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Acknowledgements

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Summary
This research reports on the findings from adults who took part in a cooking intervention designed to help them prepare family meals and cook more healthy options in the home setting. It is a follow-up to an evaluation report which examined the evidence for the effectiveness and efficiency of a number of cooking interventions run by Can Cook. The initial report showed that the interventions were effective in bringing about changes in attitudes, skills and confidence among participants. What could be said with confidence was that the courses were well run and conducted and had an impact. What remained unclear was the effect of the intervention over time, i.e. were the changes observed at the time of the intervention or course due in large measure to the controlled conditions of the intervention itself. The key to ultimate success is to maintain the first changes overtime. The question for this research was: how do people behave beyond the confines of the course or class? This intervention was designed to address this question by following-up 11 families who took part in the classes, three to four months after the intervention.

The research used a number of approaches to documenting the changes in attitudes, skills and behaviours of the participants. All this was subject to rigorous analysis.

Key Findings
We evaluated the impact of the Can Cook programme on eleven families. The Can Cook programme improved the skills and increased the confidence of the family cooks. This change led to some significant changes in diet including increases in fruit, vegetable, rice, pasta, and potato consumption. All of these changes are considered ‘healthy’. These changes have not only occurred in the diet of the cook but also the diet of the whole family.

First some background to the way people live in the area of Speke:
- Many of the families reported problems with affordability of food not just a healthy diet, which we know costs more.
- The importance of Scouse as a dish with cultural meanings, one woman said ‘My little girl loves it. My partners not that fussed on it cos he’s from Wales so he’s like “What else goes with it?”, it’s like “No Seinre, bread, beetroot”’, but the kids love that from being round here [WN].
- Responses to questions about the recognition of healthy diet focused on the importance of fruit and vegetables and cutting down on eating take-away foods and fat in the diet.
- There was a high reporting of families preparing and eating food in the home. Concomitant with this was a low reporting of the incidence of households eating out or eating from take-aways. There was some reporting of men using take-aways during work or leisure time.
- Many did not have a separate dining area. The following quote show this: Normally just the living room cos our house is that small that we haven’t got a dining room so we just sit in the living room, yeah.
- Few prepared deserts as a routine meal component.
- There were problems identified with getting children and partners (men) to eat fresh vegetables.
- Fresh fruit was reported as being routinely available as a snack item or to be eaten at home.

The above shows the background and context to food purchasing and preparation in the home. Below is a summary of the changes in purchasing and cooking (knowledge, skills and attitudes):

- A number of participants who actively said they disliked cooking reported that post course they now found it less of a chore and a challenge.
- The largest spend both pre and post programme were on meat and eggs; the second largest proportion of spend was on carbohydrate foods like bread and potato.
- The reported change in intake of foods that can have a positive impact on diet were centred on reported changes in items such as 100% fruit juice, fruit and vegetables. Overall there was an increase in juice intake (pre 12 portions and post 17 portions); vegetable intake (pre 19 portions and post 28 portions); fruit intake (pre 16 portions and post 24 portions).
- These changes in fruit and vegetable intake were supported by data which showed mean change in intake. A significant increase in intake was reported in fruit, p= 0.011 (CI -1.36 – (-0.24)) and vegetables 0.009 (CI = -2.52 – (-0.47)).
- Significant increases post course in intakes of pasta or rice, and boiled or mashed potato were also reported.
- There was a measurable increase in spending post intervention on more on fruit and vegetables and less on take-away meals and alternatives.
- Five of the eleven cooks expressed a dislike of cooking pre-intervention.
- Families who had been on the course reported being more likely to sit down together to eat:
  - Yeah, that’s the only time we all do sit together.
  - “Yeah, for the first time me and Xxxxx sat together eating spaghetti bolognese the other night.”
- People made changes and amendments to dishes or meals they were used to or learnt on the course. They were able to plan better from the section on the course which dealt with shopping and planning. They also had more confidence to introduce less familiar meals and dishes following the course. This resulted in some of the changes in fruit and vegetable consumption reported above.
- There was a significant improvement in all the skills that the cooks practised at the Can Cook sessions, in cooking from basic ingredients (p= 0.001); in following a simple recipe (p<0.025); preparing and cooking new recipes (p<0.038).

Some of the barriers to changes in the family setting were not to do with skills or knowledge but with family structures, such as income, preferences and tastes. In fact although the family cook is often thought of as in control of these issues s/he is negotiating a series of structural barriers starting with economics of providing a healthy diet. S/he is in fact negotiating a complex set of interactions. Taking this into account and combining it with the issues the cooks identified as the advantages of the programme in the studio, which were preparing and tasting something before trying it at home; there may be a case to extend the tasting to the whole family.

The outcome is that more families are eating meals cooked from basic ingredients at home and less takeaway meals, even though this number was small pre-intervention. Overall Can Cook has had significant impact on the cohort and has achieved their aim of reaching parents to cook meals, and particularly healthy meals, for their children and families from scratch.

The intervention has had an impact on the participants which was extended to the families. The keys to success are based on a well-designed programme which combines skills and healthy eating messages within a fun context and one which helps develop not just skills but also confidence. The changes are small in terms of overall dietary changes but nonetheless significant and importantly seem to remain steady over time. The running of the programme with families in an area is likely to have a public health impact at a group or population level. The Can Cook programme had developed materials to support and extend its work in schools. Funders and commissioners, on the basis of the findings reported here, should give consideration to funding work to support the family initiative. This might include course follow-ups or the development of an ‘app’ to deliver healthy recipes and on-going encouragement to participants post-course.
1. Outline and background

This report focuses on Can Cook CIC - with a specific focus on the cookery programmes Can Cook delivers for adults in the community, with an emphasis on family eating, it measures the outcome of this specific intervention. An initial report was carried out on the impact Can Cook programmes deliver to discrete groups and in specific settings. This current report provides detailed follow up and further analysis, with families three to four months after a family based intervention, to gauge what skills, knowledge and behaviours have transferred or remained static over time.

The initial report highlighted the process and impact of a number of Can Cook’s interventions (school, community, family and adult based). These showed that the conditions of the interventions themselves could be attributed to changes in knowledge, skills, behaviour and increases in confidence. At that stage we could not address with any degree of confidence, the longevity of the changes once the conditions of the intervention itself, the studio setting, the cook/demonstrators and the presence of other participants were removed. At the end of interventions which are well run and constructed there is a ‘halo effect’. Here the focus was on the long-term effects beyond the ‘halo effect’ of the programme.

1.2 Short Background to Can Cook

Initially it is important to place Can Cook within its broader remit. Can Cook is an organisation with food and cookery services unique to the UK. Central to Can Cook is food and the mission to developing innovative solutions to alleviate poverty and specifically food poverty. Can Cook, set up in 2007, is a social enterprise and was the current climate the delivery of this mission is possible due to the entrepreneurial nature of the organisation.

‘Social enterprise is always created in a community where there is a need and failure of important services. The services social enterprises create are done so by individuals/groups who have an implicit understanding of that need and have the trust of their constituency – at all times people matter.’

This represents a unique set of organisational prospects and opportunities. Within this report we can’t fully explore Can Cook within this current climate and the organisational structure, however it is clear there is a lot to be learned from the experiences in Liverpool with reference to enterprise and the provision of community based cooking classes. There is more detail to be found in the first report on the various aspects of the Can Cook programmes.1

The Speke area is indexed as the 8th most deprived area in England – this deprivation is emphasised by the geographical ring-fencing of the area from the remainder of Liverpool – Speke touches no other community on any of its borders. It was here that Can Cook’s mission to alleviate poverty and particularly food poverty was defined and in this context that the community training was developed. The conditions in Speke required information and understanding to enable a training delivery that understood the availability of skills and knowledge present within the community and the barriers that would provide obstacles to progression.

The area was recently reported as having one food bank but no bank. A survey in the area during 2008 found that residents identified cooking as their priority in terms of budgeting and food a second concern. This was of course before the increases in food prices and food prices were identified as a key issue, second only to fuel costs ahead of debt repayments.2 Can Cook was developed in line with a Food Report commissioned in 2008 in Speke which reported on the food habits of residents. The report concluded:

Diet is about what is available, what is accessible, what knowledge people have, what skills they have in shopping and cooking and about how these things have settled into the family and community tradition.4

The focus on cooking comes from concerns with the modern food system making people, and by extension families, feel isolated from food production and preparation with a concomitant feeling of less confidence around food and food preparation concern identified in the 2008 survey.5 Can Cook aims to tackle these issues within the context of food as a fun activity and with an emphasis on experiencing making meals, handling and tasting food. It links in a subtle way the messages of healthy eating with culinary skills, what some others have termed culinary nutrition.7

Can Cook’s focus on cooking was initially a result of local concerns, with local people expressing apprehensions about their lack of cooking skills and lack of confidence in approaching cooking in the home. The concerns that drive the Can Cook initiatives are mirrored in national and global approaches to food which stress skills, engagement with and the enjoyment of food.8 Can Cook originated from the needs of local parents saying they wanted to learn to cook meals, and particularly healthy meals, for their children and families from scratch.9

The values of the Can Cook team are illustrated by a quote from the website:

“If it’s our passion for food and cooking and giving people the confidence and know-how to get back into the kitchen that really gets us going. Plus, it’s fun! Everything from the live tutorials to actually cooking the dishes themselves have a light hearted feel to them, you don’t have to worry about making the odd mistake or getting things wrong, it’s all part of the learning curve and we embrace that. So don’t worry if your quiches break or your kebab skewers burn, you’ll get there eventually and we’re there every step of the way to help you out.”

