1 **Title:** Barriers and facilitators to implementing a healthier food outlet initiative: perspectives from
2 local governments

3 **Short title:** Lessons from a UK healthy food service policy

4 **Authors:** Tara Boelsen-Robinson[1,2,3,4], Anna Peeters[2], Anne-Marie Thow[4], Corinna Hawkes[3]

5 **Affiliations:**

6 [1]School of Public Health and Preventive Medicine, Monash University, Clayton, Australia

7 [2]Global Obesity Centre (GLOBE), Institute for Health Transformation, Deakin University, Geelong,
8 Victoria, Australia

9 [3]Centre for Food Policy, City, University of London, London, United Kingdom

10 [4]Menzies Centre for Health Policy, School of Public Health, University of Sydney, Camperdown,
11 Australia

12 **Corresponding author:**
13 Tara Boelsen-Robinson
14 Tara.b@deakin.edu.au
15 Alfred Centre, Level 5
16 99 Commercial Rd
17 Melbourne, Australia
18 3004
19

28 **Conflict of interest:** All authors report no conflict of interest.

29 **Author contributions:** TBR, CH and AP designed the study. TBR coordinated and conducted data
30 collection. TBR and AMT conducted data analysis. TBR, CH and AMT interpreted the data. All authors
31 contributed to the writing of the manuscript.

32 **Ethical Standards Disclosure:** This study was conducted according to the guidelines laid down in the
33 Declaration of Helsinki and all procedures involving research study participants were approved by the
34 Monash University Human Research Ethics Committee (reference 9076) and the City University of
35 London Sociology Research Ethics Committee (reference Soc-REC/80025567). Written informed
36 consent was obtained from all subjects/patients.

Title: Barriers and facilitators to implementing a healthier food outlet initiative: perspectives from local governments

Abstract

Objective: Local governments have integral roles in contributing to public health. One recent focus has been on how local governments can impact community nutrition by engaging food service outlets to improve their food offer. The Healthier Catering Commitment (HCC) is an initiative where London local governments support takeaways and restaurants to meet centrally-defined nutrition criteria on their food options. Using the case of HCC, this study aims to provide 1)practical learnings of how local governments could facilitate and overcome barriers associated with implementing healthy food service initiatives in general, and 2)specific recommendations for enhancements for HCC.

Design: Key informant, semi-structured interviews were conducted with local government staff involved in HCC, exploring barriers and facilitators to HCC implementation in food businesses. A thematic analysis approach was used, with results presented according to a logic pathway of ideal implementation in order to provide practical, focused insights.

Setting: Local governments implementing HCC.

Participants: Twenty-two individuals supporting HCC implementation.

Results: Facilitators to implementation included flexible approaches, shared resourcing, and strategically engaging businesses with practical demonstrations. Barriers were limited resources, businesses fearing negative customer responses, and low uptake in disadvantaged areas. Key suggestions to enhance implementation and impact included offering additional incentives, increasing HCC awareness, and encouraging recruited businesses to make healthy changes beyond initiative requirements.

Conclusions: In order to facilitate the implementation of healthy food initiatives in food outlets, local governments would benefit from involving their environmental health team, employing community-tailored approaches, and focusing on supporting businesses in disadvantaged areas.

Introduction

An unhealthy diet is estimated to be the second highest behavioural risk factor contributing to disability-adjusted life years lost worldwide, and the highest risk factor for mortality in 2017[1]. Unhealthy diets include those high in salt and sugar sweetened beverages, and low in whole grains and fruits and vegetables[1]. Contributing to these unhealthy diets are the food environments in which people live, work, play and learn [2]. Of particular concern is the increase in the consumption of foods from food service outlets (e.g. restaurants, cafes, fast food chains, and independent takeaways) [3], which is associated with a greater total energy and fat intake[4], and higher body weight [5].

While comprehensive actions across sectors are required to address unhealthy diets[6], local governments internationally have the potential to engage in innovative and impactful strategies aimed at improving food environments within their communities. Local governments have a historic role in promoting public health[7], have existing influence and relationships with food service outlets through the enforcement of food safety regulations[8-11], and have been identified as key settings in which to test innovative and progressive policies aimed at addressing obesity at a community level[12]. Local government are thus uniquely placed to impact local food environments, with previous examples of policy action including mandatory menu labelling[13], limiting the development of new takeaway outlets through planning regulations[14], and giving tax credits to grocery stores that stock fruit and vegetables in low-income underserviced communities[15]. The Heathier Catering Commitment (HCC) is an example of a voluntary London, UK initiative where local governments support food service outlets to create healthier food offerings. Local governments award food outlets a HCC certification once their food and beverage offerings have been assessed to meet specific, centrally-defined nutrition criteria. HCC certification (a certificate and promotional materials) communicates to customers that the food outlet is providing healthier options. Figure 1 provides an in-depth description of the HCC criteria, and how it is implemented.

What is it?

The Heathier Catering Commitment (HCC) is a London-based certification given to fast food and other restaurants in reward for increasing the healthiness of their food offer within their business, according to set criteria. It was developed by the Greater London Authority (GLA), the Chartered Institute of Environmental Health (CIEH), and the Association of London Environmental Health Managers (ALEHM) in 2012[16].

