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The impact of Covid-19 and the resulting mitigation measures on food and eating in the East of England: Interim Report

Claire Thompson, Laura Hamilton, Angela Dickinson, Rosalind Fallaize, Elspeth Mathie, Samantha Rogers and Wendy Wills

Centre for Research in Public Health and Community Care (CRIPACC)

University of Hertfordshire

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Executive Summary

Measures to control the spread of Covid-19 are impacting food systems, household food practices, and organisations supporting vulnerable people in the UK. We report here on the interim findings of an ongoing qualitative study which aims to understand how Covid-19 is affecting local food systems, household food practices and efforts to mitigate dietary health inequalities in the East of England. The findings presented are from the first 35 interviews carried out with households (n=24) and those involved in community and local authority schemes (n=11) providing assistance in relation to food.

Our findings so far suggest that Covid-19 and the mitigation measures put in place from March 2020 (e.g. 'lockdown' and social distancing) are serving to amplify existing dietary health inequalities. Those who are relatively more secure financially have been able to spend time addressing and improving their dietary health, whereas those struggling financially or in economic hardship have experienced their diets worsening. Older people living alone and/or on low incomes have had to contend with difficulties in accessing food and a lack of opportunities to eat socially. Those with physical impairments and limited mobility sometimes find busy supermarkets potentially hostile and stressful environments and this has been amplified by the instore changes related to Covid-19. Online food shopping has been a particular challenge reported by participants. For some, the Covid-19 mitigation measures meant they were shopping online for the first time. Participants expressed frustration at the difficulty in securing a delivery slot and deliveries arriving with missing products and/or unsuitable substitutions. There was a general perception that food prices have risen since Covid-19 mitigation measures, especially in supermarkets. Participants suggested this was due to a reduction in the availability of food products and special offers.

Across the East of England, locally organised efforts to support and feed people included setting up community funds to supplement the income of organisations working with vulnerable people and with local businesses and partners to organise food supplies. While the Government food parcel scheme focused on feeding those in the shielding category, local authorities worked on supplementing the scheme, where required, by helping to feed and support other vulnerable groups in the community. Food banks have seen a rapid increase in need for their services and have also had to change their operating practices. Some have had to close or change venue and operating hours to accommodate changes to their volunteer base. While media coverage during the pandemic has reported a reduction in donations to foodbanks, some of our participants reported that donations to food banks have increased. This has created the need for increased storage capacity and processing facilities. Despite ongoing difficulties, local groups across the region have devised, adapted and operated a range of schemes to support and feed vulnerable people, tailored to the needs of local residents. Some of the feedback and recommendations provided by households and organisations thus far are summarised at the end of this interim report.

The Covid-19 pandemic has impacted on food and eating practices across the East of England in a range of ways. While some groups have been merely inconvenienced, others have had to manage with less healthy food and less money to buy food. The potential of the pandemic to amplify existing dietary health inequalities is a theme that we will continue to explore and report on as our research progresses into 2021.

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Introduction

Inequalities in diet, health and socially related outcomes are well recognised in the UK [1]. The 2010 Marmot Review [2] states that the health inequalities across England are a consequence of 'social and economic inequalities in society' (p. 37). According to The Health Foundation [3], 'low income is the most salient disadvantage, and a clear associate of poor health' (p. 12). In particular, it is more difficult for lower-income families to meet Government dietary recommendations and nutritional guidelines [4]. Healthier and more nutritious food typically costs more than less nutritious food [5, 6]. Across England, Wales and Northern Ireland, it is estimated that in 2016 approximately 21 per cent of adults experienced marginal, moderate or severe levels of food-insecurity [7]. Households with children are also significantly more likely to experience food insecurity.

Public health and economic crises impact disproportionately on low-income households, disadvantaged groups and populations [8].[1] Specifically, Covid-19 has implications for dietary health, food security and access to food. Therefore, there is a need to investigate these implications in order to inform effective and targeted interventions to maintain health and wellbeing and to ensure it is sustained throughout this crisis period and beyond.

The Covid-19 pandemic has brought health and social inequalities into sharp focus. Measures to control the spread of Covid-19, such as lockdown, social distancing and self-isolation, are impacting on food systems, household food practices and organisations supporting vulnerable people [9].[2] Emerging evidence suggests that these have changed the way households shop for food, cook and eat [10], with reported increases in 'cooking from scratch', shopping locally, and snacking [11].

Maintaining food systems and supplies has quickly emerged as a public health and economic priority as national and regional strategic responses to Covid-19 unfold. Increasing demand in supermarkets, 'panic buying', income-crises and social distancing have severely disrupted food practices. Inevitably, this will disproportionately impact low-income and vulnerable groups including those who may have existing health conditions and caring responsibilities that make accessing food in these circumstances difficult. More than three million people reported "going hungry" in the first three weeks of the UK's Covid-19 lockdown [12].

In July, part one of the 'National food Strategy' was launched in response to the Covid-19 pandemic. The report recommends that, in the wake of the pandemic, urgent action is needed to address dietary inequalities and food poverty for children. Further, it identifies that Covid-19 has highlighted the inequities and failings of the UK food system [13].

