

Opening Doors to More Healthy Communities: The Healthy Communities Collaborative, UK — Widening Access to a Healthy Diet in Low Income Groups

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Abstract

The Healthy Communities Collaborative was set up to test whether the collaborative method of improvement science could be effective in reducing health inequalities in a community setting. After successfully piloting the approach in reducing falls in older people by 32 per cent against a target of 30 per cent in one year, teams went on to work at widening access to a healthy diet. Fifteen community-led teams, based in deprived areas, worked with local professionals to improve the recognised food poverty issues of accessibility, affordability, availability, acceptability and awareness of a healthy diet. Using a range of simple interventions the teams have addressed these issues and their effects on all members of the community. Initiatives include cookery courses for widowed people to maintain independence and relieve depression, blender schemes, breakfast clubs, food cooperatives and many others. They support local nutrition initiatives and involve local retailers and industries. This work cuts across education, health services and the development of the community. Social capital improvements are in evidence and collected via a social capital questionnaire performed before the initiative began and repeated at the end of the first year.

In 12 months the teams have increased the number of available food outlets by 19 per cent (27 new initiatives) and improved the quality of existing outlets under the categories of awareness, availability and accessibility by 18.9 per cent. During the period of one year it was proven to be too difficult to tackle all of the issues so affordability and acceptability were not measured. During the same year the teams facilitated 333 people onto basic food and hygiene courses. At the time of writing this paper this has increased to 668. As the main thrust of this work was communities and civil renewal, consideration was given to those aspects of wider health impact such as employment. In the first year the sites created two new employment opportunities and have received much publicity for the intergenerational nature of the work. A video of the work recently won the Dartmouth Hitchcock Clinical Microsystems (USA) Film Festival in the category of 'Joy in Work'.

Background

The Healthy Communities Collaborative (HCC) is a groundbreaking initiative from the National Primary Care Development Team (NPDT), England. It seeks to use recognised quality improvement techniques to reduce health inequalities by creating new partnerships across agencies and with residents in some of the most deprived communities in England and

Scotland. A theoretical model was developed that merged the best of community development and improvement science in the form of the collaborative process, to form a community action model. The model hypothesised whether it was possible to take an 'alien topic' into a geographical community, get successful action on that topic, in turn building social capital and stimulating communities to go on to improve on other topics. The model was developed in 2002 and tested in 2003–04 using reducing falls in older people as the focus. Once it was proved possible to have a community-led project and to gain success in the topic, the sites went on to a new area of interest, 'widening access to a healthy diet'. Since the pilot phase there have been two more waves of HCC — falls and an additional wave of HCC — widening access to a healthy diet. The success of the work has been recognised by the UK government who have invested £6 million to roll out the initiative across England from 2006. What follows is the detail of the pilot and its link into widening access to a healthy diet.

Introduction to the pilot phase

The story starts in 2000 with a conversation between Sir John Oldham, general practitioner and founder of NPDT, and Yvette Cooper, then the minister for health in the UK Government. The minister asked Sir John whether he could replicate the improvement in access to general practitioners,¹ with communities. She was referring to the issue of worsening health inequalities that existed in the UK, and still do. Despite extensive policy initiatives to try to redress health inequalities there has been little impact, in fact the gap in health outcomes between the richer and poorer communities in the UK is widening. In fact, the current government has acknowledged that wide inequalities in health exist and that inequalities in healthy diets are a key factor in this health divide (Hewitt et al. 2002). The NPDT is an organisation that has its roots in the improvement of public services and had a track record of using the collaborative method² to bring about rapid sustainable change in the access times to see a family doctor, or a primary care professional such as a nurse. A reduction in the mortality rate of patients with known coronary heart disease³ was also achieved using this method. We commenced with developing a theoretical model to build our work around. This posed a number of questions which, if we received positive answers to, would bring about some change.

¹ The National Primary Care Collaborative, England

² Adapted from Deming.

³ The National Primary Care Collaborative, NPDT, UK.

The theoretical model

We then had to decide on a topic and establish how it would fit with the collaborative methodology. The collaborative methodology has a number of components which when put together form a rigorous process for learning and change.



- Can we take an alien topic into a community?
- Can we get successful action on that topic?
- Will this create community development and stimulate the community into using the learning for other community priority issues?

The collaborative methodology

This consisted of a number of stages:

- Topic selection
- Evidence scan
- Reference panel
- Site selection
- Pilot year
- Evaluation.

The topic

The topic chosen for the pilot was reducing falls in older people. The topic was chosen as falls are recognised as being multi-factorial and therefore requiring a multi-agency response. There was also a lot of interest in the topic from a variety of organisations trying to achieve the milestones of the National Service Framework for Older people (NSF),⁴ standard six falls. The NSF has specific milestones that had to be achieved by April 2005 namely, “that by 2003 local health care providers should have risk management procedures in place to reduce the risk of older people falling” and by 2005 “all local health and social care systems should have established integrated falls services”.

