Annex E

The final step of the Fairer Scotland Duty assessment process is to complete the **SUMMARY TEMPLATE** which should be published alongside other impact assessments.

FAIRER SCOTLAND DUTY
SUMMARY TEMPLATE

Title of Policy, Strategy, Programme etc	**Food Standards Scotland Strategy 2021-26: *Healthy, Safe, Sustainable: Driving Scotland's Food Future***
Summary of aims and expected outcomes of strategy, proposal, programme or policy	This is an over-arching strategy document which sets out Food Standards Scotland's purpose, its priorities, and how it will deliver over the next five years. The strategy lays out FSS's Statutory obligations under the Food (Scotland) Act 2015 to protect the public from risks to health that may arise through the consumption of food, to improve dietary health, and to protect the other interests of consumers in relation to food. The document describes how FSS will deliver these objectives, outlining its priorities over the next 5 years and how it will deliver them through a set of values, guiding principles, approaches and key goals.
Summary of evidence	FSS's remit covers dietary health and prevention of foodborne illness in the Scottish population. <u>Dietary Health</u> Tackling obesity and poor diet in Scotland is a major aim of the Scottish Government and there is recognition that obesity in Scotland has a strong link with inequalities with lower socio-economic status associated with higher levels of obesity[1]. FSS has identified that people living in the most deprived areas of Scotland tend to have the poorest and most energy dense diets, and suffer the greatest burden of diet related disease[2]. The relative cost of healthier foods may be one factor implicated in poorer diets of low income households as healthier food choices tend to be more expensive, costing three times more to get the energy required from healthy foods rather than unhealthy foods[3]. Food poverty and insecurity can lead to uncertainty and an inability to consume sufficient food and is another factor in poorer diets in low income households. Food insecurity increased with increasing levels of deprivation and those who experienced food insecurity tended to also consume a lower proportion of fruit and vegetables[4]. Poverty and low socio-economic status have an impact on individuals decision making processes which tend to be focused on coping with immediate stressful circumstances at the expense of longer-term goals, such as the pursuit of a healthy diet[5]. In a similar vein, an in-depth qualitative study of four households living on a low income in Ireland found that the

[1] Public Health Scotland (2021) Obesity - Diet and healthy weight - Health topics - Public Health Scotland

[2] Food Standards Scotland (2018) The Scottish Diet: It needs to change, Situation_report_-_the_Scottish_diet_-_it_needs_to_change_-_2018_update_FINAL.pdf (foodstandards.gov.scot)

[3] Gov.uk (2021) Food Statistics in your pocket: Prices and expenditure - GOV.UK (www.gov.uk); Jones, N, Conklin, A, Suhrche, M, and Monsivais, P. (2014) Meeting UK dietary recommendations is associated with higher estimated consumer food costs: an analysis using the National Diet and Nutrition Survey and consumer expenditure data, 2008–2012 | Public Health Nutrition | Cambridge Core

[4] NHS Health Scotland (2018) Food Poverty, Health inequalities: briefing 12 Food poverty (healthscotland.scot); Scottish Health Survey (2018) scottish-health-survey-2018-edition-amended-february-2020-volume-1-main-report.pdf

[5] Sheehy-Skeffington, J and Rea, J. (2017) How poverty affects people's decision-making processes, Joseph Rowntree Foundation, How poverty affects people's decision-making processes | JRF

	participants tended to live in 'the here and now' and prioritised making the most of a limited budget on a day by day basis. The main priority was to put food on the table and not nutritional content. While participants knew what constituted healthy eating they faced barriers because of cost, convenience and potential food waste which were difficult to overcome[6]. Other factors implicated in barriers to healthy eating include local availability of and access to retailers selling affordable, nutritious food, access to transport, access to cooking, storage and preparations facilities, appropriate food skills and knowledge, food marketing and advertising, social norms and culture[7]. There is some evidence that interventions which promote effective provision of information and facilitate goal setting can be effective in promoting positive behaviour change in low-income groups, although it has been recognised that there is a need for on-going research in this area. However, providing information was only effective when combined with more active behavioural change strategies which teach self-management techniques such as goal setting[8]. Another, more recent, review of interventions to change behaviours among low-income groups found that including the techniques of self-monitoring of behaviour and face-to-face contact promoted increased effectiveness in interventions to improve dietary behaviours. Targeting multiple behaviours together (such as diet and physical activity) also increased effectiveness[9]. One issue raised is that people from disadvantaged backgrounds seem to have less success in achieving behaviour change following participation in formal programmes than people in the general population. This may contribute to widening inequalities because people in the general population potentially gain more from interventions than disadvantaged people[10]. Others have argued that the disparity may not be because the programmes are less effective but because those from disadvantaged backgrounds start with a lower chance of success because their starting levels are lower, and because of barriers in their social and physical environments[11]. <u>Dietary Health – Intersectionality</u> There is some evidence that dietary health of those on low incomes is linked to particular protected equalities characteristics. Some women on low incomes may have less healthy diets. Women in pregnancy who are older, more educated, with higher incomes or other markers of affluence were more likely follow 'healthier' dietary practices such as consumption of grains, fruit and vegetables and nutrients important in pregnancy[12]. While levels of food insecurity were similar among men and women under 65 living alone, food insecurity was particularly prevalent among single parents (mostly mothers), including being worried about running out of food, having eaten less and having actually run out of food due to lack of resources[13]. In addition, mothers experiencing food poverty have been found to skip meals so that their children can eat[14]. Age has been found to be linked to food insecurity with younger adults more likely to experience food insecurity than older adults. Similarly, when it came to having eaten less than they should because of a lack of money or other resources, more younger people reported having done so compared to older groups[15].

