support.
- Providing opportunities for older people to be involved in the design, delivery and ongoing management of community-based initiatives.
- Overcoming social isolation through social contact with other older people building on food activities, such as cooking from scratch and sharing meals, and other activities involving the wider community.
- Promoting intergenerational activities by involving older and younger people in food-based and social activities
- Providing choice in meeting nutritional needs, including delivery of shopping by volunteers or accompanied shopping, and befriending support.
- Increasing affordability of, and access to, basic foodstuffs in suitable quantities.
- Addressing specific support needs of hard-to-reach groups, such as men affected by mental health issues and bereavement, and carers of older people.
- Informing and influencing approaches by service providers to the needs of older people, including the impact of nutrition on mental health and wellbeing.
- Delivering training on the specific nutritional needs of older people.
- Influencing local and national policy on food access for older people.
- Providing outcomes for volunteers, including older people, such as transferable skills and the opportunity, through supporting others, to increase their own self-worth.

6. Influencing factors

Support

- The Scottish Government's 'Reshaping Care for Older People' programme is looking to transform how services are currently delivered. The development of outcomes-focused commissioning by the public sector is enabling longer-term solutions to be developed by community food and health projects.
- Investment by the public sector is supporting the following: cooking initiatives, such as fitting out community kitchens and providing access to kitchen facilities in day centres; providing allotment facilities for older people affected by dementia; and promoting information on a home delivery food service through libraries/library housebound services.
- Innovative partnerships are developing around food access, for example with housing providers and the retail sector.
- Cross-subsidy strategies, based on social enterprise models such as community cafés and wholefood suppliers, are funding preventive work around support for older people in the community. In addition, there are opportunities to generate income through delivery of training to service providers and the sale of training packs on the nutritional needs of older people.
- Department of Work and Pensions-sponsored employment programmes are promoting work experience through volunteering. This provides a pool of volunteers for food and health projects.

Barriers

- There is a lack of public understanding of ageing as a process involving moving from independence to dependence, with implications for flexible support provided on that journey.
- The focus on the nutritional needs of young people and early years has meant a lack of recognition of malnutrition among older people, including older men.
- The current economic situation necessitates creative ways of addressing the needs of older people, including malnutrition and complex support needs, while at the same time making efficiency savings. Despite many older people having multiple problems, they may not be assessed as requiring home care and are therefore not supported in terms of shopping or hot meal services. They may also find such services too costly to sustain on a fixed income. Older people can therefore miss out on services designed to address malnutrition if they are not already known by service providers.
- The removal of ring-fenced funding within the public sector has resulted in disparities between provision for older people in different parts of Scotland – which has been described as a lottery – in terms of support provided and by whom. The voluntary sector has been left to meet gaps in services (such as taking over the running of lunch clubs). This is in addition to the short-term funding of initiatives and withdrawal of funding for support staff at the end of pilots. There is a need for the Scottish Government to set national preventive malnutrition outcome measures for older people.
- There have been cutbacks in contributions made by the NHS and Social Work departments to shopping services for people recently discharged from hospital.
- Bureaucratic barriers, such as health and safety and child protection regulations, are restricting access to education and other suitable facilities for group cooking activities.

7. Assumptions

- Growing older is a process, and therefore support needs to be tailored to promoting independence as well as responding to increased dependence. This will be achieved by meeting changing needs as defined by older people themselves, and responding to what might be the tipping points for the individual older person, e.g. the death of a partner or neighbour, losing the ability to drive, etc.
- Developing social capital is achieved by bringing together older people and volunteers (many of whom are older themselves), with food acting as a shared focus of interaction and engagement.
- Co-production of food and health services means involving service users in the design and planning of services, and informing service providers about the key aspects of the services.
- Nutritional health and the risks around malnutrition in older people are not being addressed. This may be due to the social isolation of many older people, mental health issues, and the constraints on public expenditure.
- It is necessary to target older people who are not attached to 'traditional' groups and clubs, such as lunch clubs, hence the importance of marketing strategies through, for example, libraries, other referral agencies and word of mouth using networks of volunteers.
- Volunteers and workers from support services, and the general public as a whole, need to be better informed about the importance of nutrition to older people both physically and mentally, and the impact that poor nutrition can have on seemingly unrelated accidents and deterioration in health.
- Home delivery shopping projects, which support older people cooking for themselves, are providing alternatives to the provision of frozen meal services for housebound older people.
- Services need to be sustainable, requiring long-term investment, as continuity of provision is very important to service users.