Much of Can Cook’s work, particularly in communities, predates the work of Jamie Oliver and his cooking initiatives, in fact while his community cooking projects have been running into operational difficulties, Can Cook has expanded and developed and this can be attributed to two factors, firstly that it was created and shaped in the community and secondly it’s entrepreneurial nature.

To provide some context and understand the scope of Can Cook as a social enterprise, below is a summary which demonstrates the breadth of the operation. This offers some indication of the various income streams that are reinvested into the community. Can Cook operates within the following areas:

1. Cookery training in a state of the art 20 place cookery Studio and 10/16 place mobile Pop Up Studio: Central to the mission is teaching everyone to cook (see more detail in background to the family intervention below). All profits from training for businesses and the general public are reinvested into the community.

References

2. **Consultancy, training and delivery in the food industry:** Can Cook consults with and trains organisations to develop their own enterprise solutions - to both establish and sustain high quality and healthier practise across the food industry. Current work includes Care Homes and Councils.

3. **Kitchen Share – offering support packages and facilities for small and start up food businesses.**

4. **Retail:**
   - A community cafe providing healthier food in communities.
   - Can Cook is currently developing a Street Food pilot to train ex-offenders and put an innovative healthy street food services on the streets of Merseyside in bespoke kiosks.
   - Can Cook have published three cookery books, beginning with Can Cook Will Cook which documents a 10 week community training course (see figure A).

**Figure A - Copies of book covers**

The world of takeaways is either loved or loathed. Recipes are designed to provide a quick, tasty food fix.

This was the second cookbook and focused on getting everyone to take on a healthier lifestyle.

The first cookbook includes recipes designed by Can Cook! Chefs and trainees!

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1.3. The Family Programme settings and delivery

Here we set out the background to the family project, the details of other cookery programmes run by Can Cook can be found in the first report. 1

1.3.1. **The Can Cook Cookery Studio**

The Family Project was run from the Can Cook Cookery School, based in a state of the art twenty place studio at the Matchworks business park, with its own history, in South Liverpool. The studio is 5000ft² and features 26 cooking stations, a Chef demonstration area, cooking hobs and a dining area. It was financed by Five, a commercial loan, a small grant from the PCT and the help of a local business (Belling) who supplied the cookers. All programmes are delivered by Chefs.

The Studio has a full evening and weekend programme for the general public including cooking from scratch, a range of specialisms and world cuisines from cook and dine to full day courses.

1.3.2. **The family Intervention; recruitment and ethos**

Supporting the family as a unit and providing family members with skills in making meals, handling and preparing food is and has been central to the Can Cook ethos. All classes incorporate an element of ‘healthier’ eating, whether this is a focus on cooking techniques, substitution in menus or messages about healthy eating. The sessions are fun, engaging and exciting with live demonstrations from skilled chefs at the heart of every course, along with time for participants to cook their own dishes in the state of the art kitchen. Such an approach has been called ‘culinary nutrition’ 10 recognising the links between skills and abilities necessary for healthy eating. The facilities at the centre have been further marketed to corporate groups with food as a focus for team building, to generate additional strands of income.

The family intervention was targeted at families in Speke who were already being supported by Five Children and Families Trust; these families were generally socio-economically disadvantaged. There is extensive research and robust evidence that proves that socio-economically disadvantaged families tend to have diets that are less healthy than the average diet; and they also have greater barriers to accessing a ‘healthier diet’. One of the barriers is cooking skills.11 Recruitment was through this route and

The programme is delivered by chefs who engage with the participants in helping obtain new practical skills, basic hygiene and knowledge and skills regarding cooking including purchasing and preparation of food. This is all underpinned by a course which is about fun and engagement.

Courses that introduce participants to cooking skills are broadly similar to one another. 12 The Can Cook structure differs in that it focuses on being hands on with food – on skills, techniques, using ingredients. It involves chefs giving detailed, entertaining and instructive demonstrations that take participants through every step of a recipe. They also give advice about ‘best buys’ and healthy choices. Participants are encouraged to ask questions and to learn from each other and the chefs. The

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participants then go to their own work-stations where ingredients have been laid out, with recipe sheets. Using the ingredients and the recipe sheets they cook the recipe, with the Chefs available to continually assist, demonstrate and support them to take on the new skills and techniques they have observed. When the meal is cooked they sit down and enjoy the food together with the chefs and other Can Cook Family participants. This idea of trying out, testing and tasting is key as many families in the current crises cannot afford to experiment and risk the loss of food through rejection in the home setting.

The Can Cook courses focus not only on building skills and techniques but increasing enjoyment and engagement with the whole food experience to inspire participants, build confidence to continue at home with lessons learned on the programme. Can Cook is a Chef led programme. Can Cook purposely uses Chefs to design and deliver the programmes rather than cooks or nutritionists – as the focus is instilling skills and techniques rather than purely home cooking or healthy eating. It is the skills, techniques and knowledge that Chefs are able to teach that enables participants to maintain and develop their cookery outside the courses. The Can Cook Chefs have 15 years’ experience working in restaurants and industry – their knowledge and passion for food and innovation creates a unique and dynamic training environment that in turn creates a momentum beyond the courses for participants. They have received training in nutrition matters and the materials and recipes used have been critically appraised by nutritionists.

1.3.3. The programme contents and structure

The training course took place over two days. The intervention was delivered by the Chefs in a relaxed and group setting and comprised the following elements on the first day:

- The day focused on basic cookery skills and meals that could be transferred into the home.
- A mixture of Chef demonstrations and practical cookery sessions, the day started with a simple and healthy breakfast dish (Mushroom Omelette).
- This was followed by a demonstration of how to de-bone and take apart a chicken, with an explanation of the different parts - breasts, thighs, wings, mini fillets etc and how the whole chicken can be used for lots of different meals, with an emphasis on the cost effectiveness of this approach to buying the different components separately.
- The group then went on to de-bone their own chicken thigh, and after a demonstration from the Chefs - used the chicken to make a chicken curry and pilau rice.
- The group then sat down together in the studio and ate the food that they had cooked.
- The afternoon sessions consisted of apple crumble - using oats and less sugar to make it a slightly healthier version of the classic - a recipe that can easily be made for the whole family at home and is ideal for getting younger children involved.
- At the end of the cooking session - once the group were more comfortable, the Chefs got everyone together and discussed what the next step would be in the project - what they usually eat at home, the foods they enjoy and wanted to learn to cook. The majority admitted that their families all enjoyed Chinese takeaways but acknowledged this wasn’t necessarily the healthiest of choices. The chefs explained that they had made healthier Chinese dishes in the past and it was agreed this would be the focus of the next session, with a sub-focus on making the meals cheaper than from a takeaway and suitable for the whole family.

The second day focuses on the issues raised by participants on day one and becomes more bespoke to their specific needs. The menu on Day 2 consisted of Chicken and Sweetcorn Soup (another dish that could be made using meat from the whole chicken demonstrated on Day 1), Pork Cheeks (one of the cheapest cuts of meat available) in Blackbean Sauce with Fried Rice, Sweet and Sour Vegetables and Apple and Pear Sweet Samosas for dessert. At the end of the day the group, again, sat down together again at Can Cook and ate the food that they had cooked.

2. Methodology

As has been noted this is a follow up to an initial process and impact report from 2012. This 2012 report detailed the inputs to the programme and the immediate impacts in a number of areas such as teaching cooking to children and adults. This first report highlighted many improvements in knowledge, skills and behaviour at the end of the various interventions. The research gap that remained was what happens after the course ‘halo effect’ wears off in say three months time?

Based on these initial findings the research set out to tell the stories of individual families and the impact that the intervention had on family life not just on the cooks themselves. The sample group chosen was small so that the research could offer depth into the behaviours and motivations of the participants. The overall aim was to gauge how Can Cook activities and engagement impact on and change a family’s food preparation and food intake.

Twelve families were recruited to take part in the Can Cook Family Programme. These were initially approached through Five Children and Families Trust. The person responsible for cooking (hereafter referred to as the cook to distinguish them from the Chefs who carried out the teaching and demonstrations) and shopping then attended sessions at the Can Cook Studio. These classes were delivered to all 11 of the 12 (1 cook withdrew) participants as a cohort by a member of Can Cook. There were two days of classes which covered the programme as outlined above.

The research focused on three dimensions, process, impact and outcomes. In addition we devised and collected much contextual data from the families. This helped provide perspective and background to the findings. One of the key issues highlighted in the initial report 1 and in some of the systematic reviews is the lack of follow up data and whether changes at the end of the intervention were maintained over a period of time and also to see if changes extended beyond the individual to the family or household. This report tracks participants in the Can Cook sessions and reports on their behaviours before and three/four months after the intervention ended. Interviews, home visits, photographs and questionnaires were undertaken and completed by the participants with the help of staff from Five Children and Families Trust. These staff received half a day’s training on interviewing and collecting data. The training included the opportunity to have open discussions. The training was delivered by the research team, City University, aided by a member of the Five team.

