

An independent evaluation of Food for Life cook and eat courses, Shoreditch Trust

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Executive summary

The cook and eat courses are run by the Food for Life Health and Wellbeing programme at Shoreditch Trust, a community organisation located in the London Borough of Hackney. The courses are mix funded by the local authority within their Community Kitchens programme, Hackney and City Wellbeing Network, Shoreditch Trust and private donations (McQuarrie).

The research was commissioned by the Trust and was undertaken between May 2016 and April 2017 by researchers from the Centre for Social Justice and Change, School of Social Sciences, University of East London.

Reviewed research studies provide strong evidence to support the idea of introducing community-based 'cook and eat' initiatives particularly in disadvantaged areas and in Caribbean and South Asian communities where residents tend to have the least healthy diets.

The research approach to evaluating cook and eat course is problems-based and realistic and draws on monitoring data, staff reports, self-completion questionnaires (40), in-depth interviews (8), and observations (2). Research participants include a wide range of participants with a bias towards those with more complex health and social problems.

The study reviews the six week courses designed for adults run in five community kitchens on housing estates in Hackney and open to anyone in the community over the age of 18 years, and courses ran as part of the Wellbeing Network for people with mental health issues and held in the Healthy Living Centre owned by Shoreditch Trust.

The purpose of the cook and eat courses are to increase participants' knowledge, skills, and confidence in meal planning, budgeting, healthy eating and cooking, and anticipates that home cooking will improve their diets. Other intended outcomes include increased confidence to work as a group, to engage socially, and a reduction in social isolation.

Between October 2015 and March 2017, 33 courses were organised, 9 of which were for those who belong to the Wellbeing Network. Attendance is voluntary and courses are free of charge.

The monitoring data shows that in the two years from the beginning of 2015 to the end of 2016 a total of 200 participants attended the adult classes. Most were women (72%), aged between 36 and 55 years old (62%), and 20% aged 26-35 years, with few under 26 years and none over the age of 66 years.

The high number of minority ethnic attendees demonstrates that classes appeal to Hackney's diverse ethnic groups who attend for several reasons including a love of cooking, a desire to improve their cooking, to learn about healthy diets, to be in a positive social setting, and as an opportunity to meet local people.

The findings show that the courses are well run, staff and sessional workers are highly regarded, participants learn, find the courses pleasurable and many enjoy them socially. Of the questionnaire respondents: the overwhelming majority feel that the courses are warm and welcoming (98%), and that they have learnt about healthy foods (95%), feel more confident about cooking (88%), enjoy cooking with others (88%) and eating a meal together (68%).

A synergy is evident between motives for attending and the course itself, indicating the relevance of cook and eat classes to residents' wishes and needs. All courses are fully or over-subscribed and are attractive to those with poor health and poor diets.

The implementation of the courses benefit from being located at Shoreditch Trust which has strong community connections and good reputation.

With the robust implementation of the initiative we can have confidence that the courses are contributing to improving the lives of participants.

The majority of questionnaire respondents said that they have improved their diet (70%). These improvements include: cooking using more ingredients (80%); eating less salty and/or sugary foods (73%); and, eating more fresh fruit and vegetables (69%).

The majority of respondents have made notable improvements in their eating habits and report that they: cook more for themselves, family and friends (80%); eat less processed or ready to eat meals (74%); and, eat fewer takeaways (58%).

The majority feel more optimistic about the future (63%), better about themselves (55%) and many feel more able to chat to other people (50%) and some feel more confident about making friends (40%).

We found that the target outcomes do not capture the full impact of the initiative, particularly for those in poor health, those anxious about their future health and those struggling to live on low incomes and in poverty. For these attendees classes enable them to feel valued, to have fun and to laugh, and gives them a great deal of pleasure.

Repeat attendees further improve their healthy eating outcomes by consuming more fruit and vegetables and buying fewer takeaways. Social outcomes are particularly beneficial for those who are lonely.

Implications of findings and further actions

Cook and eat classes can act as a springboard for participants to make further improvements to healthy lifestyles. The research findings show that attending cook and eat classes represents a moment in time when participants are motivated to improve their lifestyles, it is a time of heightened awareness about their health and they learn that they can make a difference to their own health. This situation presents an opportunity to develop an integrated set of interventions alongside cook and eat sessions to support participants sustain these improvements such as exercise.

Cook and eat attracts a diverse group of local people who express a desire and willingness to meet other local people. Engaging further with these participants may provide a productive opportunity to increase community action.

As may be expected it is more difficult to achieve positive personal and social outcomes for those who have the poorest and most complex health issues. Creating incentives for staff to keep working hard to engage these groups includes thinking about how best to measure and assess 'success', for example, by monitoring returners, and reward the additional effort required to engage with this group.

1. Introduction

The cook and eat courses are run by a team within the Food for Life Health and Wellbeing programme at Shoreditch Trust, a community organisation located in the London Borough of Hackney. The courses are funded by the local authority within their Community Kitchens programme under the auspices of public health.

This evaluation study reviews the six week courses designed for adults, run in five community kitchens on housing estates in Hackney and recruits participants from a Well-being Network for people with mental health issues and is run at the Healthy Living Centre owned by Shoreditch Trust.

The research was commissioned by the Trust and was undertaken between May 2016 and March 2017 by researchers from the Centre for Social Justice and Change, School of Social Sciences, University of East London.

1.1 Cook and eat

The purpose of cook and eat is to increase participants' knowledge about different foods, healthy eating and food safety and the development of food-related skills such as chopping/mixing, following recipes, meal planning and budgeting and cooking. With an improved knowledge about healthy foods and increased cooking skills it is anticipated that participants will make healthier food choices. Other intended outcomes include increased confidence to work as a group, to engage socially, and a reduction in social isolation.

Between October 2015 and March 2017, 33 courses were organised, 9 of which were for those who belong to the Wellbeing Network. At the end of a course participants receive a certificate of completion.