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[1] Defined as those on a low incomes, marginalised groups and those with a health and/or social care need.
[2] 'Lockdown' refers to the period from mid-March in which households were instructed to remain at home and schools and businesses closed in order to prevent the spread of Covid-19. These measures have been eased since early June 2020. During the Covid-19 pandemic the term 'lockdown' has been used colloquially to refer to localised and national restrictions on movement and social interaction.

In April, the UK Government introduced a national 'shielding' patient list (SPL).[3] Those on the list were the most clinically vulnerable to the consequences of Covid-19 due to health conditions, for example those with diabetes or cystic fibrosis. Specifically, these people were asked to strictly remain at home and 'shield' themselves from any social activities, including food shopping. This meant that people who were on the SPL could access supermarket priority shopping lists for online food deliveries and receive essential food parcels from their local authority. Alongside this national scheme, local authorities have co-ordinated regional multi-sector working groups to support those who may not have been placed on the SPL but still at a high risk (e.g. older people and pregnant women) to ensure they have enough food at the local level. Although those on the SPL can continue to access priority deliveries from supermarkets, the Government food parcel delivery scheme came to end on July 31st, 2020.

We report here on the interim findings of an ongoing qualitative study which aims to understand how Covid-19 is affecting local food systems, household food practices and efforts to mitigate dietary health inequalities in the East of England.[4] This diverse region includes a mixture of both wealthy and more socio-economically deprived populations living in coastal, urban and rural settings. The lessons learned in this study will be useful for other regions and further findings will be published as the study progresses.

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[3] NHS Digital compiled the shielding patients list of clinically vulnerable patients based on an algorithm which was constantly updated. It enabled partner organisations across government to identify and support those who need shielding due to their existing health conditions.

[4] The region covered by the NIHR Applied Research Collaboration East of England (who funded this study).

Research Design

In March and April of this year (2020) several online surveys started appearing via social media and other websites, asking people across the UK to document their experiences of a range of issues, including food, health and social isolation. Through our ongoing links with community organisations and professional networks across the East of England, we were aware that many individuals had a lot to say regarding Covid-19 and its impact on households and the organisations trying to ensure adequate food reached people in the region. We therefore decided to use qualitative methods to investigate how household food practices, including cooking and shopping, were being affected by the pandemic and the experiences of the local organisations who were trying to lessen the impact of it.

The overall aim of this research is to understand how Covid-19 is affecting local food systems, household food practices and efforts to mitigate dietary health inequalities in the East of England. In particular, we aim to include the views and experiences of a variety of households (as detailed below) and to enable immediate lessons to be learned so that local authorities can address these challenges now and in the future. The objective is to remotely interview a total of 80 – 100 households and 40 – 60 professionals/volunteers (involved in food related support work).

Participants, Sampling and Informed Consent

Households and organisations across the East of England are being recruited for the study in a number of ways. During the first phase of recruitment, the study was advertised on the NIHR ARC EoE website and on social media sites (e.g. via Twitter) via our professional and personal accounts using relevant 'hashtags'. The details of the study were also shared amongst our relevant professional contacts and networks, who agreed to pass the details to relevant individuals and organisations, via monthly newsletters or their social media accounts. Some of those contacts were also invited to take part in the study as professional participants, if they were involved in providing support for local residents in relation to food, for example. Some hard copies of study information leaflets were also distributed to households receiving food parcels through the local authority scheme in one county. After exhausting professional networks, the research team are now contacting local services across the region directly, such as carers groups, family centres and food banks as recruitment will continue into the Autumn/Winter period.

When interested participants contact the study via email, households are directed to complete an online screening questionnaire and provide their contact details, including their postcode to check that they live within the East of England. The screening questionnaire includes further questions such as working status, household composition and food shopping practices. Where it was not possible for participants to complete the screening questionnaire online (e.g. if individuals have no internet access), this is completed by the research team via the telephone with the participant, prior to the interview.

Where possible, participants are sent electronic consent forms via email. The consent forms can be completed electronically with an electronic signature and returned prior to the interview. Or they can be completed via the telephone with a researcher prior to the interview. Where participants do not have an email or access to the internet, consent forms are completed via telephone only. When completed via

the telephone this is audio-recorded and signed electronically on behalf of the participant by the researcher.

The research aims to include interviews with people living and working in the East of England, including:

i. Approximately 80 – 100 households. With a particular focus on recruiting the following: those with infants and/or school-aged children; families eligible for free school meals; low income households or those on state benefits; those aged 70 years+; households with people who are self-isolating or shielding due to a health condition; and households with key workers.

ii. Approximately 40 – 60 professionals/volunteers providing support in relation to food access and/or dietary health, including: those in a paid or voluntary capacity; people working for local authorities/councils; members of community organisations; and food bank organisers or volunteers.