To receive the certification, businesses must meet a minimum of 8 of a possible 25 criterion. Four of these are mandatory criteria that all businesses must meet; 1) use of healthier fats or oils when cooking food 2) where salt is added after preparation, customers add their own salt 3) healthier packaged drink options are available and prominently displayed and, 4) smaller portions are available and advertised. A further 3 criteria are mandatory if the business sells fried food; 1) cooking oil is heated to optimum temperature, 2) excess fat is drained before food is served, and 3) frying oil is properly maintained. The remaining criteria encompass using healthier cooking methods, healthier ingredients, less salt and sugar, increasing the availability of vegetables and healthier carbohydrate options, smaller portion sizes, as well as health promotion by staff[17]. Food businesses are only eligible to join if they have a minimum of 3 out of 5 in the Food Hygiene Rating Scheme, a local government assessed measure of a business' hygiene standards[18].

Compliant businesses receive access to promotional materials including a certificate they can display in their premise that identifies them as being part of the HCC. Some local authorities offer incentives to join such as free food hygiene, nutrition, or allergy awareness training.

In some local authorities, the HCC is tiered. For example, businesses meeting the basic requirements of the award (e.g. meeting a minimum of 8 criteria) receive the "bronze" level of the award. Businesses who meet additional criteria can be awarded "silver" and "gold" levels.

Local authorities delivering the HCC come together within the HCC support network, composed of individuals delivering the HCC from different local authorities, as well as representatives from the organisations involved in its development (GLA, ALEHM).

How is it implemented?

Local governments in London choose whether or not they will deliver the HCC in their borough, and the environmental health and public health teams often work together to do this. Most often, the environmental health officers (EHOs) recruit food businesses and support them in meeting specific criteria related to the healthiness of their food and drink offerings. Once EHOs have assessed food businesses as being compliant, the EHOs may support businesses in meeting the criteria by identifying what changes they need to make and how they could be made and providing basic nutrition information.

While most of HCC delivery is focused on independent food outlets, there has also been work conducted with a number of other organisations. This includes a key supplier of takeaways to deliver price discounts on healthier cooking oils, and working with small chain food outlets with headquarters in London and sports and recreation centres to increase healthier food provision.

90   Figure 1: Description of the Healthier Catering Commitment

While there are a plethora of policies and recommendations on how local governments can tackle obesity and unhealthy food environments[13, 14, 19-24], there is less evidence on the barriers and facilitators to doing so, and how these policies could be strengthened. One study examining local government-delivered initiatives aimed at creating heathier takeaways found that retailer engagement was a key challenge to policy uptake[25]. A further study examined the effects of a program to incentivize grocery stores to stock healthier options in San Francisco – interviews with non-participating store owners revealed that some were unable to meet the eligibility requirements due to practical considerations such as space and fear of loss of profits[26]. Yet there is growing interest in initiatives aiming to improve the healthiness of food options in existing retail outlets. For example, the Healthier Oils Program in NSW, Australia offers advice to food service retailers on how to switch to healthier cooking oils in order to reduce saturated fat in the food supply [27]. In Singapore, food service operators that make healthy changes to their menus are eligible to apply for a grant that can be used to promote their healthier options, under the Healthier Dining Programme[28]. If these types of healthy food service initiatives are to grow, more needs to be known about how local governments can facilitate their implementation and overcome barriers.

This study aims to identify how local governments can facilitate implementation and overcome barriers to healthy food service initiatives, using the case study of the Healthier Catering Commitment, a voluntary initiative implemented in London (Figure 1).

Methods:

Overall method and theory

HCC was chosen to study through a document review of all accessible London local authority Local Plans, relevant Supplementary Documents and Health and Wellbeing documents, where it emerged as the most frequently mentioned initiative targeting the healthiness of options in food service outlets.

A qualitative descriptive method of enquiry was employed. The design of the study was based on a collective case study approach, in order to gain a broad understanding of the central phenomenon under study[29]. A logic pathway of ideal implementation was used to guide interviews, analysis and presentation of results (Figure 2). Logic pathways demonstrate the sequence of activities involved in a policy or program and hypothesize the outcomes they are intended to achieve[30]. This allowed us to identify potential elements to strengthen the implementation of healthy food service initiatives delivered at a local authority level, and to

understand how elements may be adapted to other social systems. The terms "implementation" and "delivery" are both used within this study to describe the actions taken by local government staff towards the outcome of food service outlets obtaining HCC certification, including engagement of businesses, internal resourcing etc. The term "implementation" is used in the context of policy theory[31], and is therefore used when discussing theoretical implementation. "Delivery" is the term favoured by the local authorities interviewed for this study and is therefore used in examination of the results.
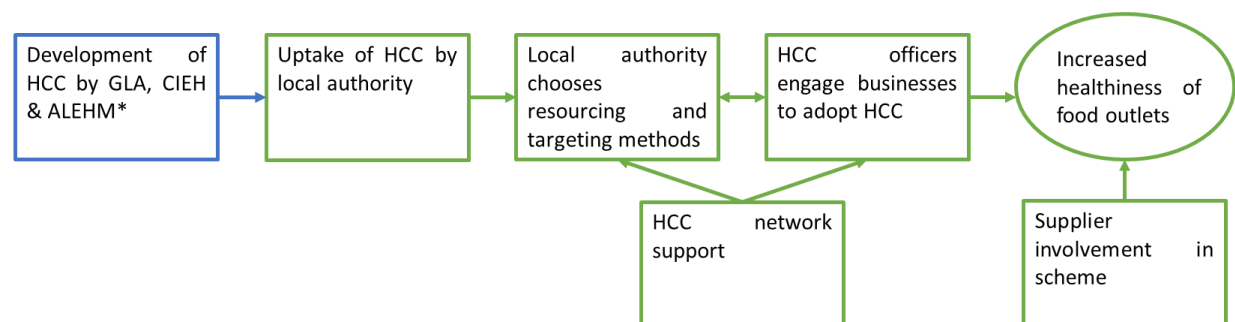
* HCC (Healthier Catering Commitment), GLA (Greater London Authority), CIEH (Chartered Institute of Environmental Health, ALEHM (Association of London Environmental Health Managers)
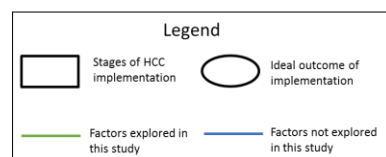
Figure 2: Logic pathway of ideal implementation of Healthier Catering Commitment