2. Ill-health, poor diets and improving healthy eating

Numerous studies provide evidence of robust causal relationships between poor diet and ill-health.¹ Food-related illness arises from, for example: too much salt that is linked to high blood pressure, stroke and coronary heart disease; too much saturated fat is connected to cardiovascular disease; and, added sugar to tooth decay.²

Data on overweight and obesity among adults (defined as people aged 16 and over) are mainly from the Health Survey for England (HSE) and results for 2015 show that 63% of adults were overweight or obese (68% of men and 58% of women). Ill-health associated with obesity has increased from 15% to 27% between 1993 and 2015. In the UK, socioeconomic

¹Rees, R., Hinds, K., Dickson, K., O'Mara-Eves, A., and J. Thomas (2012), *Communities that Cook: a systematic review of the effectiveness and appropriateness of interventions to introduce adults to home cooking*. EPPI-Centre Report No. 2004. London: EPPI-Centre, Social Science Research Unit, Institute of Education, University of London.

² Rees, R., et al., op cit., see footnote 1 above.

inequalities have increased since the 1960s and this has led to wider inequalities in both child and adult obesity, with rates increasing most amongst those from poorer backgrounds, and South Asian and black Caribbean communities. The most serious health consequences associated with overweight and obesity in adults include Type 2 diabetes, cardiovascular disease (including ischaemic heart disease, stroke and peripheral vascular disease), musculoskeletal disorders and some cancers.³ These studies indicate how medical, psychological and social problems increase due to a reduction in exercise, loss of confidence, 'comfort eating' due to depression, leading to additional weight gain and further medical complications. However, evaluations typically use a medical model of assessment and measure changes in amount of carbohydrates consumed, bowel movements, and Body Mass Index, for example, and pay less attention to social outcomes.

One response to these issues is to introduce 'home cooking initiatives' to encourage healthy eating. In a systematic review of studies on the effects of home cooking courses for adults in the UK conducted in 2012 the authors concluded that the findings are inconclusive due to a lack of high-quality evaluations.⁴ The review included studies with comparison groups but other research designs able to assess causal linkages were excluded, and evaluation studies not included in the review suggest that home cooking initiatives have potential to contribute to improvements in healthy eating and to have social outcomes.

The research studies described above that connect poor diet to ill-health provide strong evidence to support the idea of introducing community-based 'cook and eat' initiatives particularly in disadvantaged areas in the London Borough of Hackney where residents tend to have the least healthy diets. The challenge for practitioners is to implement their programme in a manner that encourages attendance and enables participants to improve their diet and their ability to cook. Existing evaluation studies can be limited in what outcomes they measure and there is a case for knowing more about the contribution these initiatives can make to everyday lives. In this study possible additional outcomes are explored by drawing on in-depth interviews and self-completion questionnaires.

3. Research

3.1 Research approach

Our approach is problems-based and realistic. We start by finding out how social, psychological, economic, and community problems are formulated or characterised by an initiative, and ask 'to what problem is this intervention a solution?' An evaluation finds out if

³ See the following websites: http://www.noo.org.uk/NOO_about_obesity/severe_obesity, and http://www.noo.org.uk/NOO_about_obesity/inequalities.

⁴ Rees, R., Hinds, K., Dickson, K., O'Mara-Eves, A., and J. Thomas (2012), *Communities that Cook: a systematic review of the effectiveness and appropriateness of interventions to introduce adults to home cooking*. EPPI-Centre Report No. 2004. London: EPPI-Centre, Social Science Research Unit, Institute of Education, University of London.

the problems to which an intervention was designed as a solution have been modified, and how, and takes into account unintended consequences or harm.

In keeping with realist evaluations, we produce evidence on what works, for whom and under what conditions.

- We consider interventions as theories; these theories of change may be non-linear, inconsistent, and are causal only when they are active. Interventions impact upon the conditions that make them active and this can affect outcomes.
- The effectiveness of interventions is sensitive to the context within which they are implemented.
- Interactions with other social programmes affect the operations and outcomes of the intervention.
- Community factors influence the anticipated causal mechanisms.
- Interventions typically evolve and change as different decisions are made and an evaluation takes this 'life course' of an initiative into account when assessing its progress.

We think that it is useful to conceptualise interventions as having four key features and these structure our data collection and analysis:

- a) Referrals: are the participants who can benefit from the intervention being referred/self-referrals?
- b) Attractiveness: is the intervention relevant and does it act as a 'hook'?
- c) Influencing: does the intervention change attitudes, 'mind sets', behaviour?
- d) Facilitating: are there pathways to other programmes to meet multiple needs of participants over time?

The primary data collection is structured to gather information on these issues and in interviews we enquired about decision making and the reasons for making particular decisions rather than others as well as identifying reasons for changing or not changing shopping, eating and cooking habits. We also asked about participants' circumstances and their feelings as they can explain when changes occur and the reasons poor eating habits persist.

In this study the short term effects of attending are taken into account, but the findings suggest that longer term effects are possible particularly with respect to changes in weight, health and joining community groups.

3.2 Data collection

Information for this study was collated from various sources and a multi-method approach to data collection was used to gather information from staff and participants and the context within which the programme is managed. Secondary data sources included project

monitoring data, evaluation reports written by staff, information from websites, and the academic literature.

Primary data collected included:

Face-to-face interviews were conducted with eight participants; four women and four men, aged between 30 and 54 years and from a variety of ethnic groups including two black British and two white British, Irish, Latin American, black Caribbean, and one who defined himself as Jewish. Interviews were conducted in a public place and lasted between 30 minutes to over an hour. Six interviews were recorded and transcribed to facilitate analysis and for the two others, one was conducted by telephone and the other took place in a noisy café, notes were taken contemporaneously and additional notes and reflections completed immediately after the conversation finished.

Self-completion questionnaires were on-line and distributed at the end of a course. They were completed by 40 participants of whom 82% were women and 18% were men. Respondents were mostly white British, Irish or European (31%), followed by an equal number of Asian or Asian British (23%) and black African, Caribbean, Black British (23%), as well as dual heritage (6%) and six respondents from other ethnic groups including white African and American. They were predominantly aged between 36 and 55 years old (62%), 24% were aged 26-35 years and 11% were aged 56 to 65 years, with one respondent aged between 17 and 25 years. A third (33%) said that they had physical disabilities and/or a long term illness. The majority of respondents lived on their own (55%) or with family or relatives (29%) and most lived in council or housing association accommodation (46%), private rented accommodation (30%) or had their own mortgage/owned their home (24%). The data were entered onto a statistical package for social scientists to facilitate analysis.