The basic principle underlying the research has, where appropriate, been to get a baseline (how people behaved and cooked before undertaking the class) and an impact or outcome measure (how people behaved and cooked 3 months after undertaking the class). So for example the structure of the research is that pre – intervention participants are interviewed, complete pre-intervention questionnaires and provide shopping receipts. This approach is repeated post intervention. An outline of the overarching approach is provided as Figure B. Classic research interventions follow up a number of months after an intervention to determine which changes have become regular or stable. Given the nature of the interventions here, and after discussions with the Can Cook team and staff from Five, we decided that the best approach would be to take baseline measures (T1) before the programme and measures at three/four months (T2).

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1 Rees, R., Hinds, K., Dickson, K., O’Mara-Eves, A., & Thomas, J. (2012) Communities that cook: A systematic review of the effectiveness and appropriateness of interventions to introduce adults to home cooking. A report of the Social Science Research Unit, University of London: London.


This was done using the following five methods:
1. 24 hour intake of indicator foods for all family members older than 11 years. This was used to identify:
   a. foods that are unhealthy when eaten in excess - sweets & chocolates, crisps, fizzy drinks.
   b. analysis of foods that are indicators of a healthy diet – fruit and vegetables.
2. Photos of food in storage – cupboard and fridge.
3. 7 day shopping record – including shopping receipts.
5. Pre-intervention questionnaire for cooking skills

2.2. Measurements of impact of sessions three months post class (T2)

This was done using the same methods as above from T1 to T4 with the additional use of a questionnaire to gauge the impact of the cooking skills programme.

2.3. Research processes and instruments

Below some detail on each of the process and questionnaires used is detailed.

Family shopping habits/food consumption: This was measured by asking participants to collect shopping receipts over a week, and aided by photographs of food cupboard and fridge contents. These were analysed to work out an average spend at both times and to gauge if any changes had taken place in shopping baskets. These receipts were also used develop an indicator to changes in food habits. This was done by using the 5 food groups that make up the Department of Health, Eatwell plate. Using these 5 groups: fruit and vegetables, bread, rice, potatoes, pasta and other starchy foods, milk and dairy foods, meat, fish, eggs, beans and other non-dairy sources of protein and foods and drinks high in fat and sugar – we highlighted the foods in each group and counted the number of times they were purchased pre-intervention. We then compared this to the number of times the foods in each group were purchased post intervention. From this the total spend on each of the Eatwell food groups was calculated. Additionally the proportion of the weekly spend allocated to particular food groups (eg fruit and veg) was then calculated.

To triangulate this data we used a structured questionnaire (Appendix B), a validated cooking skills questionnaire (Appendices C and D) and a semi-structured interview. We asked participants and each member of their family over 11 years of age to complete a structured questionnaire asking the number of times they ate fruit and the number of times they ate vegetables each day.

The validated cooking skills questionnaire was used to measure self-reported fruit and vegetable consumption pre and post intervention. The magnitude of changes between the 2 points in time points (T2–T1) was compared in the intervention group using statistical analysis. Although intakes of particular foods such as fruit and vegetables are not normally distributed, other similar work has found that actual changes in consumption are and so we analysed using a parametric method. Changes in rank of scores of on knowledge of fruit and vegetables portions were analysed using Wilcoxon signed rank test.

During the semi-structured interview participants were asked about the range and price of fruit and vegetables available to them at the place where they usually shop. The key influences on purchasing patterns were also explored, as well as how and why any changes in food preparation were made. Barriers and aids to change were also identified in these interviews.

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17 We used a good quality questionnaire to collect information about how much fruit and vegetables the families were eating. We asked the cooks to fill in the questionnaire before they went to the classes and after they had been to the classes. When we analysed the information we used a mathematical test to find out if the cooks were using more fruit and vegetables in their cooking after the classes.
We checked that the information was accurate by cross-checking against pictures of stored in cupboards and fridges as well as shopping bag contents. The family weekly food spend was gauged by using shopping receipts.

**Food preparation in the home:** This was measured using the semi-structured interview and structured questionnaire both were used pre and post intervention. The semi-structured questionnaire (Appendix A) concentrated on:

- **Topic:** Do you enjoy cooking?
- **Topic:** What food do you usually cook at home?
- **Topic:** What comes to mind when you hear the phrase ‘healthy food’?
- **Topic:** Barriers to healthy eating
- **Topic:** Does your family cook because they like to or because they have to?

The semi-structured interview data was analysed using grounded theorising and the structured questionnaire data was collated for each family. It is used to help shed light on the quantitative changes or indeed the reasons why change did not occur.

**Cooking confidence pre and post intervention:** We used a validated cooking skills questionnaire 11 to measure cooking skills and behaviours pre and post intervention. A scale was used to measure cooking confidence and the lower the score the more confident the person reported feeling on using specific cooking skills. The data was analysed using SPSS. The magnitude of changes between the 2 points in time points (T1–T2) was compared.

We also gathered data on this through the semi-structured interview, this helped shed more light on the issues and processes involved.

All interviews were recorded and transcribed. Ethical approval was obtained from the University Research Ethics Committee. Participants were provided initially with an information sheet and all recorded data on this interview was transcribed. Ethical approval was obtained from the University Research Ethics Committee. Participants were provided initially with an information sheet and all signed consent forms at both T1 and T2 stages.

3. Results

As noted twelve families were recruited to take part in the Can Cook Family Programme, eleven families completed forms and interviews and provided receipts. We therefore collated eleven complete sets of data. We have set out the results with the background and context for the decisions and cooking options people make, then the evidence for changes from pre to post programme are set out; finally the evidence for what led to these changes is set out.

3.1 Background and contextual data

A breakdown of the gender of the cook, the age breakdown of the household, and weekly income can be seen in Table 1.

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<th>Gender</th>
<th>How many adults &amp; &gt;16 in your household?</th>
<th>How many children under 16 live in your household?</th>
<th>How many adults do you usually prepare food for on a daily basis?</th>
<th>How many children &lt; 16 do you usually prepare food for on a daily basis?</th>
<th>Weekly household income before tax and including benefits?</th>
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</table>

The majority of the family cooks were female, 9 of the 11 participants. Of the 11 families six were two parent households and five were one parent households including the two males. There were flexible arrangements in some households with children spending time at another parent’s house or partners coming and going. All this reflects the modern family with all its complications and jigsaw fittings, which introduce other complexities for feeding and food.

In the interviews many of the families reported problems with affordability of food not just a healthy diet, which we know costs more. Only one family in the above table had an income of more than £300/week and this was for 5 household members; another had £100/week with 4 household members. The median income was between £150-200/week. This places the majority of families in the lowest decile income groups in the UK.

Some general issues about behaviours emerge from the interviews. These help paint a general picture of the lives of the households. These demonstrate a degree of consensus over some attitudes and behaviours. Key among these were the following:

- The importance of Scouse as a dish with cultural meanings, one woman said ‘My little girl loves it. My partners not that fussed on it cos he’s from Wales so he’s like “What else goes with it?” it’s like “No Scouse, bread, beetroot”, but the kids love that from being round here’ (WN).
- Responses to questions about the recognition of healthy diet focused on the importance of fruit and vegetables and cutting down on eating take-away foods and fat in the diet.
- There was a high reporting of families preparing and eating food in the home. Concomitant with this was a low reporting of the incidence of households eating out or eating from take-aways. There was some reporting of men using take-aways during work or leisure time.
- Waste including buying or preparing food that might not be eaten, was seen as expensive as

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most of the families interviewed were on low-incomes and some were reliant on benefits and/or non–routine or irregular income streams.

- All reported shopping in one of the major supermarkets. Most shopped in Speke at the local supermarket, those with a car or access to a car shopped outside the area in another supermarket.
- Families ate together often, in the sitting room, in front of the TV or at the breakfast counter.
- Many did not have a separate dining area. The following two quotes show this:
  - Normally just the living room cos our house is that small that we haven’t got a dining room so we just sit in the living room, yeah. And the second:
  - In the living room (WT).
- Few prepared deserts as a routine meal component.
- There were problems identified with getting children and partners (men) to eat fresh vegetables.
- Fresh fruit was reported as being routinely available as a snack item or to be taken from the fruit bowl.
- Extended and jigsaw family arrangements accounted for differing feeding arrangements and complexities as such as going to another parent, being looked after by grandparents, partners coming and going on an irregular basis to and from the house.
- One family bought and prepared fresh fish, the others all expressed a dislike of fresh fish, the smell the preparation needed, but said that prepared breaded fish products, mainly fish fingers, were often consumed in the home.
- Five of the eleven cooks expressed a dislike of cooking pre-intervention.

All were preparing food in the home but many expressed a lack of confidence in what they were doing and a sense of failure if they did not cook meals from scratch or fresh ingredients. However this was balanced with a tension between wanting to try new things and introduce healthier eating to the family and fear of ‘failure’. This failure took two aspects; the first was fear of rejection of the food prepared from family members and the second issue was that of waste. Waste was seen as expensive as most of the families interviewed were on low-incomes and some were reliant on benefits and/or non–routine or regular income streams.

The photographs of fridges and cupboards help paint a picture of what was happening in households, the following images help portray a sense of context.