Methods and Data Analysis

The topic guides were informed by ongoing engagement work with community food organisers and volunteers. In April, the research study idea was discussed at a University of Hertfordshire Public Involvement in Research group (PIRg) meeting. Members were asked for suggestions on recruitment strategies, interview content and to volunteer for pilot interviews. Six PIRg members provided comments on the topic guides about language and suggested additional topics for inclusion. After a research team discussion, the topic guides were amended and the changes were fed back to the PIRg members. PIRg members then provided further suggestions on how to recruit participants and two PIRg members made introductions to their local contacts which facilitated recruitment. In addition, five pilot interviews (including 2 members from the PIRg) were undertaken to test the topic guide and the use of remote video (e.g. via Zoom, MS Teams) and telephone interviews. Community stakeholders were also invited to comment on the topic guides. Ethical considerations were taken into account when designing the study such as the potential for discomfort or distress (due to the questions asked) and any consent and privacy issues related to conducting remote interviews. Community gatekeepers are helping us to recruit 'hard-to-reach' groups and potentially sensitive topics are often explored in interviews and discussions with these gatekeepers before attempting to recruit their service users. Ethics approval has been granted by the University of Hertfordshire (protocol no. aHSK/SF/UH/04132(1)).

Interviews are conducted remotely via telephone, Zoom or MS Teams as per the participant's preferred method. The topic guide for households consists of questions about the household's background, their views about Covid-19 and their general food practices and typical routine before and after Covid-19. It also includes sub-sets of questions relevant to the particular characteristics of the household, including families: (i) with an infant; (ii) with school-aged children; (iii) who are eligible for free school meals; older people; and those shielding or isolating for health reasons. The topic guide for professionals and volunteers providing support in relation to food access and/or dietary health covers: community support for infant feeding; support for children or key workers and those eligible for free school meals; and

support for older people. Participants are also invited to send photographs relating to their food practices and/or their work in the community. In the immediate term, these are being used to illustrate study findings. In the longer term, we intend to use them as discussion prompts if we re-interview participants at a later date. If we receive enough visual data, they will be subject to a visual analysis.

Interviews are being audio-recorded and professionally transcribed verbatim and pseudonyms are assigned to each participant. Transcripts are then uploaded to the qualitative data management software NVivo and subject to a thematic analysis [14]. Where photographs have been sent prior to interviews, these are supplementary to the interview data.

The East of England Region

The East of England includes Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Norfolk and Suffolk (see Figure 1). The NIHR ARC East of England is focusing its research on some specific 'populations in focus' including Peterborough and Fenland in Cambridgeshire; Thurrock in Essex; Stevenage in Hertfordshire; and Great Yarmouth and Waveney in Norfolk. The East of England is incredibly diverse, consisting of costal, urban and rural settings. There is also a mixture of both socio-economically deprived and wealthier areas. Figure 2 presents data from the English Index of Multiple Deprivation (EIMD) [15] highlighting areas in the highest EIMD deciles (low levels of deprivation; dark blue) to those in the lowest deciles (high levels of deprivation; light blue). In particular, the coastal regions and the 'populations in focus' have some of the most deprived postcode areas in England.
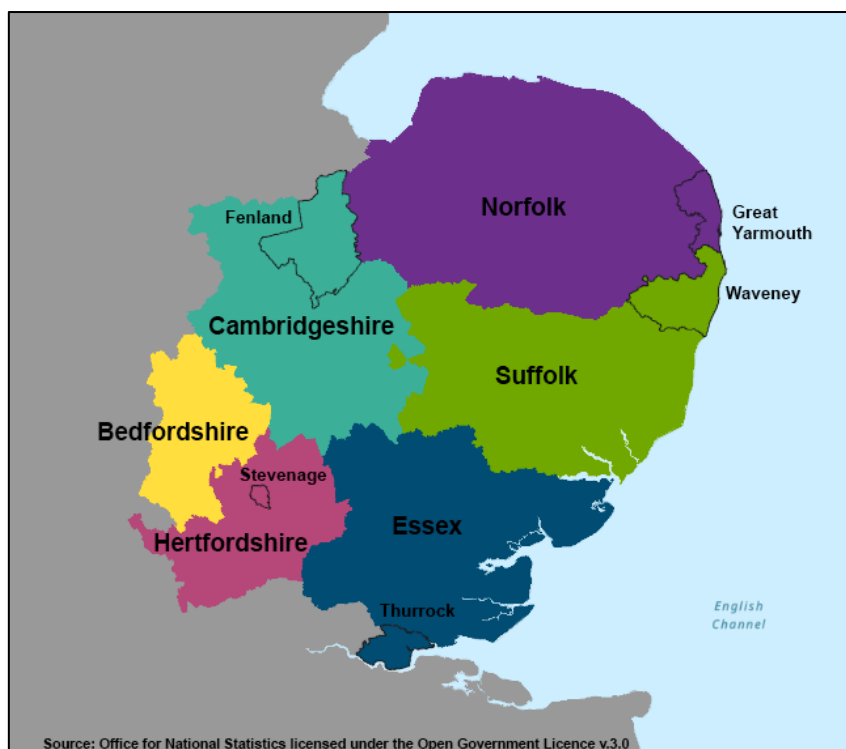