The sites

The three sites were Gateshead, Easington and Northampton and were chosen from an application process that received 147 applications for three places. They are very different sites in terms of rurality, urbanisation, culture and disease prevalence and were all recognised by their application teams as suffering serious deprivation and health inequalities. Populations were predominantly white British, although the Northampton team covered an area where a high proportion of Bangladeshi people had settled. Subsequent waves have

⁴ (NSF) Older People, Department of Health, UK — standards surrounding the care of older people.

more diverse communities such as Coventry, which has 98 per cent of the teams originating from South Asian communities.

Applying teams were composed of senior representation from a range of agencies in the area with an interest in falls or older people. Part of the application process was that they had to demonstrate joint working, particularly in projects pertaining to older people. They were not chosen for a history or evidence of the existence of community groups although early work identified this. The sites were required to have an easily identifiable boundary. Some of the sites were villages but others were not, and boundaries were drawn around postal codes or some other way that the community, not agencies, would recognise as their boundary.

Each site identified five team areas (15 teams) in a manner that meant something locally. Each of these areas then set about recruiting to community teams. In some cases the community team was composed of up to 100 per cent local residents with support being provided from local agencies within a central support group structure. Other teams were composed on a more equal footing of 50 per cent residents and 50 per cent staff from the agencies that support older people in the area. This could be clinical people from health, social services, transport, voluntary agencies and others. All of the teams had different membership and reflected their priorities and the local provision. In the areas that were underserved they developed a way of sharing expertise across teams. The average age of participants in the teams was 70.

The pilot year

The teams were exposed to the evidence relating to falls and to community development, and some practical examples of the work. They were also given training in some techniques to test the ideas in their own areas. Examples of the tools and techniques are PDSAs, process mapping and participatory appraisal

The collaborative method requires three learning workshops equally spaced over the period of the year and the three sites were brought together for this in a central place.

Diagram of the Collaborative Process

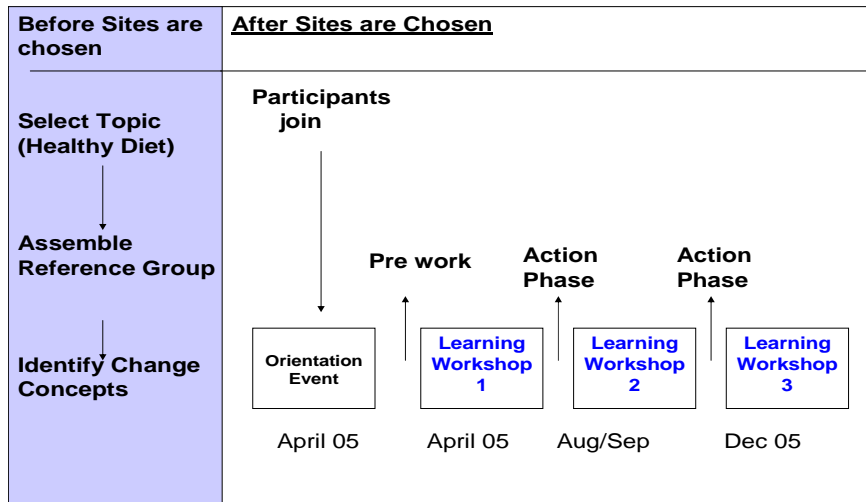


Figure 1. Diagram of the collaborative process

The collaborative process is a framework of learning and doing where participants embark on a structured journey to make an improvement in a topic. Once the early work of establishing a topic, the change package and recruiting the sites is completed the participants enter into an orientation phase. This is where they get their first understanding of the process. They then attend a residential workshop where they are given examples of what works in improving the topic and are taught the necessary tools and techniques to achieve improvement. After the workshop they enter into an action phase where they test out changes in their own area. This is repeated to the next learning workshop, usually three to four months after the first and the action phase is also repeated.

PDSA (community change cycles)

PDSA stands for Plan, Do, Study, Act and is one of the simple methods that are taught to the participants for them to make changes. This process involves the participants thinking about what small change they can test to bring about improvement. They then plan what they would like to test, do the test and study the response and then act on their findings.

In their first year they reduced falls by 32 per cent against a target of 30 per cent and they demonstrated measurable improvements in social capital as the following figures illustrate.

Do you think people show concern for each other?

Figure 2 shows that between the beginning and the end of the first year perceptions of the community at large are that there is an improvement in social cohesion. There was an almost 10 per cent increase in the number who felt that there was more concern shown in the community, with reductions in those that were unsure or previously answered no.