Two observations were carried out at different venues and sessional staff and 17 participants were observed for two hours on both occasions. The researcher took the opportunity to talk to sessional staff and engaged in conversations with participants during the meal at the end of the class. These data are used in this report.

Formal conversations with staff included an initial meeting and a further one mid-way through the research. Several informal conversations took place to clarify the monitoring data.

3.3 Data representativeness

Achieving a sample of research participants who are representative of all those who attended cook and eat classes at the time of the research is extremely difficult to achieve. However, the reliability of research findings can also be achieved by including a wide range of different types of participants whose experiences maybe typical of their group. This approach is particularly important for the cook and eat classes which is a universal and targeted provision and is relevant to our interest in how the initiative works, for whom, and in what circumstances.

Interviewee names and contact details were given to the researchers by Shoreditch Trust staff and we asked for a variety of participants from all those who were attending at the time of the research and who staff had contact details for. When setting up the interviews several participants either did not answer their telephones three times or their number was unobtainable (7 participants) and some declined to be interviewed (5 participants). Thus 20 participants were approached and 8 agreed to be interviewed giving a response rate of 40%. Of the eight interviewees there is a bias towards those with complex health issues and those who were lonely. These participants are the target group and the interviews provide rich insights into how attending cook and eat classes work for these participants and, arguably, is more useful than having most information gathered from those with few health issues.

We have little information about how to assess the representativeness of who completed a questionnaire. We note, however, that compared to the monitoring data more women and Asian or British Asian completed the questionnaire, that the ages are comparable, and significantly more questionnaire respondents had a long term illness or physical disability. Thus, overall our research sample is bias towards the targeted group of participants.

3.4 Data analysis

All data were analysed from the situated logic of the participants. We used this information to generate hypotheses about how the project works and used the data to refute these hypotheses and selected those that best fit the data. We discussed how the classes accommodated those with complex health and social issues as well as those who were socially confident and had healthier lifestyles. By using this approach to data analysis we gained some insights into how the cook and eat initiative works, for whom, and under what circumstances.

We considered causality and other factors that may contribute to the outcomes. In our judgement there are strong reasons to believe that the cook and eat classes contributed to the changes identified in the study including the robust implementation and participants' prior motivation to improve their diets. We worded questions on the questionnaire that started with a phrase like 'Since attending cook and eat classes...' to encourage the respondent to relate any changes to the initiative. We also asked if there was a positive change, no change or a negative change for each factor, for example; 'Since coming to cook and eat, I feel more confident, less confident, or about the same, to... make friends or to cook for friends/family' and so on, to encourage honest responses and gain a balanced perspective about outcomes.

Quotes are used to illustrate and as evidence.

3.5 Limits of study

This independent evaluation study is focussed on short-term and self-reported changes arising from attending cook and eat classes. Some repeat attenders started attending 18 months before the research commenced and information from these participants gives us some insights into changes in diets over a slightly longer time period. The findings are

dependent on the honesty of participants and the interview schedule and questionnaire included some similar questions and responses to these questions remained consistent.

We have, however, no systematic information about the continuation or otherwise of the many improvements we found in the longer term, although at the time of the research the majority of participants were motivated to keep improving their diets and felt more confident in doing so.

4. Who attends?

The monitoring data shows that in the two years from the beginning of 2015 to the end of 2016 a total of 200 participants attended the adult classes run in community kitchens.⁵ Almost three quarters of the attendees were women (72%) and over a quarter were men (28%) indicating that men are under-represented since they are more likely to be overweight or obese than women. A minority of attendees specified their age (38%) and of this group most were aged between 36 and 55 years old (62%), and 20% aged 26-35 years, 10% aged 56 – 65 years, and 8% aged 17-25 years old, with no participants over the age of 66 years. Sixteen participants declared that they had physical and/or a long term illness such as a heart condition, epilepsy or mobility difficulties.

The ethnicity data for participants are presented in the table below and their comparison with information on ethnic groups living in the borough of Hackney show that the cook and eat project is successfully attracting ethnic groups who typically have higher rates of ill-health due to cultural diets and obesity, namely black Caribbean and south Asians.

Table 4.1: Ethnicity of participants compared to ethnic population in Hackney

	Cook and eat participants (percentage)	Hackney (percentage)	Difference (percentage)
White British, Irish or European	43	54	-11
Black African, Caribbean or British	28	23	+5
Asian or British Asian	17	12	+5
Dual heritage	8	6	+2
Other ethnic group	4	5	-1

Note: data from the 2011 Census are used for the ethnic groups in Hackney.

The monitoring data from April to November 2016 show that the courses were over-subscribed indicating a demand for the courses. [NEEDS DATA]The challenge for staff is, however, to sign up residents who live locally and who have low socio-economic status.

The table below gives the area postal codes for the centres and the percentage and number of attendees living in the same location. Whilst these centres are situated in areas of deprivation, the distribution of multiple deprivation in 2015 shows that Hackney has pockets

⁵ This information includes the five community kitchens and the Healthy Living Centre.

of intense disadvantage interspersed with more affluent places. Focussing on the poorest neighbourhoods and expecting only to recruit poor participants is, therefore, going to be challenging as centres are used by many different income groups, particularly if they are also children’s centres, nurseries and run after-school activities. ⁶

It is possible that a social mix of participants may be beneficial for achieving outcomes and improves community inclusiveness. Tutors described how a diverse range of ethnicities attend and those from different social backgrounds, and how there is a strong sense of comradery, as well as mutual respect, in the classes. However, sometimes no attendees on a course live on the housing estate where the community kitchens are located.

Table 4.2: Post codes of centres and attendees living in the same area

Postal code area of the Centres	Attendees living in same area Percentage (number of attendees)
NI	10 (20)
N16 (two Centres)	20 (39)
E2	8 (39)
E8	20 (38)
E9	9 (18)
Total	67 (130)

For the most part attendees addresses are in the same postal code district as a community kitchen with one exception, the largest group who live in E5 and account for almost a quarter of attendees (23%). E5 is situated to the east of the borough and does not have any courses in their area. The Centre located in E9 lies to the south of E5 and two Centres in N16 to the west and are accessible to E5 residents. The remaining 10% of participants live mainly in Hackney.