Data collection

The lead author conducted key informant interviews using a semi-structured interview schedule. Participants were 1) those delivering or overseeing delivery of the HCC within local government or supporting organisations (e.g. that provide funding or technical expertise for HCC delivery) and were identified using a purposive sampling approach and 2) individuals who could give context to the HCC, e.g. a supplier involved in the HCC, others involved in healthy food service initiatives, and were identified through snowball sampling and were invited to participate via email. Purposive sampling was employed in order to collect the

146 perspectives of individuals with the most proximate knowledge of delivering HCC to

147 businesses. Data triangulation was pursued through the inclusion of individuals at different

148 levels of seniority and involvement (e.g. Environmental Health Officers delivering HCC and

149 Public Health Leads overseeing delivery), from different departments (Environmental Health,

150 Public Health), from different local authorities, and the inclusion of individuals from

151 supporting organisations. Local authorities were identified as participating in the HCC through

152 the 2016 Good Food for London guide[32] and communication with the HCC network, a

153 collection of individuals from local authorities who delivered the initiative. HCC coordinators

154 were asked to participate by an email sent out by the HCC network coordinator and were

155 reminded at an HCC network meeting. At the time of this study, there were 24 local authorities

156 delivering the HCC[33], all of whom had a representative in the HCC network. Participant

157 recruitment was conducted until data saturation was reached where no new themes emerged

158 from the interviews, and the research questions had been sufficiently addressed.

159 An interview guide containing open-ended questions were developed prior to the interviews,

160 developed based on existing experience with food policy implementation research by several

161 authors. An interview guide was developed for each type of participant (e.g. local authority

162 HCC coordinator, HCC-supporting organisation, supplier engaged in HCC etc.). See Appendix

163 I for interview running sheets. Questions examined the participants role in delivering the HCC,

164 challenges in engaging food businesses in the initiative and strategies for overcoming them,

165 existing tools and resources used to deliver the HCC, and how the HCC could be improved.

166 Semi-structured interviews were conducted by the lead author either in person at a location and

167 time convenient to participants (at their place of work, excepting one participant who attended

168 the University of the lead author), or over the phone if no convenient time could be determined

169 between the interviewer and interviewee to meet in person. Interviews lasted from 25 to 70

170 minutes. Interviews were audio recorded and then transcribed by a professional transcription

171 company. Participants were given the opportunity to review their transcripts over email, with

172 two interviewees adding further details to their statements. The remainder of participants

173 agreed with their transcripts in their entirety or did not respond to the communication.

174 <u>Analysis</u>

175 Thematic coding and organisation of themes arising from all interviews was conducted by the

176 lead author using QSR NVivo Version 11[34]. An open coding approach was employed, with

177 descriptive codes applied to blocks of text[35]. Deductive and inductive coding approaches were

178 applied. Descriptive codes were organised into overarching deductive themes related to
179 implementation stage, see Figure 2 (i.e. uptake of HCC by local authority, business engagement
180 method, adoption by food business, and effectiveness of changing food offer). If descriptive
181 codes did not map onto any implementation stage, they were organised under emergent themes
182 as arising from the text. Themes and sub-themes were identified by the consistent contribution
183 of ideas across participants. Another researcher conducted thematic analysis of three of the
184 interviews with HCC coordinators, with discrepancies resolved and final key themes
185 consolidated through discussion with the lead author.

186 This study was conducted according to guidelines laid down in the Declaration of Helsinki[36]
187 and all procedures involving research study participants were approved by [REMOVED FOR
188 BLINDING]. Written informed consent was obtained from all participants.

189 **RESULTS**

190 Forty-four individuals were invited to participate in an interview, of which 22 participated.
191 Seventeen of these individuals were directly involved in, or supporting delivery of the HCC
192 (representing 10 of the potential 24 local authorities), and the remainder were individuals who
193 could give context to the HCC. Table 1 describes participant details.

194 *TABLE 1 INSERT HERE*

195 Overview of results

196 Results are reported according to the stage of implementation pathway; (1) the choice of local
197 authorities to deliver HCC, (2) methods targeting food businesses, (3) the adoption of HCC by
198 food businesses, (4) the effectiveness of the HCC at increasing the healthiness of the food
199 environment within these contexts, and (5) the supplier perspective. Within each stage, results
200 are organised according to barriers, facilitators, and participant recommendations (presented in
201 matrix form in Table 2).

202 *TABLE 2 INSERT HERE*

203 **Uptake of Healthier Catering Commitment by local authority**

204 **Facilitators**

205 The local authorities interviewed perceived the HCC as a key part of a package of strategies
206 designed to improve food environments to deliver on their commitments to improve diet-

related public health in their communities. HCC officers reflected on the many positives of the initiative, stating that it was easy to deliver, recruit and assess due to the existing resources and documents available.

"...in terms of the actual package and the resources available, it's quite easy to pick...I mean it's not like myself or anybody in the council needs to develop it further" HCC Officer, Local Authority 7

Barriers

Participants reflected on why other local authorities did not deliver the HCC, or stopped delivering it, noting that there had been limited or reduced funding to local authorities as a whole, and Environmental Health teams in particular. Funding for HCC was largely focused on employing HCC Officer/s.