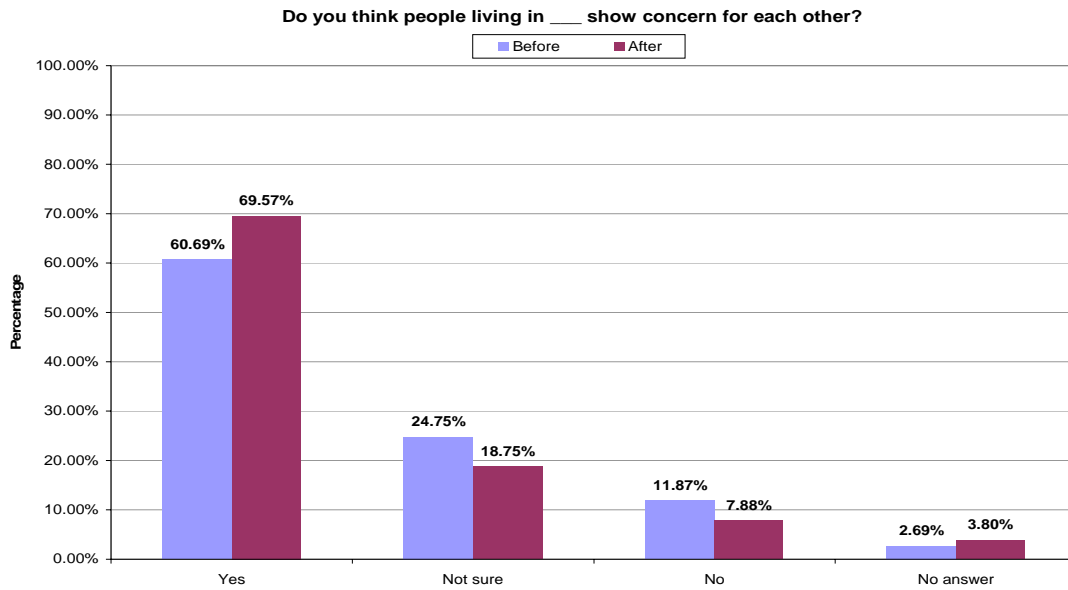


Figure 2. Perceptions about people’s concern for each other

Do you think.....is a good place to live?

Figure 3 shows there is a 10 per cent improvement in the number of people who felt that their area was a good place to live. As the year had been spent on improving relationships between service providers and residents and on providing inclusive community-led events, the initiative was given high profile.

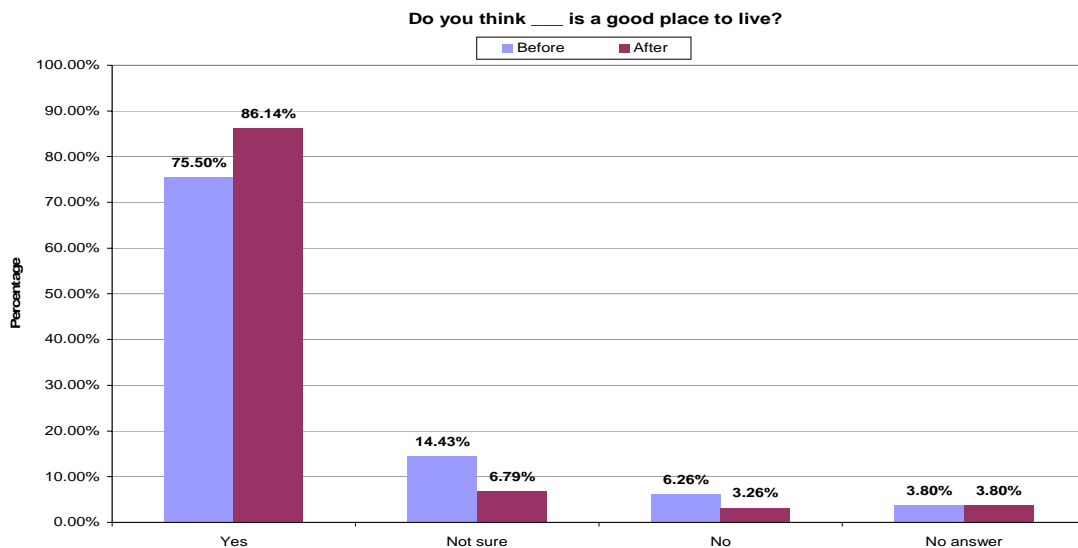


Figure 3. Perceptions about whether people thought their area was a good place to live

Social and human capitals are collected by the application of a social capital questionnaire (SCQ), developed by the participants, the HCC team and the New Economics Foundation. This asked for pre- and post-collaborative assessments on the impact of the work, both on the team members and the communities at large. The tables above represent the answers to two out of 30 questions relating to aspects of social and human capital. In addition to the SCQ, social capital is recorded by a wide variety of audio visual means, videos, photographs, journals and testimonials.

Some quotes from participants included:

“I was meeting people I hadn’t seen for years, so I would say to anyone, don’t be so lonely — join in.”

“I am glad that I accepted the challenge offered me. I too have gained in many ways and have been lucky to not only make good relationships with my local team but also with people I have met at the workshops.”

Good company, friendship and stimulating workshops. I’ve collected some very good ideas.”

They also began to look at how they could use what they had learnt in other topics of interest in their area. Because of the links between osteoporosis, bone health and nutrition they discovered that a healthy diet is difficult for older people in deprived communities to access. It might be that there is no local provision, poor transport, large pack sizes, lack of nutritional information on packs or one of a host of practical reasons why older people could not eat healthily. What became obvious was that these issues were not only a problem for older people but also young families in deprived areas suffered from the same issues. They decided as a group to do something to address widening access to a healthy diet. The NPDT used the format applied in the reducing falls work and put together an appropriate program of work.