[6] Safefood (2011) Food on a low income - report | safefood
[7] NHS Health Scotland (2018) Food Poverty, Health inequalities: briefing 12 Food poverty (healthscotland.scot); Majowicz et al (2016) Food, health, and complexity: towards a conceptual understanding to guide collaborative public health action | SpringerLink; Corfe, S. (2018) What are the barriers to eating healthily in the UK?, Social Market Foundation, https://www.smf.co.uk/wp-content/uploads/2018/10/What-are-the-barriers-to-eating-healthy-in-the-UK.pdf
[8] Michie, S. (2007) et al Low-income groups and behaviour change interventions: A review of intervention content and effectiveness (kingsfund.org.uk)
[9] Bull et al (2014) Are interventions for low-income groups effective in changing healthy eating, physical activity and smoking behaviours? A systematic review and meta-analysis | BMJ Open
[10] Bull et al (2014) Are interventions for low-income groups effective in changing healthy eating, physical activity and smoking behaviours? A systematic review and meta-analysis | BMJ Open
[11] Michie, S. (2007) et al Low-income groups and behaviour change interventions: A review of intervention content and effectiveness (kingsfund.org.uk)
[12] Doyle et al (2016) Determinants of dietary patterns and diet quality during pregnancy: a systematic review with narrative synthesis | Public Health Nutrition | Cambridge Core
[13] Scottish Health Survey (2018) scottish-health-survey-2018-edition-amended-february-2020-volume-1-main-report.pdf
[14] NHS Health Scotland (2018) Food Poverty, Health inequalities: briefing 12 Food poverty (healthscotland.scot)
[15] Scottish Health Survey (2018) scottish-health-survey-2018-edition-amended-february-2020-volume-1-main-report.pdf

	Evidence in relation to the intersection between socio-economic characteristics and other protected characteristics such as race, religion, disability and maternity and motherhood is limited. <u>Foodborne Illness and food hygiene practices</u> Evidence regarding foodborne illness and food hygiene practice are constrained by the availability of relevant and up to date baseline data. The evidence available shows: Campylobacter is the most common cause of foodborne illness in Scotland and in an FSS report found that the average cost per case (over 70% of overall cost was attributable to hospital stays) was higher in the most deprived areas than in the highest quintile[16]. However, the actual reported incidence of campylobacter was actually lower among those living in the most deprived areas of Scotland although the incidence of serious illness resulting in hospitalisation was higher among those in the lowest quintile[17]. Another FSS report concluded that there was evidence from multiple sources that deprivation is protective for campylobacter with explanations for this phenomenon ranging from differences in culinary habits, levels of environmental exposure, disease severity, reporting and foreign travel. The same report suggests that the reason for the higher rate of hospitalisation in the most deprived areas was unclear but is probably related poorer general health and/or social circumstances[18]. Food hygiene practices are important in reducing the risk of foodborne illness. FSS produce bi-annual reports which track (among other issues) food safety behaviours among a sample of the Scotland population. The most recent survey only found one risky practice (defrosting frozen meat by placing it in water) was more likely to be carried out by people in lower socio-economic groups[19]. Evidence in relation to the intersection between socio-economic characteristics and other protected characteristics is severely restricted.
Summary of assessment findings	The strategy recognises the importance of considering inequalities in the development of policies and interventions arising from future work aimed at reducing the levels of overweight and obesity in Scotland and the burden of diet related disease and foodborne illness. This partial assessment has been completed by carrying out initial desktop research. It identifies that those experiencing socio-economic disadvantage tend to have a less healthy diet and are more likely to experience food insecurity, but there is further scope for an evidence review examining the intersection between socio-economic disadvantage and other protected characteristics. There is also potential to assess the feasibility of carrying out further analysis of existing datasets (such as the Scottish Health Survey and the up-coming FSS Intake 24 add on) to examine if it is possible to analyse intersectionality further. Evidence on what interventions work best to change dietary behaviours among the socio-economically disadvantaged and other intersectional characteristics is patchy and sometimes contradictory. There is a need for a more systematic evaluation of interventions which encompass national and international research. The evidence on the incidence of foodborne illness and on food hygiene practices among socio-economic groups is contradictory and limited. There is scope for further analysis of data on food hygiene practices which is collected by FSS and FSA but which is not currently systematically analysed by socio-economic disadvantage or other protected equalities.

[16] FSS (2020) Campylobacter: Estimating the healthcare cost of gastrointestinal infection in Scotland CampyCostsPaperFinal v3_NC ND_Comments (foodstandards.gov.scot)
[17] FSS (2020) Campylobacter: Estimating the burden of gastrointestinal infection in Scotland using data linkage, HPS_-_Campylobacter_Data_Linkage_Report.pdf (foodstandards.gov.scot)
[18] FSS (2020) Factors affecting variations in Campylobacter disease rates in Scotland (February 2020)
[19] FSS (2021) Consumer Tracker Wave 11 Report for Publication (on eRDM)

	There is a lack of evidence on factors associated with food hygiene behaviours more generally and specifically in relation to socio-economic disadvantage and other protected equalities characteristics. There is also limited evidence on what interventions are successful in changing food hygiene behaviours among these groups. There is scope for more thorough literature and evidence review of national and international research in order to establish an evidence base. There is a scarcity of evidence (or even discussion) about the actual or potential links between food hygiene behaviours and dietary behaviours. This is an area where the expertise within FSS is uniquely placed to make a positive contribution. It is recommended that further exploration is undertaken to scope the potential of developing this as an area of work in relation to socio-economic disadvantage. For instance, exploring the inter-related impacts on diet, nutrition and food hygiene practices among those experiencing food poverty and insecurity.
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