The self-completion questionnaire data shows that less than half of the respondents (42%) live within 15 minutes walking distance of the course. There may be many reasons why it is difficult to recruit people who live within a short walk of the kitchens including a lack of confidence to try something new, associating a course with school that ‘never did anything for me’, shift work, chronic illness or an unwillingness to be out-and-about in the early evening. How to motivate local people with poor diets to attend may require ‘extra’ encouragement from GPs, nurses, voluntary organisations or housing officers, for example.

⁶ Indices of Multiple Deprivation 2015 Briefing.
www.hackney.gov.uk/media/2666/Deprivation/pdf/Deprivation

One interviewee was referred by a doctor, he is overweight, has been hospitalised several times with panic attacks, suffers from depression and is lonely. He commented:

I was referred to it by my doctor. It was mentioned to me, 'Would you like to do cooking?' and I said yeah. It's a good way to talk to people but as I say, learning about food, which is something I hadn't done, it's microwave and doughnuts. When you're depressed you eat. (Interviewee 2, male)

Of those who completed a questionnaire 33% had a physical disability/long term illness and 73% said that they suffered from anxiety or depression, suggesting that these target group are being reached through the Wellbeing Network.

Interestingly, only half the questionnaire respondents said that they attend because the course is held locally (50%), suggesting that being on the 'door-step' local is not necessarily a strong motivating factor for attending for some. As this participant notes accessible public transport can be important:

I just hop on a bus, it's straight up the road, it's simple and easy. (Interviewee 8, female)

5. Implementation

5.1 Planning and recruiting

Two members of staff manage five course leaders, 12 sessional workers and five volunteers. Each class has a sessional leader and worker and sometimes a volunteer who are food professionals including nutritionists. The sessional staff buy the food and as far as possible purchase locally sourced produce. The Shoreditch Trust staff liaise with the owners of community kitchens and there are challenges associated with using shared spaces with multiple users and ensuring that kitchens are clean at the beginning of each class.

Considerable effort is made to advertise the courses in the local neighbourhoods and to attract local people. Staff place flyers in community centres, advertise in newsletters, and inform other local community groups. The classes are also advertised more widely across Hackney in Hackney Today, by Shoreditch Trust health coaches, in libraries, GP surgeries, and flyers are handed to parents and carers outside school gates. Although staff recognise the importance of recruiting those with low socioeconomic status, they also realise that these can be the hardest group to attract to classes.

5.2 The courses

Courses held in the community centres start at 6pm and last for two hours and those that take place at the Healthy Living Centre are run during the day. The courses include budgeting and shopping skills, learning practical cooking skills and food hygiene, eating healthily and adapting recipes to make them healthier and special dietary needs. Sessional leaders pair more experienced cooks with those who need support and those with low self-confidence with more confident participants. The following observational notes illustrate what happens during a class:

Participants are split into two groups, one is making meatballs, and the other is making the vegetable accompaniment. Each individual makes a different component but they work together in a team, e.g. one chops the onions, one the herbs, one makes breadcrumbs.

When the prep is done they all cook together in the kitchen area. Whilst cooking staff prompt them with questions like “why do we use wholemeal flour instead of white?” They get some responses and inform them of other health benefits not mentioned. When making the apple scones staff also direct them to leave the skins on the apples, informing them of the health benefits of the apple peel.

Towards the end of each class participants sit down for a meal and eat the dishes they have cooked. During one observation they talked about the treats they like eating such as cakes and chocolate, two men shared stories about growing up with physically violent criminal fathers, and the conversation included accounts of broken home appliances including washing machines and phones. The researcher also observed silences which were typically broken by the more sociable participants.

Data on the courses themselves unequivocally show a positive and learning environment; the overwhelming majority feel that the courses are warm and welcoming (98%), and that they have learnt about healthy foods (95%), feel more confident about cooking (88%), enjoy cooking with others (88%) and eating a meal together (68%).

The following quotes illustrate some of the factors that contribute to creating a positive environment and includes the warmth and kindness of tutors, as this questionnaire respondent explains:

Sacha⁷ and Afsia were lovely teachers, very warm and kind and a pleasure to learn from. (Respondent, self-completion questionnaire)

Several research participants commented on the inclusiveness of the tutors and how they like the recipes, as one respondent comments:

Fantastic hosts who value inclusion and learning for all and great choice of food. (Respondent, self-completion questionnaire)

Others commented on how much they learnt and the following respondent was one of several who refers to their weight loss:

Teachers were very good at making sure everyone was involved, the food we cooked was excellent and I learned a lot. I also lost some weight. (Respondent, self-completion questionnaire)

Several participants surprised themselves by finding cooking is much easier than they had anticipated and being able to take the recipes home is particularly welcome. Two interviewees explains:

I was brought up in care and when I left the children’s home I didn’t know how to cook. You didn’t have to cook at children’s home. I didn’t know how to cook. This has shown me how easy it is. It’s giving you a lesson. It’s a crash course for me and now I’m reading recipes. (Interviewee 2, male)

⁷ Pseudo names are used throughout this report.

Yeah so like I say, I took the recipe cards that we got from it and I've still got them and so I would take them out now and again... 'Oh yeah, those Vietnamese wraps and stuff like that there and Turkish breads and stuff.' They're quite easy to put together but you just need the reminder of the recipe... (Interviewee 1, male)

5.3 Reasons for attending

Attendance is voluntary and free of charge and the cook and eat courses are a good example of local people taking up an opportunity to improve their own lives. Several reasons explained participants' motivations to attend. Some are clustered around cooking and healthy eating; to learn how to cook (63%), they like cooking (58%), and to learn how to buy and eat healthy food (55%). Other reasons are social and the courses provide an opportunity to meet local people (73%). Loneliness motivated almost a quarter of respondents to attend and for them the course is 'something nice to do' (23%), or participants are worried about their health in the future (23%). A few who attended are unable to cook at home (4 respondents). Others are not motivated by outcomes, they come 'for something to do' (9 respondents) and a few come for free food (4 respondents). Every participant gave several reasons for attending and said that they benefited in several ways as shown by the findings on outcomes described in the following section.