Section 2

The evidence base

Economic evidence

If you are new to the idea of economic evidence you may want to look at the fact sheet that CFHS produced in 2012, which provides an introduction to different types of economic evidence and how they have been used by organisations working in the field.

Considering economic evidence? Here is some more food for thought...
www.communityfoodandhealth.org.uk/wp-content/uploads/2012/09/cfhs-factsheet-economic-evidence-august-2012.pdf

Preventative spend

Many organisations routinely use self-evaluation methods to report on the outcomes of their work and some have also commissioned external evaluations of their outcomes and economic impact. It can be hard, however, to make a consistent and compelling case for the contribution that your work makes to preventative spend without good evidence that you can use to make comparisons on outcomes and costs.

CFHS commissioned a review of evidence in relation to preventative spend for food and health work with older people to find out what evidence was available. The review looked at material from the UK and English-speaking world and found limited relevant material. The consultants suggested that this might be because:

- Much of the work to date has been promoted in the public sector and tools have been mainly trialled in public sector services, focussing on measuring health-service outputs such as potential savings on emergency admissions or GP visits.
- There is a more established evidence base in relation to physical activity. This may be a result of the fact that the improvements through short-term programmes are perhaps more easily shown in relation to physical activity than to food and health.
- Where research into food and health initiatives has been funded, the case studies produced have not always provided the kind of data on outcomes that can be used in relation to preventative spend.
- Finally, in the related area of building social capital and the contribution of, for example, community cafés, the studies tend to focus on the impact on the whole community and not just on older people.

They did, however, find some relevant material and in the next few pages you will find the details of some of the studies, with suggestions as to how you might use them.

Evaluation of The Food Train in terms of its Economic Value

Reference
Lacey, M. Community Food and Health (Scotland) (2009)

Outline of the study
The Food Train is a volunteer-led grocery delivery, befriending, and household support service for older people living in Dumfries and Galloway, Stirling, Dundee and West Lothian. In 2009 an economic evaluation of its operation in Dumfries and Galloway was carried out.

The research question addressed was, 'What is the economic value of the Food Train in delivering a volunteer-led service to support older people in remaining independently in the comfort of their own homes within their own communities?'

Applicability in evidencing outcomes relevant to community food initiatives
A logic model was developed to assess the following: direct costs of inputs such as staffing, overheads, fixed assets such as vans and running costs such as fuel and volunteer expenses; outcomes in terms of 'quality of life' benefits for customers, such as increased sense of wellbeing, independence, safety, reduced isolation and support with small household tasks or repairs; and outcomes for volunteers in terms of their own health outcomes, and for retail partners in terms of additional income as a result of facilitating shopping by housebound older customers.

Types of potential cost savings were identified for customers of the Food Train and for the public purse as a result of supporting customers to cope on their own with shopping and small household tasks without higher-cost packages of care in the community. The latter was explored by looking at the cost consequences over time of not having the Food Train services for clients of varying levels of dependency. The following potential outcomes of this might be:

- There would be an additional demand for the meals on wheels service.
- Additional home-care hours would be required.
- There would be additional hospital admissions as a result of poor diet and malnourishment (e.g. poor nutrition is a risk factor for diabetics, and wound healing from leg ulcers would be longer).
- There might be additional hospital admissions as a result of falls (e.g. older people attempting to do shopping and carrying heavy bags when not physically able, or attempting to do jobs around the house and falling).
- Patients would stay longer in hospital after surgery because they were unable to buy and carry home their own food shopping.