Figure 1: A map of the East of England, as per county and local authority boundaries, including the populations in focus.
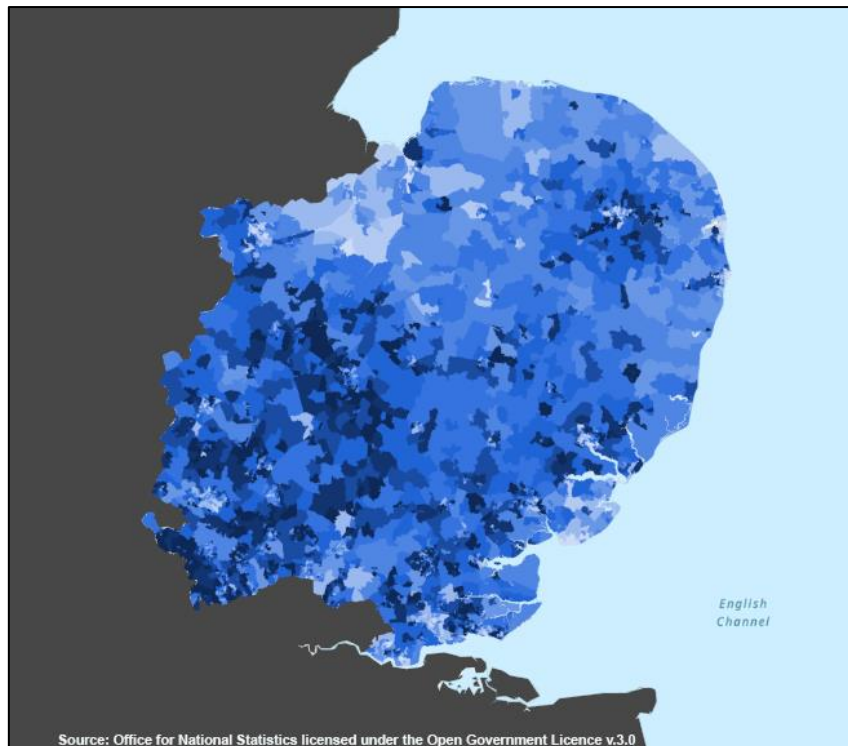
Figure 2: *An EIMD map of the East of England, highlighting areas of high (light blue) and low (dark blue) socio-economic deprivation.*

Findings

The following section highlights interim findings based on 35 interviews carried out with 24 households and 11 professionals/volunteers in May – August 2020. The professionals and volunteers were recruited from a range of organisations including local councils, food banks, charities, and community groups. The household participants were aged between 25 and 84 years and 22 of them were female.[5] The findings explore the perceived changes to diet and health as a result of Covid-19 and how local systems are working to mitigate dietary and other inequalities.

How have families and households coped during the Covid-19 pandemic?

Our interim findings suggest that Covid-19 and the mitigation measures are serving to amplify existing dietary health inequalities. Those who have remained relatively more financially secure have been able to spend time addressing and improving their dietary health. Whereas those who were struggling financially prior to and as a result of Covid-19 have reportedly worsening diets.

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[5] Participants were categorised into age groups: 18 – 24 years; 25 – 39 years; 40 – 54 years; 55 – 69 years; 70 – 84 years; and 85+ years.

Specifically, households that have not experienced a substantial drop in income and are able to work at home or have been furloughed (with a reasonable degree of certainty expressed that they will remain in employment) explained that they were trying to use the additional time available at home due to Covid-19 mitigation measures to improve their diet and lifestyle. Common pursuits included trying to cut down on 'unhealthy' foods, preparing more meals 'from scratch', cooking and eating as a family, teaching children how to cook, trying to use more fresh produce, taking time over cooking meals, and trying to take more exercise:

> *"I'm usually out by about seven o'clock for a run. By the time I get back it's sort of eight and I'll have a cup of tea and then sort of, sort of prepare my breakfast and then… start work about half eight, nine-ish… So, you know, if I can I'll take an hour for lunch now so I can kind of actually because obviously if I'm cooking something it takes longer than just eating something out of a packet that I'd, you know, or a lunch I would have taken into work… and then I can sit in the garden and maybe sort of get my brain away from work a little bit for an hour. So I have been trying to cook more stuff because I haven't got the commute, so it's a bit swings and roundabouts really. So I am trying to spend more time cooking decent food and using up all the stuff and fruit and veg." (Hhold 003; Office Manager, currently working from home)*

Although initially inconvenient and challenging, as the lockdown went on, those in a more secure financial position have stated that they have been able to adapt somewhat. For instance, they have had more time available to plan meal times and eating patterns for the family with a level of certainty and control that was not previously possible (pre-lockdown). This was because household members were eating some of their meals away from home or at different times due to school and working routines pre-lockdown. Some participants stated that being able to plan further in advance and for all meals meant that they could eat more healthily and felt able to better control what their children were eating. Figure 3 shows a weekly menu and spelling board that a young family working and schooling at home had taken to using in an effort to organise their meals and their spelling test achievements. The participant, a mother of two, explained that they had not engaged in this level of pre-planning and organising prior to Covid-19.
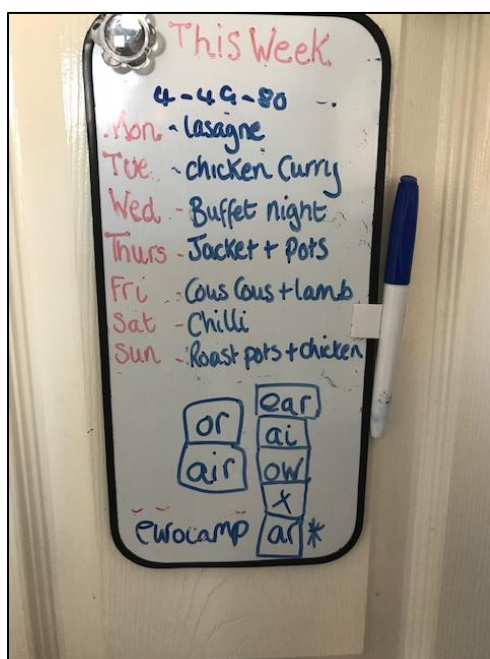
Figure 3: A household's weekly meal menu and spelling board (Hhold 009; family with an infant and school-aged child, a parent working at home and on maternity leave)