Widening access to a healthy diet in low-income groups

“Food is a good thing to build community development around: It is an enjoyable and sociable activity that is part of our culture and identity and it is something everybody does; it provides ‘common ground’” (McGlone et al. 1999).

Once the decision had been made to progress the work to widening access to a healthy diet the HCC process had to be defined. The model incorporated the learning from the previous year where the 15 teams had reduced falls by 32 per cent against a target of 30 per cent.

Some of the teams wanted to focus their attention on the older age group but others, encouraged by their success in engaging children and their parents in the falls work, wanted to widen the scope of their work to include younger people.

The aims

- To improve access to a healthy diet
- To create new partnerships to tackle inequalities
- To increase social capital.

The results — improving access to a healthy diet

In the first year of the HCC healthy diet the following results were achieved:

- Twenty-seven new providers of food locally were initiated (Figure 4)
- An 18.90 per cent improvement in the quality of retail outlets providing food at the commencement of the HCC (Figure 5)
- A total of 333 people progressed through skills-based learning courses provided by accredited training establishments in the first year (Figure 6). This is now 668 people and continues to rise. Many food projects are small and only reach a handful of people. They are often constrained by volunteer capacity, lack of facilities or equipment. Participants report that they appreciate advice from local people more than from a health professional (Hewitt et al. 2002).
- Two new employment opportunities were created for previously unemployed people.