The perceived medium to long-term impact of the Food Train services was also mapped to the performance indicators of Dumfries & Galloway's local outcomes, namely: maximising household income; caring for vulnerable people; reducing inequalities in health; older people leading healthier lifestyles; improving community safety; supporting communities; encouraging people to be responsible citizens (volunteering); and improving employment and business opportunities (retail sector).

Extent of evidence of preventive spend
Preventive spend was assumed to be savings over time depending on varying levels of dependency of customers on the services of the Food Train. In order to quantify cost consequences the concept of 'delayed take up' was used, i.e. what might be the expected reduction in expenditure for health and social-care services from the contribution of The Food Train to delaying older people requiring additional support in the community or moving sooner into other forms of accommodation (e.g. residential homes). These savings were defined as the comparable costs of high-cost care packages for vulnerable clients living in the community – namely private nursing homes, residential care and sheltered housing – and low-cost care packages such as home care, support from a district nurse

or occupational therapist, visits to a GP, meals on wheels, or use of community transport or escort services to attend a day centre. Compared with the weekly cost of these services, varying from £16 to over £600 per week, the Food Train services averaged out at £5.77 per fortnight per customer.

Potential learning from study for community food initiatives

Cost-consequent analysis requires information on the costs of alternative services that might be required to meet either the nutritional needs or other needs of customers in the medium to long term. One way of identifying such costs is to use national data produced by government departments or from academic reports. For this study, 'Unit Costs of Health and Social Care' (Curtis, L. 2008)[1] was used to compare unit costs of the Food Train services with high-cost care packages for vulnerable clients living in the community. In order to assess the likelihood of such savings, estimates were made of the number of customers by level of dependency on the Food Train Services.

[1] Curtis, L. (2008), Unit Costs of Health and Social Care. PSSRU

Evaluation of peer-led community-based food clubs

Reference
Moynihan P, Zohoori V, Seal C, Hyland R, Wood C. Food Standards Agency (2006)

Outline of the study
The study looked at the impact of 'food clubs' on practical food preparation and healthier eating delivered by 'peer leaders' to older adults living in sheltered accommodation in north-east England. A 20-week food club was designed by a home economist and a dietitian, based on practical food preparation and healthier eating delivered by 'peer leaders' to older adults living in sheltered housing. Twenty-two people, aged 60 years and over, were recruited and trained to become Community Nutrition Assistants (CNAs) and to work as peer leaders delivering the food club (21 successfully completed the course and were awarded an Open College Network Certificate in Nutrition Skills). They were provided with a recipe file of easy-to-prepare dishes that were low in fat and sugars and high in fruits, vegetables, fibre and vitamin D, plus session plans. Nine older adults from each of 32 sheltered housing schemes (in total 288 older adults) in socially deprived areas were recruited to the programme. Half of the schemes received the food club over a period of 20 weeks; the other half served as a control group and did not receive the food club. The mean age of the 97 participants who received the food club and the 104 in the control group was 76 years (ranging from 71 to 84, with 15% being men).

Applicability in evidencing outcomes relevant to community food initiatives
Before the food clubs started, baseline information was collected from all subjects on:
- Diet (e.g. intake of total and saturated fat, carbohydrates (including sugars), fibre, vitamins and fruit and vegetables).
- The daily amount of foods belonging to the food groups of the Balance of Good Health.
- Blood levels of vitamins (as a marker of intake of fruit and vegetables).
- Weight and body fatness.
- Bowel movements (as an index of the adequacy of fibre intake).
- Knowledge of nutrition and food safety.
- Attitudes towards eating more healthily and perceived barriers to healthy eating.