**Figure C: A Dry store cupboard (pre-intervention)**

The store cupboard above was contrasted in this family’s case with a small number of goods in the fridge (see below). This was partially explained by issues of storage and what children would eat. It was felt to be easier to buy dry goods such as pot noodle for storage and then have them to draw on at times of crises and/or when money was short.

**Figure D: Fridge from same family as Figure A**

**Figure E: Another fridge**

The above (figures C to E) were typical in about half of the families interviewed. This can be contrasted with the photographs below (figures F & G) which show another dimension. Although most fridges were as follows below. A key point here is that all families were making decisions about domestic economy and managing on limited resources and were aware of the importance of fruit and vegetables in a healthy diet.

The photographs indicated two diverse models of purchasing and storage. The first as seen in Figures C, D and E above suggest that the purchase of dry goods was one way of storing up for times when money was tight. In these instances the fridges are used for some basic everyday items such as milk, cheese and meat/chicken slices.
Figure F: A well-stocked fridge

Figure G: Another stocked fridge

The context of all of this is that families were managing but struggling to manage and there were reasons for their decisions on food purchases which were not always guided by healthy eating messages. In fact the majority of the cooks interviewed knew and recognised the importance of five-a-day healthy eating messages. For some food purchases were dictated by ensuring that there was sufficient food in the house form one ‘payday’ to another. Any changes brought about must be considered within the confines of these limitations of geography and family incomes.

When asked about the goods in their fridges/cupboards there were reasons for the reasons. The goods there were not the result of unconscious decisions or of impulse shopping but well thought out and reasoned responses to domestic management.

3.2. Changes in Family shopping habits/food consumption

The results of supermarket purchases analysed in line with the recommended intakes of the Eatwell Food Plate model food group pre-intervention are presented in Table 2.

As noted earlier some families had complicated inter-household arrangements with partners or family carers such as grandparents. The following quote illustrates this

Yeah because my son will spend a lot of time in his Nans house so if his Nan’s going to the chippy for tea, you can guarantee he’ll get there. He’ll get his, so nine times out of ten he could eat fast food two to three times a week, without me even knowing because I only live literally five minutes away, he’ll take himself off cos he’s nine this year so he’ll just toddle off and the last thing I know is he’s had something to eat cos he’s been to the chippy so you don’t even know half the time they just...

At the two time points we found that before the Can Cook intervention (T1) the largest proportion of spend for most families was on protein foods (meat, fish, eggs and beans); the second largest proportion of spend was balanced between on foods high in fat and/or sugar and carbohydrate foods (bread, rice, potatoes and pasta). The proportion of spend on fruit and vegetables had the greatest variation 0% - 36%.

Table 2: Supermarket purchases pre-intervention

<table>
<thead>
<tr>
<th>Pre - Can Cook</th>
<th>Weekly spend on milk and dairy products</th>
<th>Weekly spend on meat, fish, eggs and beans</th>
<th>Weekly spend on bread, rice, potatoes and pasta</th>
<th>Weekly spend on fruit and veg.</th>
<th>proportion total weekly spend on fruit and veg.</th>
<th>proportion total weekly spend on meat, fish, eggs and beans</th>
<th>proportion total weekly spend on bread, rice, potatoes and pasta</th>
<th>proportion total weekly spend on milk and dairy products</th>
<th>proportion total spend on foods high in fat and/or sugar</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 £5.70</td>
<td>11.76%</td>
<td>£2.71</td>
<td>5.63%</td>
<td>£18.80</td>
<td>38.79%</td>
<td>£5.63</td>
<td>11.62%</td>
<td>£32.47</td>
<td>25.73%</td>
</tr>
<tr>
<td>2 £7.10</td>
<td>8.93%</td>
<td>£17.50</td>
<td>22.01%</td>
<td>£24.41</td>
<td>30.70%</td>
<td>£4.70</td>
<td>5.91%</td>
<td>£32.62</td>
<td>15.87%</td>
</tr>
<tr>
<td>3 £9.00</td>
<td>0.60%</td>
<td>£19.90</td>
<td>32.06%</td>
<td>£5.47</td>
<td>33.06%</td>
<td>£1.12</td>
<td>7.06%</td>
<td>£3.99</td>
<td>24.51%</td>
</tr>
<tr>
<td>4 £13.96</td>
<td>11.33%</td>
<td>£31.15</td>
<td>6.86%</td>
<td>£48.09</td>
<td>33.33%</td>
<td>£7.29</td>
<td>4.42%</td>
<td>£42.05</td>
<td>26.53%</td>
</tr>
<tr>
<td>5 £6.13</td>
<td>4.18%</td>
<td>£32.55</td>
<td>22.18%</td>
<td>£36.10</td>
<td>24.60%</td>
<td>£13.05</td>
<td>7.53%</td>
<td>£32.52</td>
<td>22.18%</td>
</tr>
<tr>
<td>6 £34.66</td>
<td>16.23%</td>
<td>£2.00</td>
<td>4.94%</td>
<td>£39.92</td>
<td>34.46%</td>
<td>£8.00</td>
<td>19.77%</td>
<td>£9.54</td>
<td>23.56%</td>
</tr>
<tr>
<td>7 £5.82</td>
<td>15.32%</td>
<td>£8.45</td>
<td>10.65%</td>
<td>£39.75</td>
<td>44.09%</td>
<td>£2.50</td>
<td>5.58%</td>
<td>£6.05</td>
<td>13.39%</td>
</tr>
<tr>
<td>8 £6.16</td>
<td>10.42%</td>
<td>£12.04</td>
<td>10.37%</td>
<td>£33.06</td>
<td>26.01%</td>
<td>£2.96</td>
<td>5.08%</td>
<td>£6.03</td>
<td>6.82%</td>
</tr>
<tr>
<td>9 £8.57</td>
<td>12.96%</td>
<td>£9.90</td>
<td>10.47%</td>
<td>£37.92</td>
<td>34.05%</td>
<td>£5.47</td>
<td>7.14%</td>
<td>£9.09</td>
<td>12.73%</td>
</tr>
<tr>
<td>10 £1.08</td>
<td>1.89%</td>
<td>£7.90</td>
<td>10.94%</td>
<td>£11.20</td>
<td>19.56%</td>
<td>£8.50</td>
<td>11.35%</td>
<td>£8.41</td>
<td>14.60%</td>
</tr>
<tr>
<td>11 £0.99</td>
<td>0.60%</td>
<td>£7.75</td>
<td>10.66%</td>
<td>£8.57</td>
<td>13.75%</td>
<td>£9.30</td>
<td>19.46%</td>
<td>£9.42</td>
<td>11.30%</td>
</tr>
</tbody>
</table>

The qualitative interview data regarding vegetable consumption hinged on two/three areas, the first was where cooks themselves had not a liking or taste for vegetables as in the following two quotes:‘I: Do your family like vegetables?  
CJ: No. That could be down to the fact I don’t like them and I don’t cook them. … Peas, that’s the only one I do do. But my mum does them, we go to my mums once a week and she does them and they won’t eat them there but they’ve never really had it enforced so.  
PJ No, the most I’d eat I’d say was probably peas and carrots, but I’ve always been like that and I think that’s part of, because I don’t eat vegetables, my partner doesn’t eat vegetables it rubs off on the kids. And I know that’s the mistake I’ve made now, I should have done it. With my son being nine he never got, cos we didn’t eat it, he just thought well we don’t, but with my other two children that are younger I do try to push it a bit but they learn from the others you see, they think “Well I’m not going to eat” you know? “He doesn’t eat it, I don’t like it either” so. That’s the mistake I’ve made so.

19 The food plate model is a visual representation of the types and proportions of foods needed for a healthy and well balanced diet. See http://www.food.gov.uk/images/document/eatwellplatea.jpg
The second issue was where the cook was catering to the likes/dislikes of others as can be seen from the following quote:

PJ Not really, the kids they'll have a go, they are starting to eat like carrots and stuff but nothing like broccoli or nothing like that, they won't. I'll try and disguise it a bit you know chop it up and so they don't know what they're eating. We call it rainbow mash, just chop everything in the mash so you will get them to eat a bit but.

Results of supermarket purchases analysed using the Eatwell Plate model post-intervention are presented in Table 3, this is an attempt to link the intervention to any changes in purchasing behaviour supported by data from the interviews.

Table 3: Supermarket purchases post-intervention

<table>
<thead>
<tr>
<th>Post - Can Cook</th>
<th>Weekly spend on fruit and veg</th>
<th>Weekly spend on bread, rice, potatoes and pasta</th>
<th>Weekly spend on meat, fish, eggs and beans</th>
<th>Weekly spend on milk and dairy products</th>
<th>Weekly spend on foods and drinks high in fat and/or sugar</th>
<th>Weekly spend on foods and drinks high in fat and/or sugar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean T1</td>
<td>8.78</td>
<td>21.2%</td>
<td>7.30</td>
<td>10.6%</td>
<td>13.8%</td>
<td>12.1%</td>
</tr>
<tr>
<td>Mean T2</td>
<td>8.78</td>
<td>21.2%</td>
<td>7.30</td>
<td>10.6%</td>
<td>13.8%</td>
<td>12.1%</td>
</tr>
<tr>
<td>Mean difference</td>
<td>0.00</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

The reported change in intake of foods that can have a positive impact on diet were centred on reported changes in items such as 100% fruit juice, fruit and vegetables. Overall there was increase in juice intake (pre 12 portions and post 17 portions); vegetable intake (pre 19 portions and post 28 portions); fruit intake (pre 18 portions and post 24 portions).