Prior motivation is a common characteristic of all the research participants and conversations with the target group reveal multiple motivations. During a conversation with a woman in her early 40s she mentioned several reasons for attending:

Because I always wanted to learn how to cook, never had the confidence to learn how to cook,... One of the other reasons that I wanted to do it is 'cause of my cholesterol levels... Been in and outta hospital for the last couple of years. Mentally it gets to you as well. That was probably one of the other reasons why I went to the cooking class, just to get out for one night a week... (Interviewee 4, female)

Attending due to experiences of ill-health and anticipating worsening health is a recurring reason for attending as another interviewee explains:

I'm 42 and this is an age now where the question of diabetes and obesity becomes apparent. Plus I was recovering from other health issues as well... I wanted to really cut down on my sugar and fat basically and eat much healthier. (Interviewee 5, male)

Other interviewees wanted to improve their cooking skills and learn to cook new recipes. One interviewee knew about healthy eating but enjoyed trying different ways of cooking and new spices and is using some of the recipes 'which the family love'. Another interviewee also knew about healthy foods, knows how to shop well and uses the 'offers as best I can'. She attended because she 'loves food' and as a person not in paid employment, wanted to 'get out of the house for an evening'. During an observation a Turkish woman said she came to learn new ways of cooking that are healthy and to cook without using salt and oil which are widely used in her culture.

5.4 Attendance

Shoreditch Trust staff make every effort to ensure that those who have signed up for a course attend regularly. The staff email and/or text participants to remind them to attend on the day of each session and call them later to find out why they did not attend. The monitoring data shows that there are some regular attendees but for many their attendance is less than 100%, with some attending twice during a six-week course.

Interviews with participants and comments on the self-completion questionnaires give some insights into the reasons for non-attendance, and the following comments are typical:

Unfortunately I didn't manage to go to all the courses as there were other things happening on Thursday evenings... (Respondent, self-completion questionnaire).

For others their ill-health can prevent them from attending as this woman explains:

A bad day is calling up my mum to help me physically, get me out of bed. That's a bad day. It's not being able to move. That's a bad day. (Interviewee 1, female)

It is not clear from this study, however, the extent to which there is a relationship between attendance and outcomes and it is possible that a complex relationship exists between them with some benefitting from attending intermittently and others attending regularly but not benefitting as much, as the findings in the final section of this report suggest.

Thus, the findings show that the courses are well run, participants learn, find them pleasurable and many enjoy them socially. They show a synergy between motives for attending and the course itself, indicating the relevance of cook and eat classes to residents' needs. In our judgement the staff are achieving the best possible rates of attendance and the reasons for non-attendance are likely to be factors over which the staff have little or no influence such as shift work, illness, and child care.

With the robust implementation of the initiative we can have confidence that the courses are contributing to making a difference to the lives of participants, identified by the many positive outcomes discussed in the following section.

6. Outcomes

Enjoying courses and learning to cook new recipes does not necessarily translate into improving a diet but rather provides a context within which participants might change their eating habits. The findings presented in this section show, however, that cook and eat participants did eat more healthy foods and benefited socially from attending. The positive and supportive environment created by the tutors is likely to have contributed to these changes.

6.1 Healthy eating and improved cooking

The majority said that they have improved their diet (70%). These improvements included:

- Cooking using more ingredients (80%)
- Eating less salty and/or sugary foods (73%)
- Eating more fresh fruit and vegetables (69%)

For participants living on a limited budget, some of whom regularly run out of money, eating healthily is more challenging and sessional staff give helpful tips about how to maintain a healthy diet in these circumstances. One interviewee who is short of money and finds it 'too expensive to run a freezer' explains how he stores healthy foods in his cupboard:

If you get the dried goods and the tinned stuff in the beauty of that is you can leave it for a rainy day but if you need to cook because you're really hungry and you're out of money you can use that to supplement your diet and keep yourself eating. (Interviewee 5, male)

The majority of participants have made notable improvements in their eating habits and reported that they:

- Cook more for themselves, family and friends (80%)
- Eat less processed or ready to eat meals (74%)
- Eat fewer takeaways (58%)

Particularly helpful for participants is the 'hands on' cooking and eating the dishes they cook. This gives them confidence to learn how to use different ingredients and to taste new flavours. Participants commented on how learning to substitute for sugar, and trying new recipes was 'inspiring':

This is an excellent course that teaches people how to cook healthy and delicious meals without salt or sugar (Respondent, self-completion questionnaire)

Catrina is the best cook and teacher. Not only do her recipes taste great they are really cheap too (frozen fish, dates instead of sugar, use beans/lentils to bulk up) thank you! (Respondent, self-completion questionnaire)

Comments by an interviewee below emphasizes how important it is to make good choices when selecting ingredients and to cater for limited budgets:

She went into those details, talking about flax seed. I don't know if you've ever had it. It's disgusting. Wouldn't touch it. I spent a fortune on health food shop and I tell you what, it's vile. I wouldn't even give it to the birds. (Interviewee 4, female)

Some findings appear less strong and these illustrate some of the challenges in delivering courses, and raise issues about assessing 'success' as personal circumstances can limit what is achievable. For example, tutors encouraged participants to read the labels on cans and bottles and just over half (53%) said that they look at labels more often but some lack energy or are in a hurry when shopping, making it less likely that they will read labels. Participants with limited budgets often already shop carefully, although 41% said that they have learnt how to shop more cheaply. Some interviewees noted how shopping cheaply can mean not buying such healthy food which causes them a dilemma.