This showed that the diet of older adults living in sheltered accommodation in socially deprived areas was high in saturated fat [13.4% energy intake compared with the Dietary Reference Value (DRV) of <10% energy intake], low in NSP (11.1g/day compared with the DRV of 18g/day) and fruit and vegetables (280g/day compared to the recommended intake of 400g/day) and low in vitamin D (2.6g/day compared with the Reference Nutrient Intake of 10g/day). At baseline the mean BMI was 29.2 kg/m^2; 76% of subjects were overweight or obese and 0.5% of subjects were underweight. At one year following the programme the change in the amount of energy from carbohydrate was significantly greater (and more positive) in the food club participants. Also preparing and cooking foods was perceived to be less of a barrier towards healthier eating for food club participants. However, other results were disappointing. Following the intervention:
- blood levels of fat soluble vitamins A and beta-carotene did not change and were not different throughout the period of the study;
- there were no significant changes in anthropometric measurements; and
- no changes in diet were observed, or changes in knowledge of nutrition or food safety.

Extent of evidence of preventive spend
In order to carry out a cost-benefit analysis, the cost of training the peer leaders and average running costs of the clubs were calculated. This showed that it cost approximately £700 to train one peer educator and that the average cost of running a food club was £130 per week. This cost would have been reduced if peer educators delivered more than one food club. For example, if each peer leader delivered five food clubs, the average cost/club/week would fall to around £70.

However, as this study had identified no significant outcomes in terms of changes in diets or knowledge of nutrition or food safety, it was not possible to complete a cost-benefit analysis.

Potential learning from study for community food initiatives

Despite this study not being able to complete a cost-benefit analysis, it does set out the approach that could be used for carrying out such an analysis. This approach would require the use of control groups to compare outcomes before and after health and other measures (one year afterwards), along with financial data on relative costs. (An appendix to the study sets out this approach in detail, including the questionnaires used.)

Community luncheon clubs

Reference
Burke D, Jennings M, McClinchy J, Masey H, Westwood D, Dickinson A. University of Hertfordshire (2011)

Outline of the study
This study of malnutrition among older people looked at how meals provided in a community setting in England contributed to the health, nutritional intake and wellbeing of older people aged 65 years and over living in the community. They recruited research participants using convenience sampling from a local volunteer-run community luncheon club for older people.

The study referenced research into the role of community food projects[2] which found that 'without community services [older people] would struggle to eat well. Those without an appetite were eating at lunch clubs and community cafés, those who couldn't get out were having community meals and shopping services and the community food projects provided support networks which would otherwise not have existed.'

Applicability in evidencing outcomes relevant to community food initiatives
The study by Burke found that community lunch group meals contributed to the nutrient intake of older people and provided benefit to their physical health and social wellbeing – nutrient intake on the day the sample of older people ate at the lunch group was higher than their median intakes for other days of the week of iron, calcium and folate, though intake of vitamin D did not reach the recommended level. Additional perceived benefits included the provision of a 'proper home-baked' meal, an increase in the range of food eaten, more affordable price and eating in a community setting which provided a space for social interaction and support.

Extent of evidence of preventive spend
The improvement in nutrient intake was seen as addressing the risk of malnutrition. According to The British Association for Parenteral and Enteral Nutrition, there is a high prevalence of malnutrition amongst older people in the UK: 35% in adults over 80 years of age; 25–35% in adults aged 60–80 years; and 25% in adults less than 60 years of age. 'Malnutrition has been estimated to cost the NHS £7.3 billion each year, which is more than double the projected £3.5 billion cost that will be spent tackling obesity. This cost is based on patients who suffer from malnutrition: needing a greater number of GP consultations; needing more frequent and more prolonged hospital admissions; and having a higher rate of complications and mortality compared with nourished patients.' (BAPEN. 2007).

Potential learning from study for community food initiatives
This study demonstrated how the use of nutrition data (quantitative analysis of seven-day food diaries of older people) compared with recipe ingredients of food served in lunch groups can provide valuable evidence in addressing potential malnutrition. Use of qualitative data from one-to-one and group semi-structured interviews can be used to further evidence other outcomes. This data is then used to make links with national evidence of preventive spend arising from tackling malnutrition among older people.

[2] Wilson (2009) Preventing malnutrition in later life: the role of community food projects.