From the cooking skills questionnaire, completed by the cooks, we were able to provide additional evidence to support the findings of self-reported increases in vegetable and fruit intake. Table 4 shows the reported mean change in intake. A significant increase in intake was reported in fruit, p= 0.011 (CI = 1.36 – 0.24) and vegetables 0.009 (CI = -2.52 – (-0.47)). The important issue of vegetable intake will be discussed in the conclusion section.

Significant increases at in intake of pasta or rice, and boiled or mashed potato were also reported. No change in the intake of chips, fried or roast potato was reported and also no change intake of fish and fish products (see the comments on fish in the opening section on findings for comments on fish). Later on in separate section on the cooking changes we will see data which adds to the reasons why this might be.

This was reflected in the qualitative accounts where the cooks reported themselves less likely to have a liking or taste for vegetables and for vegetables on the meal plate to be a contentious issue for other family members. Some reported children having more of a liking or acquired taste for fruit and that by using fruit as a snack they were able to incorporate this in diets. After the Can Cook programme the largest proportion of spend for most families was still on protein foods such as meat and eggs; the second largest proportion of spend was on carbohydrate foods like bread and potato, however one family reported spending 41.9% of their supermarket spend on high fat, high sugar food.

The third influence were the taste and food preferences of partners, in the majority of cases men, who saw vegetables on the plate as unmanly and displacing the central part of the meal ie meat. As one cook put it ‘KM: XXX doesn’t like them at all. He’ll have a fry up and a roast dinner, that’s the only time I get him to eat vegetables’. The reported change in foods that can have a negative impact on diet - crisps, fizzy drinks and sweets and chocolates over the 24 hour period varies with some family members reporting increases in crisps, fizzy drinks and chocolates and some reporting decreases. For most individuals there was no change in intake of these foods.

Table 4: Mean (standard deviation) reported change in fruit and vegetable intake and comparison between the intervention group at T1 and T2 and mean change (T2-T1)

<table>
<thead>
<tr>
<th>Fruit</th>
<th>Mean T1</th>
<th>Mean T2</th>
<th>Mean difference (T2-T1)</th>
<th>p- value</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.9 (1.35)</td>
<td>5.6 (1.38)</td>
<td>-0.7 (0.76)</td>
<td>0.011**</td>
<td></td>
</tr>
<tr>
<td>Vegetables or salad</td>
<td>4.1 (1.40)</td>
<td>5.7 (1.42)</td>
<td>-1.6 (0.47)</td>
<td>0.009**</td>
</tr>
<tr>
<td>Pasta or rice</td>
<td>3.4 (0.42)</td>
<td>4.5 (1.18)</td>
<td>-1.1 (0.47)</td>
<td>0.006**</td>
</tr>
<tr>
<td>Boiled or mashed potato</td>
<td>3.4 (0.52)</td>
<td>4.1 (0.57)</td>
<td>-0.7 (0.47)</td>
<td>0.001**</td>
</tr>
<tr>
<td>Chips, fried or roast potatoes</td>
<td>4.6 (0.98)</td>
<td>4.0 (0.00)</td>
<td>0.6 (0.18)</td>
<td>0.172</td>
</tr>
<tr>
<td>Fish or fish products</td>
<td>3.3 (0.95)</td>
<td>3.6 (0.52)</td>
<td>0.3 (0.07)</td>
<td>0.193</td>
</tr>
</tbody>
</table>

*Two-tailed test for equality of means ** significant at the 95% confidence level

The cooks showed a less significant change in their knowledge of the number of portions of fruit and vegetable portions. From Table 5 the significant change in knowledge from pre – post intervention was in the number of portions of fruit in a small carton of raspberry yoghurt, this reflects an already high level of knowledge and awareness of the five-a-day message. The correct answer was zero portions. One medium size apple, were reported correctly pre intervention by eight of the ten cooks. The knowledge of numbers of portions for all other questions one medium glass of orange juice one glass of orange squash (diluted), a thin slice of tomato, three heaped tablespoons of carrots. This suggests that healthy eating knowledge or lack of it is not the prime determinant of why people do not prepare healthy meals.

Table 5 Difference in ranks of scores of knowledge of fruit and vegetable portions pre and post intervention

<table>
<thead>
<tr>
<th>Knowledge of portions of fruit and vegetables</th>
<th>Z value</th>
<th>p- value</th>
</tr>
</thead>
<tbody>
<tr>
<td>One medium glass of orange juice</td>
<td>-1.00</td>
<td>0.32</td>
</tr>
</tbody>
</table>
One glass of orange squash (diluted) -1.00 0.32
A thin slice of tomato -1.73 0.08
Three heaped tablespoons of carrots -1.41 0.16
One medium size apple -1.41 0.16
One small raspberry yoghurt -2.00 0.05**

** significant

The total weekly supermarket spends varied between £16.28 - £164.92 pre-intervention to £13.92 - £156.45, depending on numbers in the family (Table 6). There was a wide variation in spend.

Table 6: Weekly supermarket receipts indicating pre and post intervention

|                   | Pre-intervention | Post intervention | Difference
|-------------------|------------------|-------------------|-------------
| Total weekly spend| £48.47           | £15.15            | £33.32      |
| Spend per head pre-intervention | £15.15 | £16.67            | £1.52       |
| Post intervention | £15.15           | £10.28            | £4.87       |
| Mean % spend      | 10.28            | 6.67              | 3.61        |
| Range             | 5.63-32.56       | 16.41             | 10.78       |
| Meat and meat alternatives | 13.70 - 44.07 | 25.17             | 11.47       |
| Carbohydrate foods| 5.63-32.56       | 16.41             | 10.78       |
| Fruit and Vegetables | 0-36.23  | 10.28             | 9.00        |

The range of proportion of spend for all of the families combined and the mean proportion of spend is presented in Table 7. We excluded spend on milk and dairy produce data as not all milk purchase is at supermarkets and therefore the milk and dairy produce is likely to be the most unreliable data.

Table 7: Proportion of receipt spends and mean proportion of spend by Eatwell food category

<table>
<thead>
<tr>
<th></th>
<th>Range Pre-intervention (%)</th>
<th>Mean % spend Pre-intervention (%)</th>
<th>Range Post-intervention (%)</th>
<th>Mean % spend Post-intervention (%)</th>
<th>Difference % spend between pre and post intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fruit and Vegetables</td>
<td>0-36.23</td>
<td>10.28</td>
<td>5.69-43.79</td>
<td>12.83</td>
<td>2.55</td>
</tr>
<tr>
<td>Carbohydrate foods</td>
<td>5.63-32.56</td>
<td>16.41</td>
<td>7.79-30.74</td>
<td>17.45</td>
<td>1.04</td>
</tr>
<tr>
<td>Meat and meat alternatives</td>
<td>13.70 - 44.07</td>
<td>25.17</td>
<td>0 - 32.12</td>
<td>21.58</td>
<td>-7.59</td>
</tr>
<tr>
<td>High fat and sugar foods</td>
<td>6.82 - 25.73</td>
<td>17.81</td>
<td>8.09 - 41.90</td>
<td>18.84</td>
<td>1.03</td>
</tr>
</tbody>
</table>

This shows an increase in spending post intervention on more on fruit and vegetables and less on meat and meat alternatives. For meat and meat alternatives this is in line with general trends but the increase in fruit and vegetable spend is counter to national trends.

From the structured questionnaire (Appendix B) we were able to find out how many meals were made at home for one week pre-intervention and for one week at three months post intervention. As noted earlier there was no significant eating out reported by families pre intervention, male partners were suspected of eating out at lunchtime and cares such as grandparents were reported as treating children to occasional take-ways or fast food, but the cost of take-aways was seen as prohibitive.

Table 8: Week intake – meals cooked at home & takeaway

The nine of the eleven families were eating more than five meals cooked at home in the pre-intervention week (Table 8). All of these families continued to eat more than five meals cooked at home when asked post intervention. Two families ate less than five meals prepared at home pre-intervention. Both of these families increased the number of meals that they prepared at home post intervention.
intervention. Of these one family ate more than five meals prepared at home post intervention; the other family ate two meals at home post intervention.

Five of the eleven families ate zero takeaway meals in the week pre-intervention, three families ate one takeaway meal in the week pre-intervention. In two of the families at least one family member ate more than five take-away meals during that week. Post intervention there was a decrease in the number of takeaway meals eaten during the week with four families reporting zero, five families reporting one and two families reporting two – three takeaway meals being eaten. The numbers of meals eaten outside the home was very small and was seen as a luxury or occasional treat. Men eating outside the home during working hours was reported on but details were not available. As well children were occasionally treated to a take-away or fast food meal by carers, usually family members such as grandparents.

The next set of data focuses on the changes in food preparation and cooking in the home.

3.3 Evidence for the Can Cook programme
The qualitative data helps shed light on some of the changes that the cooks made in meal preparation. The changes were qualitative in nature. The following series of quotes all from the post intervention interview show how changes were made. These ranged from cooking the same – familiar - types of food but preparing them differently to the realisation that food could be simple and include some pre-prepared ingredients. The impact of the course on skills and confidence can also be seen in the quotes below.