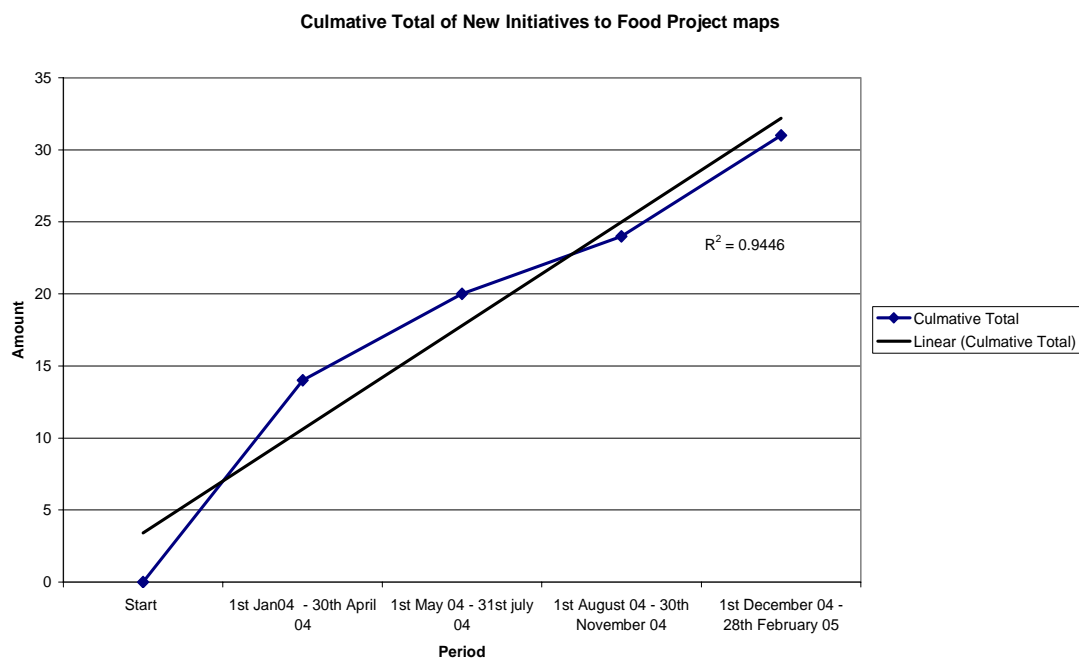


Figure 4. Cumulative total of new providers of food initiated

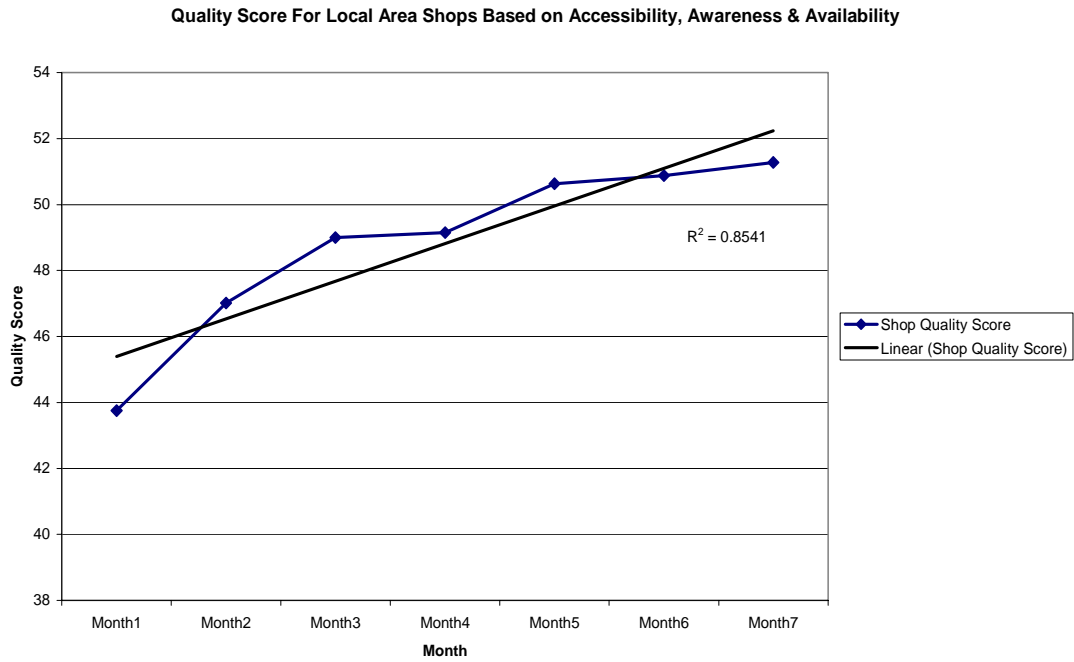


Figure 5. Quality score for local retail outlets

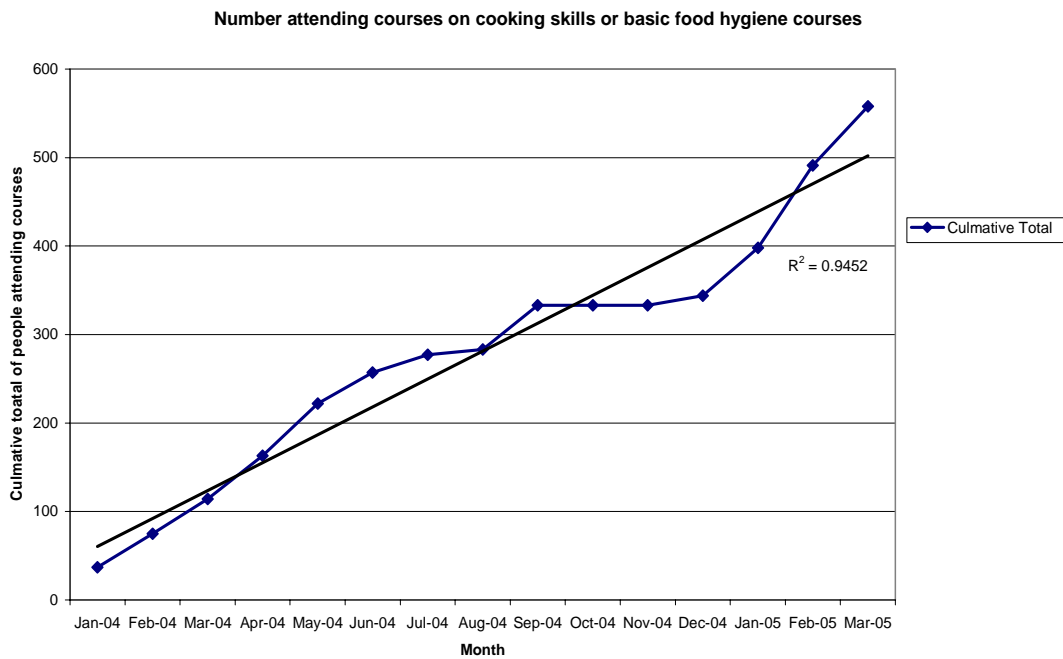


Figure 6. Number attending courses on cooking skills

Partnerships

The HCC model offers a unique opportunity to work in partnership, and in doing so create a new perspective on what constitutes a team.

The HCC has worked over three years with a wide variety of different people and organisations. Its success has depended on the equality evident from the start, where all team members, whether volunteers or professionals, are taught the methodology, the evidence and the process together. There is no greater importance allocated to one individual or organisation than to another. This has led, for example, to a flexible approach delegating small budgets to teams and voluntary organisations to avoid some of the expensive bureaucracy, within statutory agencies, which can mean the process of releasing small sums costs more than the sum itself.

By having teams composed of clinicians working alongside people they would not normally come across in their work, they have been able to appreciate the effects of their own work in relation to other's practices. In some cases clinicians have rethought their own work and its outcomes from this altered perspective.

Methodology

A reference panel was convened comprising of experts in nutrition and community-led projects. They viewed three examples of successful nutrition projects and discussed what it was about them that made them successful. In parallel to the reference panel the Health Development Agency were commissioned to trawl all sources of published evidence to use as the evidence base for this work. The reference panel agreed on the focus of the work to be 'Widening access to a healthier diet'. This was specifically to be about access as opposed to weight management or nutritional information. They came up with a set of change principles or 'golden rules' which, when present in a project, made it more successful. These are:

- Understand the need
- Segment and target the population
- Enable practical-based skills development and learning in the community.