"...a lot of local authorities have faced funding cuts, so they just cannot dedicate the same resource and capacity to delivering the HCC." Project Officer, Supporting Organisation 1

Further resources and actions to enhance implementation

Participants spoke to the idea of making HCC mandatory for all new businesses and suggested that having a dedicated HCC Officer in each borough would enable them to deliver the initiative to more businesses.

"I think it should be mandatory...because it's not too hard to implement, especially if new premises are coming." HCC Officer, Local Authority 10

Choosing resourcing and targeting methods

Facilitators

Not only was the HCC seen as easy to deliver, but delivery could be tailored to the existing strengths and resources of the local authority. Among interviewed local authorities, delivery was done by 1) a dedicated Environmental Health Officer (EHO) who delivered HCC with the support of the public health team, 2) all EHOs delivered the initiative as part of their normal duties, or 3) delivery was contracted to an external organisation. Delivery of the initiative via an external organisation played to the strengths of this particular community; the organisation in question had existing ties to the community, experience working in food environments, and was able to assign more time to deliver the initiative than the EHOs. In contrast, the benefit of using EHOs was that in their role as a local authority representative, business owners were

237 more familiar and responsive to their approaches to join. Delivery was usually enacted through
238 both public health and environmental health teams through varying different means (as
239 described above) and was seen to capitalise on the expertise of each department.

240 *"HCC is mainly driven by environmental health…[and] I borrow the nutritionist's expertise*
241 *from the health and wellbeing team".* HCC Officer, Local Authority 5

242 Resourcing of the HCC officer varied across councils, from a dedicated full-time position, to
243 one with one day a fortnight, reflecting the different prioritisation of the local authorities. Some
244 HCC officers had targets on how many businesses to sign up.

245 *"And, within each of the environmental health officers' remit [they] are…given a target to sign*
246 *up new business to Healthy Catering Commitment."* Public Health Lead, Local Authority 5

247 There was divergence in how participants viewed the role of the EHO in relation to HCC
248 delivery. EHOs most commonly interact with businesses through the monitoring and
249 enforcement of mandatory food safety regulations. This existing relationship gave them the
250 opportunity to deliver the HCC initiative, but created a challenge in terms of differentiating
251 between the mandatory (food safety) and voluntary (HCC) initiatives. Some participants
252 viewed this factor as important in getting businesses to consider the HCC, while others
253 reflected that they wanted to ensure the voluntary nature of the initiative was clear.

254 Participants drew heavily on shared resources to deliver the HCC, making efficient use of
255 existing tools, and drawing on knowledge and expertise. These were drawn from three sources:
256 1) the HCC network, where HCC officers were able to share new techniques and resources (e.g.
257 flyers), while coming up with solutions together; 2) resources shared across local authority, e.g.
258 drawing on nutrition expertise in another local authority; and 3) resources shared within council
259 e.g. relying on the environmental health officers to identify which food businesses may be more
260 willing to sign up to the HCC, or the use of internal printing services.

261 *"… the [Healthier Catering Commitment] network is so great, when I drop an email…they*
262 *would ask their nutritionist on my behalf."* HCC Officer, Local Authority 7

263 Due to limited resources, HCC officers focused on being strategic, practical and effective with
264 the delivery of the initiative. For example, one geographical location would be targeted at a
265 time, chosen by areas of highest obesity rates, surrounding schools, or being located on a busy
266 high street. Types of cuisines were also targeted at the same time, allowing the HCC officers

267 to understand what healthy changes were feasible and likely to be culturally acceptable, and
268 used this approach for similar businesses. This approach enabled HCC officers to play on the
269 competitive nature of the businesses, by noting that competitors had signed up to the initiative
270 and would attract more customers as a result.

271 *"...we also found it quite useful to target one type of business at a time, for example, at one*
272 *point we did most of the falafel shops in the borough and that was quite useful in terms of*
273 *knowing how they prepare the food and that gives us - it makes us an expert in one area."* HCC
274 officer Local Authority 4

275 **Barriers**
276 The task of engaging owners and supporting changes was viewed as time and resource
277 intensive, with varying rates of success. Getting in touch with the correct person, convincing
278 them to join, and walking them through the changes often required several onsite visits to each
279 business. HCC officers often completed HCC work as one aspect of their role in the local
280 authorities, and therefore had to balance competing demands. HCC officers were often required
281 to seek nutrition information from other sources.

282 *"... it's just been very difficult to get businesses to be interested because these are often people*
283 *we can't even get hold of. It's difficult to get hold of owner, they've got staff working in these*
284 *places and you can't even get to the owner."* Public Health Lead, Local Authority 7

285 For some local authorities, the cross-departmental relationship between Public Health and
286 Environmental Health required to deliver the HCC could be strengthened, with inherent
287 tensions existing that come from working across councils (e.g. competing or different
288 priorities).

289 **Further resources and actions to enhance implementation**
290 There was ongoing resource and tool development that participants believed would aid further
291 recognition, uptake, and customer demand for HCC. This included promotional materials being
292 developed by the Greater London Authority (GLA). These promotional materials were part of
293 a larger movement towards centralised resources, and greater involved of the GLA. Increasing
294 the consistency of branding and awareness of HCC across London would improve the uptake
295 of the initiative by businesses and raise awareness amongst customers.