By contrast, those who found themselves on a lower income, challenged with financial insecurity, or socially isolated as a result of the Covid-19 mitigation measures had a very different experience. Community organisers, food bank volunteers and those working to support people on low incomes explained that, for their clients and service users, considerations around diet and health were deprioritised in favour of more immediate concerns such as paying bills and maintaining secure housing. Job losses meant that people had to engage with the benefits system and food banks for the first time in their lives, which could be both traumatic and disruptive. Food bank organisers described how they were now helping people who had found themselves abruptly without sufficient funds to maintain their household and feed their family and were completely unaware of how statutory (benefits) and community (food aid) support could be accessed:

> *"I think local people as well haven't known where to… people don't know where to turn to at the moment… So I just think there's not the places where people… people don't know how to make the connections with people that can help them and I think some of that is now happening over Facebook but not to the same extent that it would do normally." (Org 007; Food bank and church volunteer)*

Those working for local authorities and councils highlighted how families that would ordinarily receive free school meals had to go without while the schools were closed or rely on substitutes (e.g. vouchers or food parcels) provided by schools and the local authority, where available. Alternative provision across the region was not uniform. In some cases, food could be delivered to households. But in other cases, parents would have to go and pick up food parcels and vouchers in-person.

Older people living alone have had to contend with the difficulty of accessing food and a lack of opportunities to eat socially, due to social distancing restrictions. As the restrictions continued, people found themselves unable to share a meal or even a cup of tea with anyone outside of their immediate household for several months. In effect, this could mean not eating or drinking with anyone at all during their period of shielding or not being able to invite people into their home. These prolonged episodes of isolation sometimes resulted in a lack of interest in food or dietary health and a disengagement from food-related activities such as cooking:

> *"Yeah, up until last week she [daughter-in-law] was doing all my shopping, but… I'll be totally honest I'm not eating as much as I normally would have done. I haven't got the appetite. So I mean I've got a soup that she bought me weeks ago and it's still in the tins in the fridge… As I say with the fruit it's all right if it was soft fruits, that as I say having to chop up apples and pears and plums and whatever that makes it difficult with the false teeth, and as far as vegetables go I just cannot be bothered to stand there and prepare it all." (Hhold 014; aged 70+ years retired, receiving benefits and living alone).*

Prolonged isolation and resulting low mood and disengagement was compounded, for some older people, by their inability to cook for themselves. Those supporting older people in the community explained that malnutrition is a challenge for older people, who can struggle to consume sufficient calories. Being unable to cook is a contributing factor in this. Lunch clubs and social groups would normally be somewhere where hot meals could be consumed in a social setting, meaning that those unable to cook could still access a varied and nutritious diet. Measures to contain Covid-19 necessitated these services stopping. Added to which, families who were isolating were less able to care and cook for elderly relatives, further reducing access to hot meals and social interaction for some older people.

How has shopping for food changed?

Older people and those working to support them also reported a range of challenges around food shopping. One set of problems centred around a lack of agency and control over food shopping because of having to rely on others to do their food shopping for them. Older people had concerns such as not wanting to 'make a fuss' or ask too often and the time constraints faced by those doing the food shopping for them meant that the range of foods available to older people was reduced:

> *"Then I got the letter saying that's it for 12 weeks. So we thought, well how are we going to get to the supermarket? How are we going to get stuff? Well I live in a little village and the village worthies set up a volunteer service between them and for people are quite happy to go and do your shopping for you. We weren't very keen on that… We've got a neighbour who lives next door but one… so she, for the first three weeks, did our shopping… She's got two little kids… and we felt really guilty that she might be going out and catching Coronavirus on our behalf… so when we*

asked her to get stuff, we asked for the bare minimum." (Hhold 002; Retired and shielding)

Older people and those with caring responsibilities, particularly those caring for vulnerable adults, explained that, when only able to go out once a day, shopping for food sometimes had to be sacrificed or cut short in order to prioritise picking up medicines and prescriptions. Managing prescriptions in the context of Covid-19 mitigation measures could be a complex process that required considerable effort. Community volunteer services, while appreciated by service users, were not always able to cope with this:

"Well it is but you see the problem is that it's like my medication, they would provide somebody to go and fetch my medication because it was just as simple and straightforward as that. What they can't do is start ticking the boxes on the repeat prescription form for me or making two or three journeys down there to get my medication so in that respect, if I said to them, you know, when they phoned me up to say 'are you okay?' and I say 'no I can't get my medication' and then explaining how I've got to get it, they can't provide somebody to do that. So it was like unless you've got a sort of like fairly straightforward issue." (Hhold 047, carer for adult son)