Some participants have an extremely unhealthy diet and achieving a healthy diet requires making significant improvements. During one observation two White men discussed living off chocolate and biscuits from a pound shop as well as takeaways. However, one of these men described how he has recently incorporated bananas into his diet. Others have made more substantial improvements, as this interviewee comments:

What I like about this is you're trying all different stuff at the place, fruit and veg and that. I never used to eat none of that stuff. (Interviewee 2, male)

Some participants are already achieving many intended outcomes; for example, during an observation the researcher made the following comment about a participant:

Already led a healthy lifestyle and ate healthily so there was not much need for change. (Observation notes)

Whilst fewer improvements can be expected for those who are already knowledgeable about healthy eating and have a healthy diet, a quarter of questionnaire respondents said that they found it difficult to improve their diet even though they would like to (25%). Whilst it is evident that this group have improved their diets this requires a lot of effort and they relapse, for example, cutting down on takeaways can be difficult when they feel low as they are a 'comfort' food. The following extract from an interview gives some insights into those who wish to improve their diet and the types of occasions when they find it too difficult to follow their good intentions:

I still eat crap. Sweets. It was my birthday a week ago and I spent a week eating sweets, all the chocolate and stuff. It's stuff like that. I will try to do better. I know I will try to do better 'cause I have to try and keep my cholesterol down. I want to learn as much different bits of cooking, as much different dishes as you possibly can to help that. (Interviewee 4, female)

Those who said that they have improved their diets noted that they feel better and they also talk about other changes they have made that contributes to a healthier lifestyle. This interviewee comments:

Yeah I am feeling a lot better. The weight isn't going as quickly but I think that's also to do with age and my medication probably. But I also gave up smoking and also don't drink as much and I think overall, when I feel good, I do feel better and it lasts a bit longer. (Interviewee 6, male).

Others commented on how they now know that they can control their weight and are motivated to take exercise. They notice that a healthier diet enables them to function better mentally, as this interviewee explains:

Yeah, I do. I notice the different... It's helped me to control my weight... It's encouraged me to take some exercise as well but I am concerned about it... Yeah, but just eating properly will help keep my weight down, keep my sugar levels down, keep my brain functioning properly and stuff like that. (Interviewee 5, male)

These findings suggest the cook and eat classes can act as a springboard for participants to make further improvements to their lives. Finding out if these improvements continue requires a study to follow up participants over time but the findings show that attending cook and eat classes represents a moment in time when participants are motivated to improve their lifestyles, it is a time of heightened awareness about their health and they learn that they can make a difference to their own health. This situation presents an opportunity to develop an integrated set of interventions alongside cook and eat sessions to support participants sustain these improvements, such as introducing exercise classes.

6.2 Personal, social and community benefits

The findings presented in the table below show discernible personal and social benefits for many participants. A majority said that they felt better about themselves, and more hopeful about the future, and over a third (38%) said that they feel less depressed or anxious since attending cook and eat classes. Nevertheless, a noteworthy proportion of attendees said that they remained 'about the same' and these findings occur when participants feel confident and are sociable prior to attending classes, as the following respondent indicates:

Amazing initiative! Loved developing my confidence in cooking for others. Was already healthy and happy. (Respondent, self-completion questionnaire)

The following table summarises these findings from the self-completion questionnaire as follows:

Table 6.1: The extent of personal and social benefits

	Increased or improved (percentage)	About the same (percentage)
Relaxed around other people	48	48
Able to chat to other people	50	50
Confident about making friends	40	58
Feelings about myself	55	45
Feelings about the future	63	38
Feeling depressed/anxious	38	62

Note: some percentages do not add up to 100% either due to rounding or due to a small number who were 'unsure' and one respondent who felt less relaxed around other people. Of the 40 respondents 11 said that they did not get depressed or anxious and a total of 29 respondents is used for the finding on depression/anxiety.

The findings presented in the table above show how attending cook and eat can contribute to developing social confidence including feeling more confident to make friends (40%). Interviewees explain what this means to them and the findings give some insights into the significance of social outcomes for their everyday lives. One consistent finding is the belief that cooking and sharing food is essentially a social activity, a sentiment that this interviewee conveys:

Food is a resource you have that has to be shared to be truly enjoyed... When you're cooking for yourself, it all tastes the same because you just don't have ... Whereas when you're cooking for someone else, it's like, ... You're looking to please. Whereas yourself, you don't look to please all the time. It's not actually natural. You'll just have beans on toast, a bit of cheese on top if it's going, a bit of brown sauce, it doesn't really matter. Whereas if it's someone else, it's like, 'Oh no, it'll be Welsh rarebit.' Which is the exact same but, 'Oh it's Welsh rarebit.' And it's the emotional feeling, the wellbeing, something that's important or something that's more recognised because it's shared. And I think that's a very important thing. (Interviewee 6, male)

Particularly for those living on their own and those who lack confidence socially communal cooking is fun, as the following comments illustrate:

But going to the courses was a good way of ice breaking and people to have a good laugh and to share a meal because living on your own too, cooking for yourself, isn't that much fun. Cooking for someone else, cooking with someone else is so much more fun. (Interviewee 1, male)

We found that the mix of socially confident and less confident contributes to positive outcomes for those who find social situations more challenging. Sessional leaders and participants who describe themselves as 'naturally chatty' are able to start conversations and encourage those who are shy to participate. We observed that conversations about cooking and food happen naturally during classes and is an easy way to start talking and is one aspect of the course that is appreciated by many, as this interviewee describes:

Just being with other people, talking, having the community feel about being together and cooking the same meal, having a good chat... I mean I like being single, I like doing my own decisions but I realise that it's actually quite healthy to be social as well. (Interviewee 5, male)

For some participants working together to make a dish as well as eating a meal together at the end of each session is enjoyable. During an observation the researcher noted how sharing stories and experiences as well as sharing food created a 'sense of community'. The following comments reflect the significance of the social aspect of the classes for participants:

I particularly enjoy working as a team to create the food and then eat and also the tips about how to replace salt and sugar in recipes. Thank you!!! (Respondent, self-completion questionnaire)

Similar to the health outcomes there are additional personal and social outcomes for those living in particular circumstances. Those who have been socially isolated over a number of years explain that they have lost their conversational skills and attending cook and eat provides them with an opportunity to remember how to be sociable. One man explains:

I was very isolated. I could go for two years without anyone knocking on my door. That's how bad it got. I had people come round to do gas inspection but no one else. No phone calls, no knocks on the door, nothing. That's how isolated I was... it's trying to learn to be natural amongst people and you've lost that. I've lost that art and I'm working on recapturing it, able to hold a conversation because I can't quite... (Interviewee 2, male)

For some attending cook and eat prompts them to reflect on their life and their lifestyle and to consider how they may make improvements, as one man explains:

I realise that being in a social setting has encouraged me to take a look at myself, be more concerned about my own health, physically and mentally, and that's good. (Interviewee 3, male)