296   *"And then as I said, the resources that they're now creating, I don't know how they're going*
297 *to work, but there's never been any publicity at all 'cause it's all been disparate. Different*
298 *boroughs have put different amounts of money into it, it's all been very disparate, and different*
299 *boroughs are doing different things. So to make it more unified, maybe, across London."* HCC
300 Officer, External Organisation delivering to Local Authority 2

301 **Adoption by food businesses**

302 **Facilitators**
303 Participants encouraged businesses to join by conveying the following potential benefits: a
304 growing demand for healthier options; discounted products from a supplier; promotion by the
305 local authority; offering discounted hygiene and allergy training; and that it was free to join.
306 Perseverance was key to engaging businesses, particularly in overcoming the challenge of
307 getting in touch with owners and managers. HCC officers found that being persistent, flexible
308 with visiting times, and taking the time to communicate with and address concerns of the owner
309 was essential to engagement.

310 *"Publicity is a good offering. Any business would love to get free publicity. We offer free food*
311 *hygiene training and obviously it's the sticker and being able to be identified with being a*
312 *healthier premises, or at least an award-winning premise. ... And those sort of forward-*
313 *thinking premises would love to jump on this."* HCC Officer Local Authority 8

314 Another engagement method was highlighting the potential benefit the business could make to
315 the health of the community, by reflecting on the high obesity rates of children in their local
316 area, and how unhealthy food contributes to this phenomenon.

317 *"...I talk about sort of local, the fact that obesity is quite high in [Local Authority 7] compared*
318 *to other parts of London or nationwide".* HCC Officer, Local Authority 7

319 *"...I try to explain how, regarding their type of business, how we can contribute to the public*
320 *health or the health of the population in [Local Authority 3].* HCC Officer, Local Authority 3

321 Some businesses were more open to joining the initiative: where the owner or chef has an
322 existing interest in nutrition or had a personal experience with nutrition-related chronic diseases,
323 and/or when they perceived a benefit in terms of attracting customers. Businesses that that were
324 already selling some healthy food or that already met some requirements (e.g. kebab shops
325 already served vegetables as sides) showed more interest. HCC officers capitalised on this by
326 initialling identifying what criteria the premise was already meeting. The HCC checklist

327 enabled them to demonstrate what small achievable steps could be made, was a good talking

328 point, and easy for business owners to understand. Furthermore, it didn't require a dietitian to

329 deliver.

330 *"We're also recognising, in that process, premises that are already doing or that are already*

331 *half-way there, perhaps they serve really healthy vegetables and vegetables are at the forefront*

332 *of the display and that's really positive. So we can work on the positives and suggest that they*

333 *make one or two changes, in addition to that."* HCC Officer, Local Authority 8

334 Across local authorities, HCC officers commonly reflected on having a tailored approach to

335 each business, depending on the owner, location, and type of food business. In particular, being

336 cognisant of how the initiative could be delivered within different language and cultural

337 contexts was essential in adoption by businesses. For example, creating language-specific

338 information sheets was essential in communicating the correct information.

339 *"You have to understand their business or the culture around their business … to be able to*

340 *assess how you can do the HCC or how they can do the HCC."* HCC Officer, Local Authority

341 3

342 **Barriers**

343 Participants reflected on owners' reluctance to join, citing a fear of negative business outcomes,

344 prioritisation of selling high volumes of unhealthy food for as cheap as possible to maintain

345 competitiveness and value for money, with the alternative driving customers elsewhere.

346 Business owners were concerned that it would cost time and money to implement, and were

347 limited in some aspects of change, e.g. had been given drink fridges or menu boards from food

348 and beverage companies.

349 *"[Business owners] see it as something that's going to cost them, and it's difficult in some*

350 *cases to see that they could benefit from that by serving smaller chip portions."* HCC Officer

351 Local Authority 2

352 Cultural differences meant that some healthier options would be unfamiliar to customers, or

353 challenging to implement due to traditional cooking techniques. Access to healthier ingredients

354 that met religious specifications was also challenge for some business owners (i.e. accessing

355 low-fat dairy products for Jewish business owners). Owners often failed to see the advantage

356 in joining, given there were limited incentives to offer. Low recognition of the initiative was

357 also seen as an issue, while some owners did not understand the initiative, or had little health

358 knowledge. Language barriers often limited successful communication between HCC officers

359 and business owners.

360 *"Another challenge is that there is sometimes language barriers, communication. A lot of*

361 *businesses don't have an email address or don't answer the phone."* HCC Officer, Local

362 Authority 1

363 Maintaining HCC was a challenge, and without ongoing pressure, businesses could return to

364 their old modes of operation and would automatically lose eligibility for the initiative if their

365 hygiene rating fell below a certain level. Some local authorities addressed this by working with

366 businesses to increase their hygiene rating while implementing HCC.

367 *"I've also gone back to some now to make sure they're still maintaining, not fallen off, you*

368 *know. And most of them have maintained the criteria. And sometimes… some have had to drop*

369 *some of things."* HCC Officer, Local Authority 4

370 Areas of deprivation experienced the aforementioned challenges more acutely and were harder

371 to engage; they were more likely to be micro-businesses with low margins, more likely to drop

372 in and out of meeting hygiene criteria and had a higher number of customers that were seeking

373 value for money (i.e. large portion sizes at low costs).

374 *"There was the challenge of going to more deprived areas that the businesses that are located*

375 *in the most deprived areas of the borough, they tend to have, as a whole, tend to have lower*

376 *food hygiene so we were trying to target them."* HCC Officer, Local Authority 1

377 There were also constraints where businesses that only sold a small number of products were

378 ineligible to join. Some businesses found it harder to meet the requirements, particularly if they

379 predominantly sold fried food – indicating that the least healthy businesses may remain so.