The restrictions and social distancing measures implemented in supermarkets made shopping for food more challenging and often more time consuming. Volunteers and local authority staff explained that aspects such as having to queue standing up for long periods to get into the shops, being unable to go into the store with a carer or partner and finding the supermarket toilets closed were particularly hard to deal with for those with a health or social care need:

"We've got some people in their 90s who just either don't feel confident to go out, don't feel safe to go out to the supermarkets or some of them have got such… they've got disabilities and other things which stop them being able to go out and they're not able to get delivery slots… quite a lot of people with mental health issues who may have some additional physical issues as well, so for example quite a lot of people with asthma, which may or may not officially have to self-isolate but who are feeling very anxious about going out and it's too much for them to go into a supermarket." (Org 007; Food bank and church volunteer)

Some service user groups in the region have been advising their members to engage with the Hidden Disabilities Sunflower lanyard scheme, which is designed to act as a discreet sign that somebody has a hidden disability and may require additional assistance. Supermarkets increasingly recognise the scheme [16].

The alternative to in-store shopping, shopping online, was also made much more difficult by the Covid-19 mitigation measures. For instance, due to Covid-19 some people were shopping online for the first time. Participants from a variety of backgrounds expressed frustration at not being able to secure a delivery slot and food deliveries arriving with missing products or unsuitable substitutions. Household and even neighbours had to pool efforts and sometimes shop collectively to manage the challenges of online shopping:

> *"So that's the six of us in the house and then my parents live next door, they are 84 and 78 and they tried to do online shopping in the first week of lockdown but they couldn't manage. I mean quite apart from the fact that the supermarkets went into meltdown regarding online shopping in that first kind of fortnight period, they were really a bit too old to manage with the new technology, so I have been doing all their shopping [online] for them since whatever date in March… So all in all we are shopping for eight." (Hhold 010; Family with school-aged children)*

Those who were shielding and had been identified by the Government as clinically vulnerable as per the SPL were entitled to priority delivery slots with the larger supermarket chains. However, there was considerable confusion expressed about these services. People were unsure whether or not they were eligible for a priority delivery time and there was uncertainty about how they could access these 'special slots'. A retired women aged over 70 years (Hhold 011) and living alone describes the difficulty she had understanding and obtaining a priority delivery slot:

> *"And there were some special slots weren't there, but were they just for people who were shielding? I wasn't quite clear when I talked to different people about how easy it's been to get those, and lots of people have said how difficult it's been to get online slots... I have no idea how you got them, they just said that… it just wasn't possible." (Hhold 011; Retired and living with a long-term health condition).*

For those with access to a car, 'click and collect' options were popular because it meant they were able to access food more quickly. These collection slots were easier to obtain than delivery ones. It also meant they could combine their 'click and collect' trip with other essential errands.

For some, avoiding supermarkets (in store and online) became their preference. They chose to shop solely, or mostly, in local stores within walking distance of their homes or those which provided their own delivery service. This sometimes started as a short-term response by individuals to avoid busy supermarkets, food shortages and long queues. Then, as the Covid-19 mitigation measures and restrictions continued this strategy became a point of pride because it meant engaging with and supporting local businesses. For example, Emma (Hhold 001), a mother of two children currently working from home, stated that prior to Covid-19 she bought her meat from the local farm shop only on special occasions. However, since Covid-19, she has started to purchase more of her food from the farm shop and intends to continue doing so in the longer term.

> *"Before the pandemic I would get our Easter meat there [the local farm shop], I would get our Christmas meat there, like for holidays or special occasions or sorts of things… But now [since lockdown], I don't know, I feel like going to the farm is beneficial in so many ways because we are supporting that lovely family… so for the past month and a half or something they've been open every weekend. So now we can go, it's a lot more convenient, we can go there whenever we need to and you can also put in an order. So now I'm primarily getting most of our meat there… Yeah, that's definitely something that I think we'll change permanently as well, because of this situation I intend to continue buying most of our meat from them I think."* (Hhold 001; Mother with two school-aged children working from home).

In terms of the money spent on food, a variety of experiences were reported. Some participants, especially those with children, thought they were spending significantly more on food because their children were at home with no food provided by their school. This was particularly the case for those children eligible for universal infant free school meals (primary years: reception – year 3). Others had worked on their budgeting as the weeks went on and were proud to be gradually spending less on food and saving money by purchasing fewer takeaways and not eating out. There was a high level of awareness and interest regarding expenditure on food among participants. Eating all meals at home and being unable to 'shop around' for different products led some to start scrutinising their spending habits more closely than before Covid-19.