Participating in cook and eat also yields potential community benefits and almost two thirds (65%) feel more connected to their local community. These feelings and motivations may, or

may not, translate into action but they suggest that the cook and eat classes can open up possibilities for greater community involvement. The following comments from interviewees illustrates how a range of meanings is given to feeling more connected to their local community. This interviewee reflects the views of others when he says:

And the fact that people could sit down and spend half an hour chatting over food is rewarding in lots of ways. And it helps build self-esteem, confidence and awareness within the community. You may not meet them again or you might bump into them again, it's not the point. It builds a confidence to humanity in general or society. (Interviewee 6, male)

Others said that cook and eat is one of the few community-based activities in their area and they feel more connected simply because there are few opportunities to participate. An interviewee who feels more connected to her community expresses the views of others:

Because there is nothing else going on in the community. (Interviewee 7, female)

Some commented on enjoying the ethnic diversity of the group and their shared interest in food and in this sense participating in the classes enables them to feel connected to their neighbourhood. Whilst they enjoy socialising during the classes participants are more reticent about inviting other participants into their home. One interviewee explains:

There is too much suspicion in this area, no-one would ask someone to their house, or anything like that. (Interviewee 8, female)

Almost three quarters of questionnaire respondents (73%) said that they feel more confident about joining a new group or trying a new activity. This interviewee explains how this confidence occurs:

I guess as well if you've never really taken part in many courses, either it be art class or anything like that, it's having the confidence to do another course. If you done one you can do another one. (Interviewee 1, female)

Other interviewees gave examples of groups they have joined including bird watching and pottery classes.

These findings show that cook and eat successfully achieves its social outcomes to increase confidence to work as a group, to engage socially and reduce feelings of isolation. However, these target outcomes do not really capture the richness of the social outcomes associated with participating in the classes. Particularly for those in poor health, those anxious about their future health and those struggling to live on low incomes and who live in poverty, attending the classes enables them to feel valued, to have fun and to laugh, and gives them a great deal of pleasure. The classes provide an opportunity for some to re-connect with people and to relearn how to be sociable. We also identified that participants feel more optimistic about the future (63%) and better about themselves (55%) since attending cook and eat classes.

6.3 Outcomes for specific groups

In this section data are used to find out if the effects of attending cook and eat are different for some types of participants. Data for three groups are analysed in further detail: to find out

more about those who live close to a community kitchen as they are a target group identified by funders; to assess the effects of participation on those who are lonely, anticipated to be a group with high levels of social needs; and to find out if those who repeatedly sign up for courses have different outcomes.

With the small sample sizes the findings should be interpreted with caution and understood as indications of a possible trend. Nevertheless, they reveal some interesting findings which have implications for implementing of the cook and eat programme.

6.3.1 Live within 15 minutes' walk of a community kitchen

Staff put in a lot of effort and time to attract residents who live in close proximity to the community kitchens and we analysed the data for attendees who are 'local'. There is emphasis in the project documents to recruit those who live on housing estates where the community kitchens are located.

The reasons for joining a cook and eat course for those who live within 15 minutes' walk of the venue (16 respondents) are broadly similar to all questionnaire respondents (40 respondents) with the notable exception of the increased proportion who said, 'it is an opportunity to meet local people' (82% compared to 73% for all questionnaire respondents).

For this group who live close to the community kitchen many outcomes are slightly higher but some outcomes are notably greater, that is 15% or more compared to all questionnaire respondents, and these are:

- Cook more for family and friends
- More hopeful about the future
- More confident to join a new group or start a new activity
- Feel more connected to the local community

These findings may, in part, be explained by the fact that they are predominantly women (88%), and younger (67% aged 26-45 years), and half live with family or relatives (50%). They are an ethnically diverse group and live in all types of housing.

These findings show that cook and eat attracts a diverse group of local people who express a desire and willingness to meet other local people. Engaging further with these participants may provide a productive opportunity to increase community action.

6.3.2 Loneliness

Increasingly loneliness is recognised as a social problem worthy of attention and it is likely to be prevalent in Hackney with its significant proportion of single households and widening socioeconomic inequalities that leads to feelings of injustice, social exclusion and loneliness.⁸

⁸ Indices of Multiple Deprivation 2015 Briefing.
www.hackney.gov.uk/media/2666/Deprivation/pdf/Deprivation: see also Scarf, T., and De Jong Gierveld, J.

One of the intentions of cook and eat is to reduce social isolation. As the findings above show some people consider themselves to be socially isolated but do not feel lonely. However, since participating in cook and eat has many positive social outcomes, those who feel lonely might benefit most from joining a group like cook and eat and in this section the data are analysed to consider this possibility.

Under a quarter (23%, 9 people) said that they were lonely and coming to cook and eat was ‘something nice to do’, and although the sample is particularly small the trends in the data indicate that participating in the courses is socially rewarding. The table below summarises the findings for community, social and personal indicators.

Table 6.2: Community, social and personal effects for those feeling lonely (9 respondents)

	Increased or Improved (percentage)
I enjoyed cooking with others	100
I enjoyed eating together	100
Confident about joining new groups or trying new activities	100
Feel relaxed around other people	78
Able to chat to other people	78
Confident about making friends	68
Feel better about myself	67
Connected to my local community	56
Feel more positive about the future	44
Feel depressed or anxious less often	38

Note: One respondent did not feel depressed or anxious.

Although the sample is small, encouraging lonely people to attend reaches those with high levels of social need and the findings show that cook and eat is well-suited to giving this group social support and provides them with an incentive to socially integrate by making friends and joining a new group. Being able to have ‘fun’ and to ‘have a laugh’ with others is a positive outcome for lonely people and this experience helps them dispel negative thoughts that can happen when feel alone. One interviewee explains how attending has contributed to changes his life:

I suffer depression so I live a very lonely life but things are changing... now I’m fixing up the place... Suddenly I’m meeting people, I’m talking to them and inviting them back to my place. I never used to do that. (Interviewee 4, male)

6.3.3 Repeat attendees

With courses often fully subscribed and with some over-subscribed Shoreditch Trust staff make every effort to allow those who live in poverty and are in poor health to attend more than one course. In particular those from the Healthy Living Centre who are likely to have

(2008), ‘Loneliness in urban neighbourhoods: an Anglo-Dutch comparison’, *European Journal of Ageing*, 5: 103-115.

mental health issues are accepted onto several courses. The monitoring data shows that of those who attend the courses held in community kitchens, 12% attended two or more classes and 3% attended three courses. Of those who are referred through the Wellbeing Network, the proportion of returners more than doubles to 30% attending two or more times and four times as many have attended three courses, 12%. According to the self-completion questionnaires over half the respondents attended more than one course (57%) and of these 61% had attended three times or more. We analysed the data to find out who these participants are and if there is an association between repeat attendance and outcomes.