380 **Further resources and actions to enhance implementation**

381 Increasing the awareness and (consistency of) publicity of HCC was viewed as essential in

382 both harnessing the existing desire for healthier options from customers, and in creating a

383 "tipping point" of enough food businesses joining HCC to influence others to do the same.

384 Being able to provide further incentives was also seen as a method of encouraging businesses

385 to adopt the initiative.

386 **<u>Effectiveness at changing the food offer</u>**

387 **Facilitators**

Respondents from four of the ten local authorities interviewed mentioned using a tiered version of the HCC initiative, where there were additional benefits to meeting more of the criteria, e.g. having a bronze, silver and gold level. This was seen to encourage businesses to continue to make healthy changes above and beyond the minimum requirements for joining.

"...it just encourages those businesses that are really keen to make further changes and those who are at - they have a very high nutritional standard of food can apply to go on silver and gold." HCC Officer, Local Authority 1

Three of the local authorities interviewed had award ceremonies where they would recognise businesses that had exemplified shifts to healthier food provision. An HCC twitter account that promoted new businesses that had joined the initiative was a useful way to encourage customers to engage in the HCC.

HCC was often viewed as a "foot in the door" and starting point towards creating healthier food environments, by changing the expectation of what businesses could achieve, and customer demand for healthier options, and thus shifting the culture around healthy food service. Rewarding businesses for making small changes was a long-term investment that could pave the way for further changes to be made at a later stage.

"Because the good thing about the scheme is that it does recognise small changes and therefore it gives more avenue for more changes in future." HCC Officer, Local Authority 8

Barriers

With more focus on recruitment over maintenance and evaluation of the changes, it was difficult to understand the impact of the initiative on customer behaviours and diets. Participants thought that more could be done to leverage recruited food business to make further changes in becoming healthier, and that resources or funding specified for evaluations would help measure the impact of HCC implementation on the healthiness of food environments.

"How do we monitor it afterwards to make sure that things are happening? So that it doesn't become too costly for us to do it." Public Health Lead, Local Authority 6

"I really do think that in general the HCC isn't given enough leverage afterwards. It's very easy to recruit and maybe do that assessment, and then what?" HCC Officer, External Organisation delivering to Local Authority 2

418 In contrast with the benefit of recognising was the concern that HCC could create a "halo effect"

419 whereby takeaways that were still largely unhealthy food environments could be viewed as

420 generally healthy because of the award.

421 *"… there's a lot of things on that menu that aren't healthy, especially in a take-away or a café*

422 *that does fried food…"* HCC Officer, External Organisation delivering to Local Authority 2

423 This concern was particularly revealed in the approach taken by different authorities. Many

424 HCC officers reported that they aimed to get as many businesses to sign up as possible, with

425 some EHOs having their yearly goals or Key Performance Indicators (KPIs) include having a

426 specific number of businesses signed up. Other local authorities noted that there could be more

427 benefit by maximising the healthiness of fewer businesses. Participants reflected that it was

428 possible for all food businesses to be healthier.

429 **Further resources and actions to enhance implementation**

430 Participants considered that there would be greater impact of the initiative if customers were

431 able to locate the businesses that had been awarded the HCC. There was also discussion of an

432 online map being developed that would enable this to occur.

433 **Perspective of supplier involved in HCC**

434 **Facilitators**

435 The supplier involved in the HCC noted that their business had invested time and resources

436 into the initiative, e.g. offering a short-term discount on healthier products. They viewed their

437 involvement as good for their long-term business and good for their customers, while creating

438 a positive image of the company itself through favourable media pickup.

439 *"We are still being perceived in the marketplace as the leaders in what we are doing here."*

440 Manager, Food supplier

441 **Barriers**

442 While supportive of HCC, the supplier noted that not many food businesses had taken

443 advantage of the discount available on healthier options. Part of the motivation to be involved

444 was recognition of responsibility they played in supplying unhealthy products, and the potential

445 role in promoting healthier options, while recognising that manufactures had a big part to play

446 as well.

447 *"… if I was to put my business hat on for the amount of time and effort and money that we*

448 *put into this, it hasn't given us a return. But again, I default back to my earlier answer which*

449 *is we still see it as a long-term investment. We still see it as the right thing to do and we*

450 *intend to keep following this path."* Manager, Food supplier

451 **Further resources and actions to enhance implementation**

452 The supplier noted that other businesses may not see it as their responsibility to contribute to

453 the healthiness of the food supply. Making it clear which options were healthier at a

454 manufacturer and/or supply level was recommended to further aid healthiness of food

455 provision.

456 **<u>Discussion</u>**

457 This study offers a unique and in-depth examination of the barriers and facilitators to delivering

458 the London Healthier Catering Commitment from the perspective of local authorities and offers

459 key insights into how local governments in other contexts can facilitate successful

460 implementation of food service initiatives.

461 There were many factors that supported the uptake of the HCC by local authorities, including

462 the existence of a fully formed initiative, and the sharing of resources, networks and knowledge.

463 Participants universally viewed the HCC network as an integral strength and resource that they

464 relied upon to share knowledge and learn from each other. The flexibility of the initiative meant

465 that it could be delivered differently across local authorities, a positive given their different

466 structures, relationships and strengths. Strategic targeting of businesses and demonstrating

467 culturally appropriate methods to meet the requirements engaged businesses, however low

468 recognition of the initiative, and fear of customer loss were main obstacles in adoption.