Change Principle One — understand the need

It is important to be able to identify groups at which to target interventions. Some practical ways that the teams accomplished this was by performing an access map (Figure 7), identifying by coloured dots where existing outlets were and demonstrating where the gaps and the need was.

Abington, Northampton

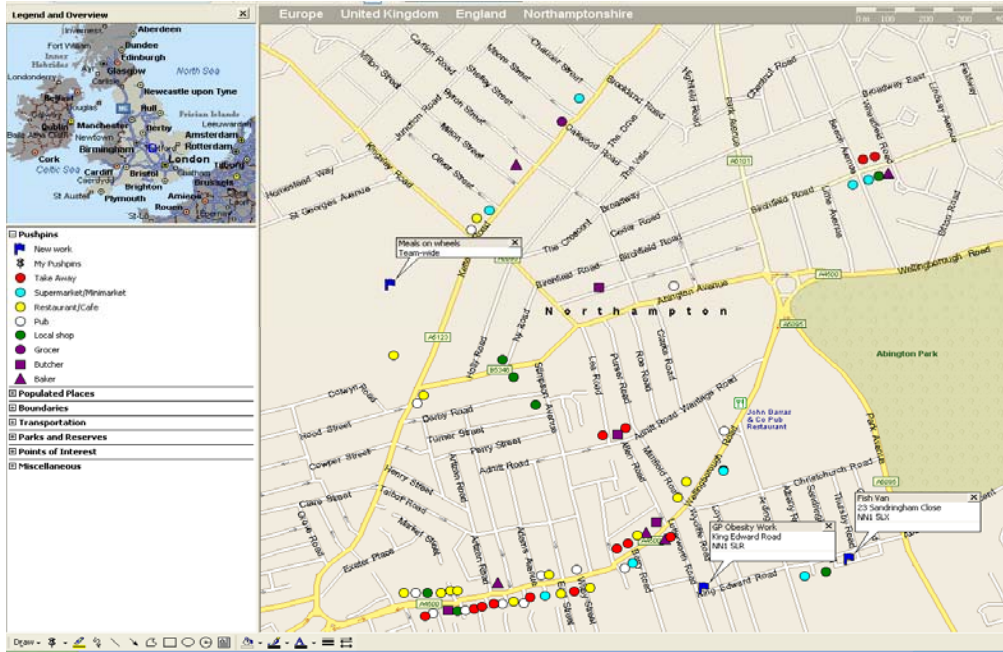


Figure 7. Example of the access map

They walked around the area tapping into their own networks, identifying schools, faith groups, shops, pubs, takeaways, community cafés and other venues where food was provided or sold. They looked at local public health data on where there was a higher prevalence of particular diet related diseases such as cancers, CHD and diabetes. They investigated whether there were cultural and physical constraints to the provision or consumption of healthy food. They were able to gain a view on what the gaps were in provision of food and services in their area.

Change Principle Two — segment and target the population

Figure 8 represents the application of the change principle *segment and target the population*. The evidence and the task were separated into the categories of pre-natal, children, general population and older population. Because of the length of the collaborative (1year) it was decided to exclude pre-natal nutrition. However, if the collaborative was to run for more than a year it would be possible to work specifically on pre-natal nutrition.

Pre-natal----- (Mother's nutrition)	Children----- (Growth)	General population----- (Good health)	Older population (Bones) ⁵
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Figure 8. Change Principle Two 'segment and target the population'

⁵ Although the teams started with bone health, they also looked at malnutrition, as one in seven older people are known to be malnourished and the evidence on nutrition and bone health is inconclusive.

Teams worked on widening access to the population from children to older people with specific interventions being appropriate to the age group. An example of this is the weaning courses for young parents where a large national retailer donated 300 food blenders per site. Parents attended a three-week course held by health visitors (community nurses), where they were taught about cooking healthy food instead of buying processed food in jars, for babies. At the end of the three-week period they were given a free blender.

Change Principle Three — enable practical-based skills development and learning in the community

The evidence for widening access to a healthy diet demonstrates that deprived communities can, on the whole, describe a healthy diet the problem is that they have difficulty gaining access to healthy choices and when they can they may have difficulties in storing, cooking and preserving food. A major part of the HCC has focussed on providing training for people to help them achieve this safely. Community teams linked into local education providers and developed a program of training and dissemination of information. Groups and individuals were brought together in community facilities such as halls, schools and colleges and were given courses that combined theory and practice.

The evidence base

The evidence was provided by the Health Development Agency, which reviewed a range of international evidence relating to improving access to a healthy diet. This was supplemented by practical examples of initiatives that perhaps had not been published but had proven to demonstrate an improvement. The review identified the following factors:

- People who suffer from chronic conditions such as coronary heart disease (CHD), stroke, cancers and obesity tend to have the poorest diets.⁶
- People from the lowest socio-economic groups eat less fruit and vegetables than those that are better off, and fewer foods that are rich in dietary fibre.⁷
- The barriers that prevent people, regardless of their income level, from eating healthily are well established.⁸ They can generally be divided into those that are 'attitudinal' and those that are economic and physical. In relation to increasing fruit and vegetable intakes, these can be summarised as follows:⁹
 - *Attitudinal barriers*
 - People's belief that they are eating enough fruit and vegetables already
 - A lack of understanding of portion sizes
 - Confusion about health benefits of fruit and vegetables and particularly frozen, canned and dried products

⁶ James et al. 1997 (Peploe 2003).