Those who attended twice or more (23 respondents) includes all the men who responded to the questionnaire, the overwhelming majority who have physical disabilities and/or long term illnesses, who feel lonely, are worried about their health in the future, and those who live on their own (62%) and over 15 minutes' walk from the Centre (72%). All ethnic groups are repeat attendees but Asians and dual heritage participants and those living in council or housing association or have their own mortgage are more likely to be returners. Arguably, these participants are from groups that the staff most want to engage with.

Repeat attendance is associated with additional improved healthy eating outcomes and one social outcome, where improvement is defined as a 4% or more increase above the average, as the table below shows.

Table 6.3: Indicators showing a greater proportion of repeat attendees with positive outcomes

	All questionnaire respondents (40) (percentage)	Repeat attendees (23) (percentage)	Difference in outcomes (percentage)
<i>Healthy eating outcomes</i>			
More informed about eating better	80	87	+7
Improved diet	70	74	+4
Look at labels more often	54	61	+7
Eat more fruit and vegetables	69	79	+10
Eat less processed/ready-to-make meals	74	78	+4
Eat fewer takeaways	58	65	+7
<i>Social outcome</i>			
More relaxed around other people	48	52	+4

Note: the indicators shown in the table are those where there is a 4% improvement in outcomes or more when the findings for all the questionnaire respondents are compared with those for repeat attendees.

This group are, however, also less likely to say that their cooking has improved and are less likely to cook for themselves, family or friends, although the proportion who do remains high. The findings show that those with health and personal problems find it harder to feel positive about their future, attending is less likely to affect their feelings of depression or anxiety, and

are less likely to feel connected to the local community than the average participant. The table below summaries the indicators where there are fewer positive outcomes for this group.

Table 6.4: Indicators showing a greater proportion of repeat attendees with fewer positive outcomes

	All questionnaire respondents (40) (percentage)	Repeat attendees (23) (percentage)	Difference in outcomes (percentage)
<i>Healthy eating outcomes</i>			
Cooking improved	88	83	-5
Cook for themselves, family or friends	80	74	-6
<i>Personal & social outcomes</i>			
More hopeful about the future	63	48	-15
Depressed/anxious less often	38	29	-9
Connected to local community	65	52	-13

Note: the indicators shown in the table are those where there is a 4% improvement in outcomes or more when the findings for all the questionnaire respondents are compared with those for repeat attendees. A total of 17 respondents are included in the analysis about depression/anxiety. Six respondents said that they did not get depressed or anxious.

The findings presented in the above table are often a reflection of the circumstances of the respondents and illustrate how it is much harder for cook and eat to impact on some lives. A number of interviewees who live alone said that they do not often cook and that their illness dominates their feelings about the future as this woman comments:

It's bleak I should say because the illness I have, it's only gonna get worse over time, but there's days I think about it and there's days I don't. Like I said before, I don't make any plans for anything. See what happens. (Interviewee 4, female)

Where lifelong illnesses contributes to depressive feelings then attending classes offer a temporary but important improvement in their feelings, as this interviewee describes:

I'm a bit depressed because I was told that my condition is for life, it's not recoverable so that depressed me... My depression, some mornings I get up and I think, 'Let me phone up and say I'm not coming in,' but then my son says I should go it will help me. So I go and it helps me. (Interviewee 3, male)

As may be expected it is evident that it is more difficult to achieve positive personal and social outcomes for those who have the poorest health but they provide a valuable opportunity for these residents to have fun and enjoy themselves. The interviewee quoted above talks about the pleasure attending cook and eat gives him:

Meeting new people for a few weeks, talking to them, laughing with them, it's like a social group in a safe surrounding. (Interviewee 3, male)

Creating incentives for staff to keep working hard to engage these groups includes thinking about how best to measure and assess 'success', for example, by monitoring returners and to reward the additional effort required to engage with this group.

7. Concluding reflections

Although this study is small the research design gives us confidence that the findings are reliable and we conclude that cook and eat is a well-implemented high impact initiative. Implementing community-based programmes in low income stressed neighbourhoods is difficult and requires skill, dedication and hard work over a long period of time. By understanding how to work closely with residents, and listening to them, Food for Life staff have designed an initiative that meets their needs and wishes. As a well-run organisation Shoreditch Trust are able to use their community connections to reach out to those with poor diets, although statutory and voluntary agencies could make better use of cook and eat by referring those with poor diets, who are overweight or obese. Staff have the confidence to show leadership by organising courses which extend the knowledge of participants to show them what is possible and what options are available to develop a healthy habits.

Key to the high quality provision and its success is the use of knowledgeable and committed sessional staff sensitive to working with those on a limited income and with an ability to incorporate those with disabilities and with long-term health issues into a group. By creating a warm and positive environment the social outcomes are numerous and have health benefits. We found that 'doing' the cooking and eating a meal together are tangible activities that are conducive to making conversation, having a shared purpose and to creating a sense of togetherness.

Our findings also raise issues about how best to assess such initiatives. The FFL team spent many hours supporting the research to produce meaningful monitoring data for the study. Whilst funded projects are required to collect data to monitor compliance, data collection including pre and post questionnaires can also be designed to assist implementation and practice. Our research findings show how, as a free-of-charge and open access initiative cook and eat is both open to all and a targeted provision and that where these constituent parts combine outcomes are most likely to be strongest for all participants. Monitoring data could usefully reflect this feature of cook and eat classes, for example. Similarly, a system of routine self-evaluation can assist initiatives maintain robust implementation strategies and high quality work.

Finally, our findings suggest that the cook and eat initiative provides opportunities for developing a more integrated system of commissioning. Complimentary projects could be run at the same centres to capitalise on the additional motivations of cook and eat participants to make further improvements to their lifestyles.