PJ: The chicken nuggets, homemade ones cos they loved it.

WN: It was just I used to think that you had to put loads of stuff together to make a meal and then Can Cook have given me a tray with a potato, a carrot and I’d look at it and think “that won’t feed two people” and then I put it together and I fed two people and it made me realise that I didn’t have to do all that work to make that meal, I just had to use less stuff and I’d still make the same meal without all the wastage as well. So it was actually quicker to do which makes it nicer to do if that makes sense.

WN: My daughter loves the omelettes that Can Cook taught me.

I: Ok.

SK: Yeah, I enjoy it a lot more now, yeah.

I: Ok, why is that?

SK: Because I know how to make things properly. And I can make the nuggets and the burgers and all that from scratch so the kids have loads of fun as well.

I’m going to ask you is, do you enjoy cooking?

HS: Yes I did tremendously, unexpectedly.

I: You did, yeah. Ok, if you didn’t enjoy cooking, why was it you didn’t enjoy it in the past?

HS: I didn’t enjoy cooking in the past because of the amount of time taken to do the preparation and the cooking process and the cleaning up after that and the output is just rubbish.

I: Right, in the past is that how you felt?

HS: Yeah, in the past yeah.

I: Ok, alright so in the last 24 hours alright, what food did you cook for your family?

HS: Yesterday we had pasta, just spaghetti bolognaise, yeah with garlic bread.

I: Alright.

HS: Cooked from scratch.

CJ: I enjoy cooking in the Can Cook studio, where it’s stress free. In the house it’s just a little bit too stressful.

Leading on to

CJ: I did have a go at cooking the chicken burgers and stuff, you know what they showed us, I did do that. We got the chicken breast and we made them ourselves and that was good cos even when the kids were eating them, they did actually all eat that. They said “These taste like KFCs or whatever”, it is just again the hassle but they did taste better.

I: Ok, alright. How often do you cook your meals from scratch, like fresh meat, fresh fish?

RJ: Since I’ve done my Can cook course I’ve only done one main meal from ingredients and that was a pan of Scouse.

What respondents reported was making changes and amendments to existing dishes from what they had learnt on the course. They were also able to plan better from the section on the course which dealt with shopping and planning. They were also more confident to introduce less familiar meals and dishes following the course. This reported increase in confidence leads us onto the measure of confidence.

3.3.1 Cooking confidence pre and post intervention
This data was collected using cooking skills pre and post questionnaires (Appendices C and D). The results show significant increase in their overall cooking confidence post intervention. Table 9 shows there was a significant improvement in all the skills that the cooks practised at the Can Cook sessions, in cooking from basic ingredients (p=0.001); in following a simple recipe (p=0.01); in tasting new food (p=0.025); preparing and cooking new recipes (p=0.038). remember the post intervention measures were taken three month after the course.

Table 9: Mean (standard deviation) reported change in cooking confidence and comparison between the intervention group at T1 and T2 and mean change (T1-T2)

<table>
<thead>
<tr>
<th>Confidence in cooking skills</th>
<th>Mean T1</th>
<th>Mean T2</th>
<th>Mean difference (T1 - T2)</th>
<th>p-value*</th>
<th>t-value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>How confident do you feel about cooking from basic ingredients?</td>
<td>4.1 (1.96)</td>
<td>2.3 (0.95)</td>
<td>1.8 (1.23)</td>
<td>0.001**</td>
<td>-1.92 - 2.68</td>
</tr>
<tr>
<td>How confident do you feel about following a simple recipe</td>
<td>3.6 (1.71)</td>
<td>1.7 (0.67)</td>
<td>1.9 (1.85)</td>
<td>0.019**</td>
<td>-1.99 - 3.23</td>
</tr>
<tr>
<td>How confident do you feel about enjoying new food?</td>
<td>5.1 (1.85)</td>
<td>3.4 (1.075)</td>
<td>1.7 (2.00)</td>
<td>0.025**</td>
<td>-1.28 - 3.13</td>
</tr>
<tr>
<td>How confident do you feel about preparing and cooking new recipes?</td>
<td>4.7 (2.79)</td>
<td>2.6 (0.84)</td>
<td>2.1 (2.72)</td>
<td>0.038**</td>
<td>-0.150 - 4.05</td>
</tr>
</tbody>
</table>

*Test for equality of means ** significant at the 95% confidence level

Some of the reasons why this score has increased from pre-intervention to post intervention can be seen in the quotes in the previous section. Some of the cooks at the pre intervention stage (T1) said things like ‘IJ And stuff like that, if you haven’t cooked something before and you’re thinking “That doesn’t look right” to us it doesn’t look right because we are the sort of people, it’s got to be well cooked. If it doesn’t look right and you think “Well have I cooked that properly?” and stuff like that, it’s more my confidence I think that’s why doing this I think it’ll build my confidence up a bit so and so I know what I’m doing basically’, this same participant was the same who said post course that she
presented the same food to her children but now she made it as opposed to buying prepared food. "PJ, the chicken nuggets, homemade ones cos they loved it'.

It was noted earlier that over half the sample started with a feeling of lack of enjoyment around food. For some it was the role, one of the single dads said in response to the question do you enjoy cooking?

RJ: No.
I: No. Not at all. Ok. Any reason why that is?
RJ: I've not really cooked much all my life, I've sort of been put in the situation where I've got no choice but to cook because I'm now a lone parent with two young children.

All of these same five were more positive on finishing the course. Often this was to do with the expectations of others such as can be seen in this quote: 'PJ It's not that I don't enjoy cooking it's just that, if I haven't done it before the problem I have and my partner has is thinking 'Is that cooked properly?' The same individual in her interview following the cooking class said 'Now I do, it wasn't that I didn't enjoy it, I just wasn't that experienced at it. Now I find that I just take the time and stuff, give the kids a go to help me, I do try different stuff now…..I'd never tried anything new.'

This individual identified the advantages of the class setting as a stress free place to experiment and hone skills to be able to say that something was cooked properly. In addition others talked about the opportunity to taste food before serving it at home.

Some of the skills learned at the classes were simple ones such as using recipes and involving children in the preparation of the food: 'PJ Oh no, it's too difficult and then but the Can Cook made it easier to follow, so I thought if I just follow their recipes what give you, which was very helpful. Even bit by bit, I'm not saying I've gone overboard, I just try maybe one thing different a week, I made the chicken nuggets last night, the homemade ones and the kids loved it, cos they could get messy'.

The results of the 24 hour intake of indicator foods indicates that the intake of foods that can have a negative effect on intake, and are an indicator of unhealthy diet, remained static or increased slightly after the intervention; the intake of foods that have a positive effect on dietary intake, and are an indicator of healthy diet, increased significantly. The analysis is presented in Table 10.

Table 10: 24 hour intake of indicator foods

<table>
<thead>
<tr>
<th>Pre-intervention</th>
<th>Post -intervention</th>
<th>% change in Intake</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisps</td>
<td>18</td>
<td>16</td>
</tr>
<tr>
<td>Fizzy or fruit drinks</td>
<td>20</td>
<td>40</td>
</tr>
<tr>
<td>Sweets and chocolates</td>
<td>19</td>
<td>22</td>
</tr>
<tr>
<td>Fruit juice</td>
<td>12</td>
<td>17</td>
</tr>
<tr>
<td>Vegetables</td>
<td>16</td>
<td>26</td>
</tr>
<tr>
<td>Fruit</td>
<td>18</td>
<td>24</td>
</tr>
</tbody>
</table>

3.3.2 Barriers to transference of cooking skills into the home environment

A key barrier identified to introducing new foods or cooking was cost aligned with the possibility of waste and rejection of meals or food by family members. Differing tastes were identified as barrier to introducing new foods into the home:

SK: 'XXX [daughter] won’t eat sweet and sour pork or pasta, she just goes into one ‘I don’t like them” our Leanne doesn’t eat fish but the others will, so it’s like each and every one has got a different one. Each night I’ve got a battle with them cos someone won’t like something that I’m making'.

The following is an extended outtake from the interview with one of the cooks who at the pre-intervention stage positively disliked cooking, three months after the course she said:

I'm going to ask you is, do you enjoy cooking?
HS: Yes I did tremendously, unexpectedly.

I: You did, yeah. Ok, if you didn't enjoy cooking, why was it you didn't enjoy it in the past?
HS: I didn't enjoy cooking in the past because of the amount of time taken to do the preparation and the cooking process and the cleaning up after that and the output is just rubbish.
I: Right, in the past is that how you felt?
HS: Yeah, in the past yeah.
I: Ok, alright so in the last 24 hours alright, what food did you cook for your family?
HS: Yesterday we had pasta, just spaghetti bolognaise, yeah with garlic bread.
I: Alright.
HS: Cooked from scratch.

Another barrier was the lack to time to enjoy it, this quote is from the single dad mentioned above who had been thrown into the role of family cook: RJ: Well it's not that I don't really enjoy cooking, I don't get much of a chance to cook because out of the seven days a week, five days a week, myself and my son and daughter go to my mother's for tea and obviously breakfast time is a case of toast or cereal. During the dinner time they're in school for their dinner, it's not really worth getting pots and pans out to cook something just for myself and as I said five evening meals a week it takes place at my mother's house.