There was a general perception that food prices, especially those in supermarkets, had risen during lockdown. Individual food items were thought to cost more and participants reported seeing fewer special offers and having to purchase branded rather than own-brand products. Some participants thought that the supermarkets were 'cashing in' on the pandemic:

> *"The first couple of weeks [of the lockdown] food wise we always used to get like not the branded cereal but the supermarket version of it, because we eat a lot of cereal in this house, I just remember like the supermarket Shreddies for example were £1.80, they didn't seem to have any supermarket cereal in, so we were spending like £3.50 on actual Shreddies which was quite distressing at the time… Yeah, there's no special offers and like Weetabix is like £5 whereas previously we were going to Costco actually to get cereal."* (Hhold 009; On maternity leave with third child)

Feeding and supporting communities

Local authorities and councils across the region have been working with community partners and the voluntary sector to mobilise resources and provide assistance to a wider range of groups during the pandemic. In practice, this has meant that while the Government scheme focused on feeding those in the shielding category, councils worked on supplementing that scheme, where required, and helping to

feed and support other vulnerable groups in the community who were not on the SPL. In order to achieve this councils and local authorities have had to undergo a rapid reorganisation of services, develop new ways of working across sectors, and increase engagement with community groups and organisations. Working more closely with food banks became a necessity:

> *"All of a sudden what was normally a small part of our work became the major most important part of our work… so for example, we usually engage with our foodbanks, so we know who they are. They apply for a community grant, they are invited to some of our community meetings, whereas when Covid kind of took hold, all of a sudden, our foodbanks saw a huge increase in pressure, nationally not just locally but also became a key pathway to ensure that our vulnerable residents, both locally and nationally, were fed and were provided for."* (Org 010; Local Authority employee).

Food banks themselves have seen a rapid increase in need for their services and have also had to change their operating practices. Some have had to close or change venue and operating hours to accommodate changes to their volunteer base. The advice for over-70s and those with health conditions to self-isolate meant many of their regular volunteers could no longer help. However, large numbers of people being furloughed and working from home meant a new volunteer base came forward. But this meant a need to train these new volunteers quickly and to incorporate the new ideas and practices that a fresh set of volunteers brought with them.

Food banks had difficulty obtaining 'essentials' for food parcels such as instant mashed potatoes and milk. However, donations to some food banks increased, from both individuals and non-essential retail outlets that had to close and needed to dispose of any food stuffs in stock – including confectionary and novelty foods. This created the need for additional storage capacity and processing facilities. In order to cope with the rising number of people using their services, some food banks have suspended their usual referral voucher system and moved to electronic referral or have started operating a self-referral or 'honesty system'.

Food banks in more rural areas have started delivering food parcels to people's homes and offering food-shopping services too in order to try and meet the needs of diverse and sometimes isolated groups of vulnerable people. Small villages with poor public transport links to bigger towns and outlets were, typically, also a considerable distance from their nearest food bank. People in more remote locations would need to travel for hours in some cases to pick up a food parcel (which can be very heavy and include multiple tins and jars) and then bring it home:

> *"So we actually set up in a very small way, starting with the delivery service the week before lockdown officially happened and just basically just bought a phone, publicised a hotline number and were just running it from the normal sort of food bank supplies, but we realised that we were going to have to scale it up. So yeah,*

> *so it's just gradually scaled up from there."* (Org 007; Food bank and church
> volunteer).

Those providing food and nutrition support to older people reported a substantial increase in referrals to their services and demand for them, especially meals-on-wheels. Few counties offer this service ordinarily, but more have started to deliver food as a result of Covid-19. Restrictions put in place to contain the spread of the virus meant that less support around food from family members was available to older people. Community groups and services had to address this. Like foodbanks, these services are heavily reliant on volunteers and, as people who have been furloughed or working at home return to work, their volunteer base is shrinking. Those organisations who were already delivering prepared food and meals to older people started to combine their deliveries with welfare checks. Complying with safety and social distancing advice while doing this and ensuring that all staff had appropriate personal protective equipment (PPE) was an extensive undertaking for some smaller groups. Community service providers explained that is was a necessary step to take because the food deliveries and welfare checks they provided were sometimes the only time their clients got to see another person for days at a time.

Challenges and new opportunities

Those that we spoke to from the local authority and from food banks explained that the major challenge they faced was sustainability and providing an expanding service. As noted in the introduction, the Government food parcel scheme ended on 31st July. Across the East of England, local authority organised food parcel schemes and services are now also being reduced and phased out. The participants we interviewed had mixed views on whether that support should be stopped or not. Some of those working in local authority led efforts felt that the easing of the lockdown and other mitigation measures meant a lessening of the need for support in relation to food because people would be able to shop more easily for themselves and others meaning there would be less need for food parcels. However, those working/volunteering in food banks were concerned that need would not simply reduce and may even increase in the longer term due to the economic impact of Covid-19:

> *"We are operating over three days instead of previously two, so we've introduced*
> *an extra day that we are actually working and that's receiving further donations…*
> *I mean obviously no one can have holidays at the moment… so literally we've been*
> *working sort of pretty much flat out since the beginning of March… I mean normally*
> *the role that I was employed for is 20 hours a week, but probably we are doing 35-*
> *40 hours a week plus. We are just doing what we have to do to make things*
> *happen. We get phone calls and people in a crisis over the weekends and you are*
> *24/7 really."* (Org 002; Food bank manager).

In the short term, local authority led efforts faced difficulties organising and allocating volunteers. Volunteers fall into two categories. Firstly, those who register to volunteer locally and then wait to be allocated a role presented administrative and logistical challenges. Volunteers need to be vetted,

especially if they will be working with vulnerable people (e.g. older people or children). They also have to be assigned roles appropriate to their skills and the time they have available. This process can be lengthy and by the time it is completed the volunteer might have returned to work or changed their mind about volunteering:

> "To ensure that that work is done to a worthwhile level in terms of efficiency and effectiveness, then I've got to do the right checks on them." (Org 010; Local Authority employee).