Effectiveness of day services: day centres

Reference
Age UK (2011)

Outline of the study
This is a briefing by Age UK on research evidence supporting the effectiveness of day centres in delivering preventive services. While day centres provide a range of services and activities, promoting nutritional health is seen as a core element of their provision.

Applicability in evidencing outcomes relevant to community food initiatives
Age UK uses the term 'day services' to cover a diverse range of services and activities which cater for a variety of people and need. Day services serve a number of different purposes, most of which are broadly preventive, as well as promoting health and nutrition, e.g. providing social contact and stimulation; reducing isolation and loneliness; maintaining and/or restoring independence; providing a break for carers; enabling care and monitoring of very frail and vulnerable older people; assisting recovery and rehabilitation after an illness or accident; and providing opportunities for older people to contribute as well as receive.

Key cost savings are achieved through day services as follows: 'the extension of independence resulting from day centre attendance can delay or prevent a move to expensive care homes, thereby achieving long-term savings elsewhere; and good mental health (for which social inclusion is crucial) is linked with reduced consumption of health and social care resources.'

Feedback from day-centre service users showed that they appreciated that hot meals are on offer at day centres and lunch clubs, as many would not otherwise bother to cook similar meals for themselves. Furthermore, it is the only time they eat in the company of others, which improves their appetite.

The study quotes a background paper for the Wanless Social Care Review, based on a survey of older people, which found that of nine domains important to older people, personal care needs were most important, closely followed by social participation. They were twice as important to people as control over meals/nutrition.[3]

Extent of evidence of preventive spend
This study quotes a number of studies that have evidenced preventive spend in terms of the following:

- Comparable costs of day-care services[4]: local authority day care for older people costs £36 per session, and voluntary sector day care an average of £36. Voluntary sector costs ranged from £26 to £52 per day (mean £36, median £35).
- Savings through 'upstream' services reducing demand for 'downstream' services. Spending on day-care and home-care services can 'buy' additional days in the community for people, thus delaying or preventing the need to move into a care home. It shows that £60 of day care per week 'buys about 265 extra days in the community for people with mild or severe cognitive impairment, or 135 days for other older people using day care (the latter being comparable to the impact of intensive home care).[5]

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[3] Nine domains important to older people: personal care/comfort; social participation and involvement; meals and nutrition; control over daily life; safety; accommodation; (standard of) employment and occupation; role support (as a carer or parent); being in their own home.
[4] Comparable costs of day-care services are based on Curtis, L (2010) Unit Costs of Health and Social Care 2010, PSSRU www.pssru.ac.uk/pdf/uc/uc2010/uc2010.pdf
[5] Wanless Review Team (2005) Social Care Needs and Outcomes. A background paper for The Wanless Social Care Review www.cpa.org.uk/cpa/social_care_needs_outcomes1.pdf. Figure 2.

- Social and productive activities are as important as physical activities in reducing the likelihood of premature mortality and institutionalisation. Factors that sustain quality of life for older people, including having social roles and participating in voluntary and social activities, are also likely to improve health and wellbeing.[6]
- Making the case for savings: The Treasury's Invest to Save-Budget-funded Measuring Outcomes for Public Service Users (MOPSU) project. This identified significant benefits from low-level day services and lunch clubs in terms of the Social Care Related Quality Of Life (SCRQOL) of service users.[7] The project developed the Adult Social Care Outcomes Toolkit (ASCOT) which was designed to help inform outcomes-based commissioning.[8] In terms of cost-effectiveness, 'the study found that day care centres were found to improve outcomes at a cost equivalent to just under £25,000 per 0.1 unit improvement or mirroring guidance used by NICE if applied to this case, we would conclude that day care for older people is cost-effective.'