Some identified broken cookers and or lack of pot and pans as a limiting factor as in the following quote 'What's sort of holding me back at the moment is the pan set which I had it was one of those cheap pan sets where you get about five pans for £12.99 or something with the plastic handle and plastic knobs and they don't heat properly, they tend to burn if they're heated too much so to be honest I've thrown them away. I've got a frying pan left at the moment and what I intend to do is get a decent, when I get this £100 voucher thing is either spend £100 on food and the money what I'd normally spend, go to a cookware shop and get a decent pan set then I do want to get stuck in and start a lot more, cos as I say I've only done it the once since it finished July the 22nd when I had the second Can Cook course, that's been like two months'.

3.3.3 Fear of the new-Food neophobia

The interviews showed that the cooks were catering in the home for a range of tastes and food preferences. The lack of income and resources meant that many of these issues could not be challenged if there was a possibility of waste.

This lack of willingness to try new foods was linked to three issues:
1. Conservatism of the cook themselves as in having no taste or liking for vegetables
2. Fear of rejection/waste.
3. The conservatism of other family members.

One cook said that "Yeah, to the extent where if I know what I'm cooking and it's just simple, with having three children you just seem to go to anything that's easiest because my children are hard to please, you put nuggets in front of them, pizza anything like that and they will eat it. If you give them anything that they don't know that looks a bit dodgy, they're really fussy they won't, so I get sick of cooking the same meals over and over again" she went on to say that when serving pasta to them that "Yeah. So they won't have the twist they'll have the shells, weird but they'll eat it"
3.3.4 Men as cooks
Although only two cooks were men, it is worth exploring some of the issues they faced in providing food and cooking. Kay among their concerns were:
• They both reported having to fulfil the role and not being prepared for it.
• Both reported that extended family was important as they often fell back on this for the provision of meals for children.
• While they recognised healthy eating and food preparation as important they were more likely to resort to eating take-away or fast food.
• Shopping was identified as a problem for them.
• Cooking had a functional aspect for them and engaging children in cooking was less important than putting a meal on the table.

Cooking had a functional aspect for them and engaging children in cooking was less important than putting a meal on the table.

All the foregoing shows the impact of the Can Cook Programme and how it has impacted positively on eating behaviour, particularly on fruit and vegetable intake, and supported an increase in foods that are known to be healthy. This is a key public health message and of importance for this and similar interventions. In line with this increase in ‘healthier’ foods we also found that there was no change in intake of food that was not addressed on in the Can Cook programme i.e. chips, fried and roast potatoes and also fish and fish products. Although fruit and vegetable intake increased there was only a small change in knowledge of fruit and vegetable portions reported by the cooks. This fits in with modern health promotion thinking where the issue is not knowledge about what is healthy but knowledge about how (skills and confidence) to make changes. The participants had good knowledge of fruit and vegetable portions prior to Can Cook. For healthier and indeed budget shopping and food preparation fruit and vegetable purchases are an important indicator. Since 2007 food prices have increased and all families are shopping down (i.e. seeking bargains) and looking to economise. DEFRA in its annual statistics shows that the average spend per family member within the Eatwell categories is £16.49. Low income households spent 16% of their food budget, or 2.57 per person per week, on fruit and vegetables. 20 The Eatwell Plate requires 33% of the plate for these foods. The participants in the Can Cook programme along with the general public show a decline in meat purchases but unlike the general population an increase in fruit and vegetable consumption.

The percentage spend on fruit and vegetables increased 2.55% post intervention. This indicates a real increase in fruit and vegetable at 3 months after Can Cook. When we look at the cook data and the family data together there is a clear indication that improving the cooking skills of the person who prepares food in the family does increases the fruit and vegetable intake of the family as a unit. This impact has not been studied previously and an important finding for the Can Cook programme. From the intake data a pattern emerged where individual members of families tend to increase their fruit and vegetable intake concurrently. This affect is most noticeable when vegetable intake increases. This can be traced to the of Can Cook programme on the cooking behaviour of the cook in the family and possibly the focus on eating together. We know from other work on increasing fruit and vegetable intakes that in the first instance fruit can be used to substitute for snacks high in salt, fat and sugar; the participants in this research reported doing this by leaving fruit around and encouraging its use as a snack. But after this one of the best ways to increase vegetable intake is to include it as an item on the meal plate, so include vegetables in dish as in soup or include it as a side dish.

All the families in this evaluation were low-income families. The low income of all families is reflected in the relatively low spend on food for each family. In our work in Preston (2010) we found that the average ‘healthy’ shopping basket in that area at that time cost £42.4721. We found a wide range of spending on weekly food purchases in this evaluation. It is not possible to identify if the Can Cook programme had an impact on the proportion of spend on specific food groups in the weekly shop. We would however maintain that the change in fruit and vegetable consumption, together with increase in pasta, rice and potato consumption is reflected in the slight changes in purchasing pattern. To make ends meet and to be at the minimum income standard a family (2 adults and 2 children) needs an income of £455/ week 22 based on research by the Joseph Rowntree Foundation. None of the families in our group came near to having this income and for the majority their weekly income was less than £250/week. These families were all on a low income and most likely experiencing the impact of that low

income on their ability to buy healthy food. The household income of one family was £200 per week for two adults and four children.

In addition to an increase in fruit and vegetables which was reported in eight of the eleven families we also found that the cooks reported an increase in use of other ‘healthier’ food such as pasta, rice, boiled and mashed potato. Again as this increase in use is significant and suggest that this is as a result of participation on the Can Cook programme.

From the structured questionnaire Appendix B we were able to find out how many meals were made at home for one week pre-intervention and one week post intervention. While the majority of families were already preparing five or more meals at home each week it was clear that the families that were preparing only one to four meals at home each week were also purchasing two to more than five takeaway meals each week. After the Can Cook sessions the families that were not cooking previously reported an increase in the number of meals prepared at home. This was reported along with a concurrent decrease in the number of takeaway meals being eaten. This change needs to be viewed alongside the reported data on cooking confidence. The cooks reported a significant increase in cooking confidence. This indicates that the increased confidence of the family cook has led to an increase in the number of meals prepared at home from basic ingredients and to a decrease in the number of takeaway meals eaten by the family.

Some of the barriers to changes in the family setting were not to do with skills or knowledge but with family structures, preferences and tastes, in fact although the family cook is often thought of as in control of these issues s/he is negotiating a series of structural barriers starting with economics of providing a healthy diet. S/he is in fact negotiating a complex set of interactions. Taking this and combining it with the issues the cooks identified as the advantages of the programme in the studio which were preparing and tasting something before trying it at home, there may be a need to extend the lasting to the whole family. Some of the cooks did in fact mirror what happened in the studio session with the chefs but others found this difficult to mimic. While it might not be possible to take all family members into the studio for two days, perhaps a final meal for all family members could be arranged over the two days of the course. In the first evaluation such a process was used in with the secondary schools competition.1

We evaluated the impact of the Can Cook programme on eleven families. The Can Cook programme appears to have improved the skills and increased the confidence of the family cooks. This change has led to some significant changes in diet including increases in fruit, vegetable, rice, pasta, and potato consumption. All of these changes are considered ‘healthy’. These changes have not only occurred in the diet of the cook but also the diet of the whole family.

The outcome also appears to be that more families are eating meals cooked from basic ingredients at home and less takeaway meals. Overall Can Cook has had significant impact on the small cohort who we evaluated and have achieved their aim of teaching parents to cook meals, and particularly healthy meals, for their children and families from scratch. Additionally there was evidence that families were sitting down to eat meals together post intervention although where they ate this was dictated by the limitations of households, put simply the absence of a dining area.

The only issue that remains unresolved is that of fish, while there are clear health outcomes from eating more fish, the current group of 11 families identified barriers to buying and preparing fresh fish. These were to do with the storage and smell associated with fish and the nature of kitchens and accommodation. Many did report eating breaded fish or pre-packaged fish products. The issues may be as much to do with kitchen facilities (eg extractor fans) and separation from the rest of the house.

5. Conclusions
The intervention has had an impact on the participants which was extended to the families. The keys to success are based on a well-designed programme which combines skills and health eating messages within a fun context and one which help develops not just skills but also confidence. The changes are small in terms of overall dietary changes but nonetheless significant and importantly seem to remain steady over time. The running of the programme with families in an area is likely to have a public health impact at a group or population level. The Can Cook programme had developed materials to support and extend its work in schools funders, on the basis of the findings reported here, should give consideration to funding work to support the family initiative, this might include follow-ups or the development of a an app to deliver healthy recipes and on-going encouragement to participants post course.

- The mode of delivery supports people on low income families to learn new skills and try new skills and dishes in a safe environment before introducing them to the family.

There are many strengths of the Can Cook programme, the family programme clearly delivers in a number of key areas namely skills and confidence. This latter issue is one that should not be underestimated as in health literacy terms it is likely that this confidence may extend to other health areas.

The programme as it is delivered currently
- Improves the cooking skills of participants
- Increases the cooking confidence of participants
- Encourages healthier eating i.e. increased intake of fruit, vegetables, rice, pasta and potatoes
- Supports participants to understand what they already know about fruit and vegetable portions

Future courses could consider the issue of food neo-phobia and include a session on how to manage this among family members.