⁷ Acheson 1998 (Peploe 2003).

⁸ Department of Health 1996, Department of Health 2000, Lobstein 1997 (Peploe 2003).

⁹ Health Education Authority 1994, Marshall et al. 1995, Anderson et al. 1998, Cox et al. 1998, British Dietetic Association 2001, Food Standards Agency 2001 (Peploe 2003).

- The influence of promotions and advertising
- Lack of motivation to try new foods and the risk of buying 'new foods' that might be left in the cupboard
- Lack of confidence and skills to prepare and cook vegetables and fruit
- Among children, particularly peer pressure and conforming to the norm.
- *Economic and physical barriers*
 - Relative costs of buying a healthy choice
 - Physical accessibility to affordable and good quality supplies
 - Shopping capacity
 - Food storage capacity.

It has been shown that low-income groups are more efficient and strategic shoppers than those living on higher incomes and that they buy more food per pound (sterling) spent. However, they also purchase calories (energy) more cheaply, which means that more foods high in fat and sugar are purchased per pound spent and less on foods such as fruits and vegetables.¹⁰

What we know works

From the evidence base we know that the following interventions are effective in widening access to a healthy diet in a community context:

- Food cooperatives and delivery schemes
- Community shops
- Transport to shops schemes
- Community based 'cook and eat' sessions
- Community cafés
- Luncheon clubs
- Growing or gardening schemes
- Breakfast clubs.

Why it works

Little rigorous evaluation of the effectiveness of small scale projects has been carried out, but a review of the effectiveness of interventions to promote healthy eating¹¹ concluded that intensive smaller scale projects generally resulted in positive changes in diet and blood cholesterol, at least in the short term and suggests that effective community interventions:

- focus on diet alone, or diet plus physical activity, rather than on a range of health topics
- are based on proven theories or models of changing people's behaviour or improving their access to a healthier diet

¹⁰ Lobstein 1997, Rainford et al. 2000 (Peplow 2003).

¹¹ Roe et al. 1997 (Peplow 2003).

- use a range of different interventions that operate on different levels for example with individuals, small groups or the wider community
- make changes to the environment to ensure that changes are affordable and available and are developed through participatory approaches.

What works in community led projects?

The following are characteristics of local community projects which appear to be the key to their¹² success:¹³

- Flexibility by agencies in responding to the needs of particular communities
- Access to secure and ongoing funds
- Professionals working in partnership with a community
- Projects that involve local people and ensure equal respect
- Evaluation which is not confined to narrow clinical and behavioural measures, but include for example, changes in food purchasing patterns, structural changes and social outcomes
- Training for professionals and members of the community to enable them to acquire skills for a new way of working
- Planning an exit strategy for health professionals from the outset. The aim of a successful community-based project should be to foster self-reliance and to set in place long term and sustainable changes to people's behaviour and the environment
- Networking and drawing on the skills and experience of existing food related projects, to enhance and extend the reach of the work within an acknowledged framework of criteria to alleviate food poverty.

The Measures and Evaluation

The HCC has clear aims of attempting to address wider health inequalities and community development within community-led nutrition projects. Evaluation in small communities is difficult (Hewitt et al. 2002). As the aim is to foster local ownership of the project local people were included in the evaluation. The evaluation of HCC consists of a range of quantitative and qualitative measures outlined below. The community teams all participated in the development of the measures and tools to evaluate the projects.

- The measures are governed by criteria related to the accessibility, awareness and availability of food or food projects
- Initiatives are measured by using the local map. As the community teams put in place a new outlet or deliver an expansion to an existing outlet via the HCC teams work, they place an additional symbol on the map (see Figure 7)
- Quality improvement is measured by plotting the quality of an existing outlet against the set of criteria. As changes are made within the outlet these move the teams further along a

¹² Hewitt et al. (2002).

¹³ McGlone et al. 1999 (Peploe 2003).

series of milestones. Each milestone receives a score up to the agreed completion of the plan.

- The numbers accessing training are collated by the teams and reported monthly to NPDT. Training is sourced from reputable outlets such as colleges of further education.
- Employment opportunities are defined when a previously unemployed person receives a course, develops skills and expertise in nutrition, as a consequence of their work in HCC, which leads them to paid employment
- The teams identify where their work can fit into the local community strategies for health.