Potential for learning from study for community food initiatives

The references cited in this review are useful examples of how assessments of preventive spend have been calculated as part of national research studies. For example, the ASCOT tool[9] is explained in this study (page 18–21). This tool was tested in day centres in order 'to measure the more intangible aspects of service use, such as having a good social life, being meaningfully occupied and feeling in control'. The SCRQOL outcome score for a service which developed from this work allows comparison between service users' hypothetical expected quality of life/wellbeing in the absence of a service with the current quality of life/wellbeing reported.

[6] The evidence base for preventive services. Research briefing number 8 (2005) Research & Development Unit, Age Concern England.

[7] MOPSU (originally the Quality Measurement Framework project) was a three-year project led by the Office for National Statistics in partnership with the Department of Health, local authorities, the Personal Social Services Research Unit (University of Kent), the National Institute of Economic and Social Research and the National Council on Voluntary Organisations. The text cited is from the interim report (July 2008).

[8] ASCOT aims to capture information about social-care-related quality of life (SCRQOL). It has two components: a measurement scale of current wellbeing and an expected outcome (in the absence of services). Further information, guidance and tools are available at www.pssru.ac.uk/ascot.

[9] The Adult Social Care Outcomes Toolkit (ASCOT), containing outcome measures and a method for applying them to produce outcomes information for commissioning purposes.

National Evaluation of Partnerships for Older People Projects

Reference
Beech R, Bowling A, Dickinson A, Ellis K, Henderson C, Knapp E, Knapp M, Lord K, Roe B. Personal Social Services Research Unit (PSSRU) (2009)

Outline
This is included as a resource for food and health initiatives. It sets out some of the questions and evidence that can be collected in order to make the case for preventive spend.

The Partnerships for Older People Projects (POPP) programme was designed to increase learning about how to promote older people's independence, particularly through joint approaches to reducing reliance on long-term institutional care and acute hospital admissions. The learning from this programme has increased the evidence base about the benefits of prevention, early intervention and the integration of services.

The focus was on four important elements of prevention:
- Delay or reverse older people's deterioration or promote their independence and wellbeing.
- Reduce the risk of crises and the harm arising from them.
- Maximise people's functioning (i.e. reablement).
- Provide 'care closer to home' (i.e. intervention that is able to appropriately meet people's needs)

Applicability in evidencing outcomes relevant to community food initiatives
The evidence from POPPs showed that for every extra £1 spent on the POPP services, there was approximately a £1.20 additional benefit in savings on emergency bed days.

Potential learning from study for community food initiatives
The appendices to this study include copies of the questionnaires used for the final evaluation of the POPP programme, which provide a useful resource for food and health initiatives attempting to evidence preventive spend arising from their programmes.

WRVS Social Return on Investment (SROI)

Reference
Frontier economics (2011)
www.wrvs.org.uk/our-impact/reports-and-reviews/social-return-on-investment

Outline of the study
The SROI looked at hospital-based activities in Leicester and community-based activities in Staffordshire. In the hospital setting there are cafés, and in the community setting there are Darby and Joan lunch/social clubs, a community centre café, meals on wheels and a garden.

Applicability in evidencing outcomes relevant to community food initiatives
The community-based work is extremely relevant, although the meals on wheels element involves just heating the food for delivery. There are useful breakdowns that show the workings, with each different element illustrated. This is perhaps most useful in offering broad comparators as it is hard to see all the fine detail from the report.

Extent of evidence of preventive spend
The ratio for Darby and Joan clubs ranges from £1.89 to £3.57 for every £1 invested, the cafe ratio is £1.23 and the garden social centre ratio is £4.65. The ratio for meals on wheels is 99p because the meals are only heated. In the hospital setting it is hard to separate the café from other retail, which comes in with a ratio of £1.83 for every £1 invested.

Potential learning from study for community food initiatives
The study uses estimations, and makes assumptions in many places, which may lead some to question the results, but there equally may be a lot of underestimation.