469 Participants identified a number of actions that would aid implementation, including consistent

470 and London-wide promotion of the initiative to both businesses and customers to increase

471 recognition and demand, making HCC mandatory for new businesses, increased funding for

472 the role of HCC officers and towards evaluation of changes, and identifying healthier options

473 at a manufacturing level.

474 There is a paucity of research that examines the implementation of local government-led

475 healthy food service policies, reflecting perhaps a lack of these policies in the first place, and

476 the lack of research literature that investigates them. Below we explore our results in the context

477 of other local government delivered initiatives [25, 37, 38] as well as experiences of other

478   implementors (e.g. researchers) who have partnered with small grocery stores [39] and

479   restaurants [40-43].

480   In our study, the uptake and delivery of initiatives by local authorities was limited by reduced

481   or restricted funding, a common finding in similar studies in local governments [25, 37]. Existing

482   relationships between different parties, between environmental health and public health, and

483   between HCC officers and business owners was seen to facilitate the delivery of the HCC; a

484   finding echoed in previous literature [25, 42].

485   We found that there were many engagement strategies that were echoed in previous literature,

486   including making small changes at a time [37, 39], offering incentives such as publicity and free

487   training [25, 37], considering the financial impacts [25, 37], delivering tailored and intensive

488   interventions [25, 39], the importance of considering language and cultural language differences

489   [25, 39], and highlighting the potential community benefit [39, 42]. Similarly, many of the

490   challenges to business engagement had been previously discussed, such as the reluctance to

491   change [37], the perception that healthy food wasn't popular with customers and would result in

492   economic losses [37-39], working with limited resources [25] and a lack of interest from food

493   business owners [25]. This study highlighted that local authorities had difficulty in engaging

494   businesses in areas of deprivation, citing lower hygiene ratings, lower profit margins, and

495   customers with more sensitivity to changes in price and portions. This echoes the findings of a

496   survey of UK local authorities and food businesses implementing various healthy food service

497   initiatives in areas of deprivation [37].

498   The supplier involved in the HCC viewed their involvement as contributing to social good and

499   as a strategic short- and long-term investment. While little other research has explicitly

500   examined the perspective of suppliers, other retailers have expressed that healthy food policies

501   contribute towards community stewardship [44] and make good business sense [45].

502   Participants identified that greater and more consistent promotion of the HCC would enhance

503   uptake by businesses and increase customer demand, consistent with findings from Bagwell [37]

504   where there was confusion over different food service initiatives.

505   Strengths of this study include that 10 boroughs were included in the research, and multiple

506   participants were requested from each of these, although not all participated. This allows us to

507   gain multiple perspectives, which is of importance when considering the joint public health

508   and environmental health delivery and interest in the initiative. Furthermore, the inclusion of

509   auxiliary interviews provides a deepened contextual view of the initiative, its challenges and

510 the policy implications. A further strength is that one researcher conducted the interviews and
511 analysis, thereby having a deep knowledge of the data.

512 This study is susceptible to selection bias, in that it is likely that local authorities who are
513 succeeding and more invested in delivering the HCC would agree to participate. A further
514 weakness is that not all local authorities delivering the HCC agreed to participate, however all
515 were invited. Future research could also explore what is holding back local authorities that are
516 not engaging with the HCC or other healthy food retailers to gain a deeper understanding of
517 the barriers in the first step of choosing to take up the HCC. Business owner and customer
518 perspectives were not captured in this study, which have been explored previously[46]. It is
519 valuable to capture perspectives from multiple stakeholders to further elucidate the potential of
520 food service initiatives to increase the provision and purchase of healthier foods, and how they
521 could be incentivised. Further research could explore the impact of the HCC on customer
522 nutrition choices, to add to the existing literature demonstrating that increasing the availability
523 of healthier options and decreasing unhealthy options in restaurants leads to increased
524 healthiness of the food environment [47, 48] and improved consumer choices [49]. Several HCC-
525 specific recommendations arose from this study that are in response to the identified barriers:

526 - Consider how further incentives could be provided to businesses for meeting HCC
527   criteria in order to engage businesses and encourage adoption.
528 - Targeted strategies for deprived areas that focus on their specific barriers to eligibility
529   and adoption (e.g. developing menu items that are low-cost healthier alternatives,
530   providing methods to reduce food wastage, increasing their food safety rating).
531 - Consider how to further leverage participating businesses to make additional changes
532   to increase the healthiness of food environments (e.g. through using tiered versions of
533   the HCC).
534 - Consider the balance between a focus on the quantity of businesses recruited to the
535   HCC, and quality (i.e. extent of change of healthiness of food environment,
536   maintenance of changes, demonstrated impact on purchases) and take a unified
537   approach throughout.
538 - Evaluate the sustainability and maintenance of HCC changes within different
539   businesses to determine how the healthiness of options in food outlets is changing.
540 - Investigate if and how businesses are using supplier discounts, and how this impacts
541   HCC maintenance and business outcomes (e.g. profit margin).

542 Reflecting on the strengths of the HCC and how they might function in other contexts, this
543 study elucidated lessons for other local governments exploring the potential of delivering
544 healthy food service initiatives:

545 - Use the existing networks and relationships between local governments, community-
546   based organisations and local food businesses to develop community-tailored delivery
547   methods.
548 - Identify the strengths, reach and capacity within local governments and across
549   departments (i.e. environmental and public health) to capitalise on existing expertise.
550 - Understand the density, cuisine and ownership of food outlets in order to develop
551   practical, culturally-relevant, and efficient delivery methods (e.g. in areas of low food
552   outlet density assign initiative delivery to all EHOs who would be visiting these
553   premises anyway).
554 - Reflect and revise the standards of entry to the initiative, or consider adding additional
555   'tiers' as more businesses become successful in their goal of creating healthier food
556   environments to leverage already engaged businesses to become even healthier.
557 - Explore how to increase awareness of the initiative amongst businesses and create
558   demand for customers (i.e. simultaneously work on supply and demand driven factors,
559   such as customer demand for healthier options[39]).