Case Studies

'Carrot Boy' – Gateshead, UK



'Carrot Boy' is an affectionate term for a young man named Anthony. He joined the HCC at the end of the falls work when he was encouraged by his mother to 'do something useful'. Along with his friend Steven, he had left school with little in the way of formal academic qualifications and was unemployed at the age of 19. His first foray into the healthier diet work was to

help out on a soup tasting day. It had been noticed by the team members during their survey that a lot of local residents, particularly younger ones were unable to make soup. As a result of a series of PDSAs they put together a soup tasting event and Anthony was enlisted to help. The plan was that the older residents would share their recipes for home-made soups and everyone would taste them. Anthony was given the task of peeling the carrots. He was put into a room on his own with a sack of carrots and told to peel them. Unfortunately he had never peeled a carrot in his life and didn't know where to start. Rather than show his ignorance he telephoned his mother who was on a train on her way to work. Unfortunately as it is with trains and mobiles, every time she started to explain the carrot peeling process their call was disconnected. It took some time but eventually they succeeded. Anthony now proudly tells everyone that it "cost him £5," but he did it in the end.

Anthony now runs sessions independently or as a contributor to other team initiatives. The local youngsters, inspired by his story made him a tee-shirt with carrot boy on it. His team has successfully recruited more young people to it. Anthony and Steven went back to school and learned about computers and websites and have produced a newsletter and are developing a web site for young people's health issues. They are getting involved in growing schemes, trying to open up derelict land for allotments, they have attempted to gain a derelict shop from

the council to use as a health shop and Anthony has just secured a data input post in the local primary care organisation.

The Abington Team and the fish van



Maurice and his wife Maureen have been members of the HCC since the start, and were involved in the reducing falls work. They are examples of the untapped wealth of skills, knowledge and experience which exist in all communities.

Having undertaken a mapping exercise of his team area, the lack of an outlet selling fresh fish was identified. Maurice and his team members then surveyed the residents to establish whether this was an issue for them. The response was that people would buy more fish if they had the opportunity.

The team found a mobile fishmonger whom they persuaded to make an additional delivery stop in their area. They delivered 300 leaflets to homes in the area advertising the new stop. That community now has regular access to high quality fish, and fruit and vegetables, which was not available to them previously. In addition, the mobile fishmonger now counts the stop as being the most lucrative on his round.

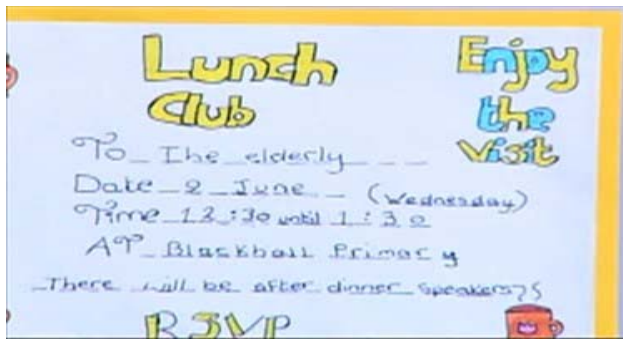
'Have Fun, Cook for One'



The Have fun, Cook for One scheme was devised by Maurice. Having heard of a local case where an elderly widower was referred to meals on wheels because he was unable to cook for himself, Maurice and the team contacted social services who confirmed that this was a common problem for men whose wives had always done the cooking. In addition,

another team had discovered through research undertaken as part of a degree course that the significance of food and eating becomes less when people are coping with bereavement and loneliness. Maurice attended a train the trainer course and received formal instruction on shopping, budgeting and cooking healthy meals for a very small outlay. He now runs six-weekly courses which consist of teaching widowers basic cooking and shopping skills. The spin-off is that a group of elderly men with a shared experience can support one another during a difficult time and have the opportunity to make new friends. It is now an alternative for social services staff referral.

Blackhall Colliery Primary School Lunch Club



The school were approached as the community members noticed that there was little provision for children in the area to have breakfast before school. The head teacher, Mr Younger, told the team that he had tried a breakfast club in the past but it



had failed. There are obvious links between childhood behaviour, poor nutrition and academic performance so the team wanted to do something to help the school out. They did a sequence of PDSAs, which led them to a lunch club that could be for the children and the local elderly population. The children designed the menus, drew up and decorated the menu cards, the team sourced table

decorations and crockery from local traders and raised funds for a heated trolley. The lunch club opened in June 2004 and is a great success. It offers the opportunity for children to experience eating as a social activity, whilst at the same time giving them the chance to sample foods which are not on the everyday school menu, so widening their diet. In the one initiative, the school have been able to address the curriculum targets of healthy eating, citizenship, and craft design and technology. The lunch club is fully self-funding and has a waiting list of people wanting to attend.

Acknowledgments

The authors wish to acknowledge the contributions from all those that continue to make this work possible: Dame Yve Buckland for providing inspiration, Sir John Oldham, Ruth Kennedy and the late Guy Rotherham for having the vision and courage to embark on this 'high wire act', the support of colleagues in the HCC team, Julie Morgan, John Timmins, Adrian Smith and Michael Hope, The project managers Maggie Woodward, Sue Watts and Karen Smith and their organisations and finally and more importantly the community members of the 15 teams without whom this work would not have been possible.

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