There is a clear case for funders and commissioners extending the funding so that the family programme becomes a key part of all healthy and anti-obesity interventions.

Finally a caveat: in these times of financial austerity the programme should not be seen as a means of encouraging low-income families just to manage within limited resources, the programme has the potential to make people aware of the food system and who controls it. Funders could consider how best to fund Can Cook bring together participants on the course to help develop a voice or advocacy for those faced with restrictions on their food choices.

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Appendix A

Semi structured interview

Family sessions

Pre Can Cook Sessions Interview

Date of interview:

Names of people being interviewed (please write down all the names and please note after the name if the person is the cook in the family):

Location of interview:

Introduction:
Please read the text below out to the group - thanks

Thank you for coming along today to take part in this session, and for signing up to the Can Cook programme. We just wanted to say thanks for helping us with this research; it is going to help us understand what works in the Can Cook sessions, and what could be improved for future sessions. We realise that you haven’t taken part in the sessions yet, we’ll do another group interview like this after you’ve been to the Can Cook sessions to see how you think they have helped you.

Today we are going to ask you about your cooking experiences. We have some questions to ask and this will take around half an hour. We are going to record this, but you will notice that on the recording – your contribution will be anonymous. The MP3 file will be kept at City University offices, on computers that are password protected. Previously you have given us your consent to take part in our research, however, you can withdraw at any time and you do not have to take part in this group interview if you do not wish to, we won’t ask any questions. Thank you again for taking part.

1. Tell us about cooking at home?

Topic:

Do you enjoy cooking
i. Do you enjoy cooking?
ii. Do you enjoy cooking why don’t you enjoy it?

Topic:

What food do you usually cook at home – questions to the cook
i. What food did you cook for your family in the last 24-hours? (Please ask if they cooked anything in the morning e.g. at breakfast, in the afternoon e.g. at lunchtime, or in the evening e.g. at teatime or dinner time?)
ii. Tell us about the last meal you made and how you made it?
iii. What was it?
iv. What ingredients did you use in the meal?
v. What time of day do you usually cook in your house
vi. Does your family have a favourite meal that you cook?
vii. If your family does have a favourite meal then what is it?

Topic:

Where do your family eat at home?

i. At home where do your family sit to eat usually?

ii. Do you all eat together as a family at one time?
iii. How many times a week do the family eat takeaway food together?
iv. If you don’t eat take-away food together do members of the family eat away food individually?
v. How many times a week does this happen?

Topic: What comes to mind when you hear the phrase ‘healthy food’?

i. What comes to mind when you hear the phrase ‘healthy food’?
ii. Do you like vegetables?
iii. Does your family like vegetables?
iv. Do you use vegetables when you cook your meals?
vi. Do you like using vegetables in your meals?
vi. Do you like fruit?
vii. Do your family like fruit?
viii. Do you use fruit when you make meals?
ix. Do you use fish in your meals?
x. Do you like using fish when making your meals?
xi. Do you like potato, rice, or pasta in your meals?
xii. Do you use starchy food (e.g. potato, rice, pasta) when making your meals?
xiii. How often do you cook meals from ‘scratch’, that is from fresh meat, fish or vegetables?
xiv. Is there anything that stops you eating more healthily than you do?

2. Where do you do your weekly food shopping?

(iif it’s not a local food store we need to know where and then why they wouldn’t use the local shops?)

a. Where do you do your food shopping?
b. Are any of these stores in Speke?
c. How do you get to each of these food shops?
d. Are any of these stores in Speke?
e. Is there anything that stops you buying food that you think is healthier?
your local shops
f. If you don’t use the local shops in Speke, why don’t you use them?
What range of fruit and vegetables can you find in your local shops? Is the fruit a reasonable price or expensive? Are the vegetables a reasonable price or expensive?

3. How many people in your family?

a. How many people live in your home?
b. How many people in your family are over 18 years old?
c. How many people in your home are under 18 years old?

4. Does your family cook because they like it or because they have to?

a. Do you have any special needs linked to food? E.g. special diet, religious diet, personal choices?
b. Do any of your family have any special needs linked to food? E.g. special diet, religious diet, personal choices?
Appendix B

To be completed by Community Worker:

Family number ........................................

Can Cook Family

Your initials: ........................................ Date of birth: ........................................

Family name: ........................................................................................................

Are you the mother / father / son / daughter / other: ........................................

Are you... ○ Female ○ Male

Today’s date: ........................................

Thank you for taking part in this evaluation.

Could each member of the family you please read the questions on the next page and answer them as honestly as possible.

Thank you

The Can Cook Team

<table>
<thead>
<tr>
<th>Family no: .........................</th>
<th>What food have you eaten in the last 24 hours, please try and remember all that you have eaten and give us honest answers? (please tick)?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Food</strong></td>
<td><strong>No</strong></td>
</tr>
<tr>
<td>Crisps</td>
<td></td>
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<td>Fizzy or fruit drinks</td>
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<td>100% fruit juice</td>
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<td>Sweets and chocolate</td>
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<td>Vegetables</td>
<td></td>
</tr>
<tr>
<td>Fruit</td>
<td></td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>In the last week (7 days) have you eaten any meals cooked at home?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Food</strong></td>
</tr>
<tr>
<td>Meal cooked at home</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In the last week (7 days) have you eaten any fast food?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Food</strong></td>
</tr>
<tr>
<td>Fast food</td>
</tr>
</tbody>
</table>

Thank you for answering these questions
Appendix C

Pre-Intervention Questionnaire for Cooking Skills Programmes

Date __________________________ Location __________________________

How do you prepare meals ...........?
Q1. What kind of cooking do you do at the moment? (Please tick as many boxes as appropriate)
   - Cook convenience foods and ready-meals
   - Put together ready-made ingredients to make a complete meal (e.g. use ready-made sauces)
   - Prepare dishes from basic ingredients
   - Other, please specify: __________________________
   - Don’t cook at all

Q2. In a normal week, how often do you prepare and cook a main meal from basic ingredients, for example, making Shepherd’s Pie cooking with raw mince and potatoes? (Please tick one box)
   - Daily
   - 4-5 times a week
   - 2-3 times a week
   - Less than once a week
   - Never

How do you feel about ............
Q3. How confident do you feel about being able to cook from basic ingredients? (Please select one)
   - Extremely Confident
   - Very Confident
   - Confident
   - Not at all Confident

Q4. How confident do you feel about following a simple recipe? (Please select one)
   - Extremely Confident
   - Very Confident
   - Confident
   - Not at all Confident

Q5. How confident do you feel about following a complex recipe? (Please select one)
   - Extremely Confident
   - Very Confident
   - Confident
   - Not at all Confident

Q6. How confident do you feel about preparing and cooking new foods and recipes? (Please select one)
   - Extremely Confident
   - Very Confident
   - Confident
   - Not at all Confident

What do you usually eat ............
Q7. How often do you eat fish? (Please tick one box)
   - Never
   - Less than once a week
   - Once a week
   - 2-4 times a week
   - 5-9 times a week

Q8. How often do you eat vegetables or salad (not including potatoes)? (Please tick one box)
   - Never
   - Less than once a week
   - Once a week
   - 2-4 times a week
   - 5-9 times a week

Q9. How often do you eat pasta or rice? (Please tick one box)
   - Never
   - Less than once a week
   - Once a week
   - 2-4 times a week

Appendix D

Post-Intervention Questionnaire for Cooking Skills Programmes

Date __________________________ Location __________________________

How do you prepare meals ...........?
Q1. What kind of cooking do you do at the moment? (Please tick as many boxes as appropriate)
   - Cook convenience foods and ready-meals
   - Put together ready-made ingredients to make a complete meal (e.g. use ready-made sauces)
   - Prepare dishes from basic ingredients
   - Other, please specify: __________________________
   - Don’t cook at all

Q2. In a normal week, how often do you prepare and cook a main meal from basic ingredients, for example, making Shepherd’s Pie cooking with raw mince and potatoes? (Please tick one box)
   - Daily
   - 4-5 times a week
   - 2-3 times a week
   - Less than once a week
   - Never

How do you feel about ............
Q3. How confident do you feel about being able to cook from basic ingredients? (Please select one)
   - Extremely Confident
   - Very Confident
   - Confident
   - Not at all Confident

Q4. How confident do you feel about following a simple recipe? (Please select one)
   - Extremely Confident
   - Very Confident
   - Confident
   - Not at all Confident

Q5. How confident do you feel about following a complex recipe? (Please select one)
   - Extremely Confident
   - Very Confident
   - Confident
   - Not at all Confident

Q6. How confident do you feel about preparing and cooking new foods and recipes? (Please select one)
   - Extremely Confident
   - Very Confident
   - Confident
   - Not at all Confident

What do you usually eat ............
Q7. How often do you eat fish? (Please tick one box)
   - Never
   - Less than once a week
   - Once a week
   - 2-4 times a week
   - 5-9 times a week

Q8. How often do you eat vegetables or salad (not including potatoes)? (Please tick one box)
   - Never
   - Less than once a week
   - Once a week
   - 2-4 times a week
   - 5-9 times a week

Q9. How often do you eat pasta or rice? (Please tick one box)
   - Never
   - Less than once a week
   - Once a week
   - 2-4 times a week
   - More than once a week