Age UK: fit as a fiddle – final evaluation report

Reference
Ecorys UK with Centre for Social Gerontology, University of Keele (2012)
www.ageuk.org.uk/Documents/EN-GB/ID201168_Fit_As_A_Fiddle_Evaluation_Report_FINAL130313_FINAL.pdf ?dtrk=true

Outline of the Study
The study presents material from the national evaluation of the 'fit as a fiddle' portfolio which was awarded £15.1 million by the Big Lottery Fund to work across nine English regions from 2007 to 2012. The portfolio targeted people aged over 50 and delivered a range of activities to help promote healthy eating and improve levels of physical activity and mental wellbeing through locally led projects.

Applicability in evidencing outcomes relevant to community food initiatives
The study provides evidence from a portfolio of activities that achieved national scale. Tracking survey data show clear impact on levels of physical activity, healthy eating and improvements to mental wellbeing as measured by a series of recognised scales. Some changes are sustained three months after the projects ended.

Chapter 2 looks at outcomes for older people and there is useful material from the national cascade programme that targeted specific groups of older people including men, older people in care settings, isolated older people and ethnic and faith groups. Specific outcomes measured in relation to healthy eating are attitudes to healthy eating, the number of portions of fruit and vegetables eaten per day, and the number of times a week the person has eaten a meal prepared and cooked from basic ingredients.

Extent of evidence of preventive spend
Chapter 7 of the study covers the economic value of the portfolio using an assessment of the value for money provided by an intervention based on a model that measures economy, efficiency and effectiveness.

Case studies using estimated cost savings of programmes and an outcomes evaluation framework to measure social value are presented. The 'substantial' economic value generated by volunteers is also considered.

Potential learning from study for community food initiatives
Large-scale study that uses measures that are recognised. Draws on regional evaluation reports, which are equally useful and available on the Age UK website.

While a full cost-benefit analysis is outside the scope of the study, it concludes that the preventative work and/or outcomes achieved are likely to have resulted in benefits in the form of cost savings related to a reduction in demand for health and social-care services amongst participants.

National and local reports

The evidence base in relation to food, health and older people is growing. Below are some recent reports that can provide supporting evidence for your work.

National reports

Older People Living in the Community – Nutritional Needs, Barriers and Interventions: a Literature Review. Scottish Government (2009)
www.scotland.gov.uk/Resource/Doc/294929/0091270.pdf

Preventing malnutrition in later life – the role of community food projects.
Age Concern, Help the Aged (2009)
www.ageuk.org.uk

Personalisation, Nutrition and the role of community meals. ILC-UK (2010)
www.ilcuk.org.uk

Meals and Messages - a focus on food service for older people living in the community in Scotland. Consumer Focus Scotland/CFHS (2011)
www.communityfoodandhealth.org.uk/wp-content/uploads/2011/06/meals_messages_report_2011-3770.pdf

A Bite and a Blether – Case Studies from Scotland's Lunch Clubs. CFHS (2011)
www.communityfoodandhealth.org.uk/wp-content/uploads/2011/06/lunch-club-online-3662.pdf

Food Shopping in Later Life. Barriers and service solutions. Age UK (2012)
www.ageuk.org.uk

Micro funding for work around older people, health and wellbeing. What are we learning? CFHS (2013)
www.communityfoodandhealth.org.uk/wp-content/uploads/2013/02/cfhs-micro-funding-older-people.pdf

Local reports

Moray Older People's Survey on Food and Related Issues. Community First Moray (2009)
www.communityfoodandhealth.org.uk/wp-content/uploads/2010/03/moray-older-peoples-survey-on-food-and-related-issues-3688.pdf

Case Study: Food Services for Older People in North East Edinburgh (2011) Pilmeny Development Project and Edinburgh Food and Health Training Hub
www.pilmenydevelopmentproject.co.uk

Reshaping Care for Older People, Glasgow's Third Sector Mapping Report. Glasgow Council for Voluntary Service (2012)
www.gcvs.org.uk/engagement/reshaping_care_for_older_people_rcop/mapping

Informal Community Action & Reshaping Care for Older People
Midlothian Voluntary Action (2013)
www.evaluationsupportscotland.org.uk/resources/239/

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