The second group are volunteers already giving their time to community groups and helping to feed the community. This could be local faith groups undertaking food shopping for people or community organisations delivering meals. While these groups can react and mobilise to address local need much more quickly than the statutory sector, they present a challenge because the local authority has oversight for ensuring that they are operating in ways that protect both volunteers and services users. For example, establishing guidelines for social distancing and safeguarding.

Despite the difficulties, local groups across the region have devised, adapted and run a range of schemes to support and feed vulnerable people tailored to the needs of local residents. For example, in a coastal area with a large number of older people, those working at and using a local community centre used the kitchen to prepare frozen lunches that could easily be heated up. Figure 2 shows an example of such meals. These were then delivered to older residents coming out of hospital and combined with a welfare check:

> "So we decided or the Tai Chi man actually asked if it was viable to… because nobody was actually doing frozen lunches. They had food bags and stuff but when people come out of hospital because they don't necessarily wanna cook so… we thought it would be a good idea, you know, just to do the lunches and they could just be heated up in the microwave… So we got a grant [from]… our local community forum." (Org 012; Community support centre currently providing food parcels).

Figure 4: Lasagne prepared and pre-cooked in a community kitchen by a local authority group.

While feedback about community group run schemes like this was generally very positive, Government food parcels were described in negative terms by those who received them. Although participants were keen to stress that they were grateful for the food they received while shielding, they were critical of the contents. Specifically, the lack of fresh produce, the poor quality of the food and the amount provided in the parcels.

Feedback and Recommendations from our Participants

When interviewing households and organisations involved in feeding communities, we asked for their feedback on services and recommendations on what could be improved or done differently, to ensure adequate and acceptable food is available across the region. Below is a summary of recommendations reported so far.

From food banks

Food bank organisers and volunteers explained that being able to flag up specific products for donation from supermarkets, rather than working with whatever they are given (based on over supply/lack of demand within supermarkets) would help them better provide food for clients and avoid needing to store foods that they were oversubscribed with, such as coffee and meat-based soups.

On feeding marginalised and hard to reach groups

Those working in community settings argued that organised efforts to feed people risked missing marginalised groups such as those experiencing homelessness, living in temporary accommodation and those with substance use issues. Better links with charities and advocacy groups are needed in order to provide pathways of food support for those who need help accessing services.

On Government food parcels

Those receiving these parcels explained that the lack of choice was a particular problem and could mean that the food received was wasted or even donated to local food banks. Providing healthier and fresh foods along with a list to choose from was suggested. The amount of food provided was also an issue. If only one person in the household was shielding, then the food parcel contained enough food for one person. However, that person may have dependents who are unable to go out and buy food, so the food parcels need to take account of the other people the shielding person lives with.

On making supermarkets and the wider food environment more accessible

More support for people with health and wellbeing needs in supermarkets, including places to sit down and rest, keeping toilet facilities open, and assistance with shopping when the store is busy, need to be provided if Covid-19 mitigation and social distancing measures are increased again.

Environmental health

Participants working for local authorities pointed out that takeaway outlets were not subject to normal environmental health inspections during lockdown. This is a potential public health issue as there has been no way of monitoring the hygiene and food preparation practices of these establishments during lockdown. Systems of remote inspection and regulation need to be explored.

Supporting households with additional dietary needs

The restrictions placed on the number of food items that could be purchased at any one time within supermarkets created pressures on households whereby one or more members had specific dietary intolerances. Ensuring these people have access to the food required for their health needs should be considered.

Conclusion

The covid-19 pandemic has impacted upon food and eating practices across the East of England in a range of ways. Disadvantaged groups and those with health and social care needs have been disproportionately affected. Those most affected have had to compromise the quality of their diet, rely on donated food, and sometimes go without. Food and eating are social practices and some people have gone for weeks and months without sharing a meal or a cup of tea with another person. The way this will impact, in the longer term, on wellbeing and how people cook and eat needs to be explored. The potential of the pandemic to amplify existing dietary health inequalities is a theme that we will continue to examine as our research progresses.

Local authorities and community groups in the region have had to mobilise and respond to issues at a rapid pace. While the innovative, effective and generous ways in which this has been approached in communities is not in doubt, there are gaps in the system and lessons to be learnt should this level of response and co-ordination be called for again. Efforts to get food to people and get it to them relatively quickly have been largely successful. Getting good quality, socially acceptable and appropriate food items in sufficient quantities remains a challenge. In order to maintain dietary health and avoid food waste, more targeted and nuanced approaches need to be developed.

Marginalised and more vulnerable groups can experience problems and barriers to accessing programmes to help feed them and questions have been raised about the quantity and quality of the food being provided. As statutory emergency provision is phased out, the third sector will increasingly be relied upon to feed those who will continue to feel the financial impact of the Covid-19 mitigation measures long after the physical restrictions have been relaxed. This is a public health, public welfare, and social justice issue, and one that the study will continue to explore.

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