560 **Conclusion**

561 In this study we consider multiple aspects of local authority decision making and involvement
562 in the Healthier Catering Commitment initiative. Local governments and other organisations
563 seeking to improve the healthiness of offerings in food service outlets in their jurisdictions
564 should consider existing interactions with food service outlets as avenues for initiative
565 engagement and delivery, and the use of personnel resources in a targeted manner. Working
566 closely with food outlet owners and managers to implement healthy changes that are acceptable
567 to their customers and which maintain business profits is likely to enhance the maintenance
568 and sustainability of such changes. The exacerbated challenges of initiative engagement,
569 delivery and maintenance in food outlets within areas of disadvantage means these businesses
570 are likely to require additional support.

571

572

References

574 1.   Global, regional, and national comparative risk assessment of 84 behavioural, environmental
575 and occupational, and metabolic risks or clusters of risks for 195 countries and territories, 1990-2017:
576 a systematic analysis for the Global Burden of Disease Study 2017. Lancet. 2018;392(10159):1923-94.
577 2.   Swinburn BA, Sacks G, Hall KD, et al. The global obesity pandemic: shaped by global drivers
578 and local environments. Lancet. 2011;378(9793):804-14.
579 3.   Jones A, Bentham G, Foster C, et al. Tackling obesities: future choices–obesogenic
580 environments–evidence review. London: Government Office for Science. 2007.
581 4.   Lachat C, Nago E, Verstraeten R, et al. Eating out of home and its association with dietary
582 intake: a systematic review of the evidence. Obesity reviews : an official journal of the International
583 Association for the Study of Obesity. 2012;13(4):329-46.
584 5.   Bezerra IN, Curioni C, Sichieri R. Association between eating out of home and body weight.
585 Nutrition reviews. 2012;70(2):65-79.
586 6.   Sacks G, Swinburn BA, Lawrence MA. A systematic policy approach to changing the food
587 system and physical activity environments to prevent obesity. Australia and New Zealand health policy.
588 2008;5:13.
589 7.   Dollery B, Wallis J, Allan P. The Debate that Had to Happen But Never Did: The Changing Role
590 of Australian Local Government. Aust J Political Sci. 2006;41(4):553-67.
591 8.   Food Standards Australia and New Zealand. The safe food system 2016 [Available from:
592 http://www.foodstandards.gov.au/about/safefoodsystem/Pages/default.aspx.
593 9.   Food Law Code of Practice (England), (2017).
594 10.   Food Code, (2017).
595 11.   Canadian Public Health Association. Who is responsible for food safety in Canada? 2019
596 [Available from: https://www.cpha.ca/who-responsible-food-safety-canada.
597 12.   Reeve B, Ashe M, Farias R, et al. State and Municipal Innovations in Obesity Policy: Why
598 Localities Remain a Necessary Laboratory for Innovation. American journal of public health.
599 2015;105(3):442-50.
600 13.   Bleich SN, Rutkow L. Improving obesity prevention at the local level--emerging opportunities.
601 The New England journal of medicine. 2013;368(19):1761-3.
602 14.   Mitchell C, Cowburn G, Foster C. Assessing the options for local government to use legal
603 approaches to combat obesity in the UK: putting theory into practice. Obesity reviews : an official
604 journal of the International Association for the Study of Obesity. 2011;12(8):660-7.
605 15.   Baltimore Food Policy Initiative. Baltimore City Food Desert Retail Strategy. 2016.
606 16.   Association of London Environmental Health Managers. Healthier Catering Commitment 2019
607 [Available from: https://alehm.org.uk/services/healthier-catering-commitment/.
608 17.   Association of London Environmental Health Managers. Healthier Catering Commitment for
609 London. Criteria and application form2018.
610 18.   Food Standards Agency. Food Hygiene Rating Scheme 2019 [Available from:
611 https://www.food.gov.uk/safety-hygiene/food-hygiene-rating-scheme.
612 19.   Freudenberg N, Libman K, O'Keefe E. A tale of two obesCities: the role of municipal
613 governance in reducing childhood obesity in New York City and London. Journal of urban health :
614 bulletin of the New York Academy of Medicine. 2010;87(5):755-70.
615 20.   Institute of Medicine National Research Council Committee on Childhood Obesity Prevention
616 Actions for Local Governments. Local Government Actions to Prevent Childhood Obesity. In: Parker L,
617 Burns AC, Sanchez E, editors. Local Government Actions to Prevent Childhood Obesity. Washington
618 (DC): National Academies Press (US); 2009.
619 21.   Lyn R, Aytur S, Davis TA, et al. Policy, systems, and environmental approaches for obesity
620 prevention: a framework to inform local and state action. Journal of public health management and
621 practice : JPHMP. 2013;19(3 Suppl 1):S23-33.
622 22.   Pomeranz JL. The unique authority of state and local health departments to address obesity.
623 American journal of public health. 2011;101(7):1192-7.

624   23.   Public Health England. Strategies for Encouraging Healthier 'Out of Home' Food Provision: A
625   toolkit for local councils working with small food businesses. London2017.
626   24.   Public Health England. Promoting healthy weight in children, young people and families: A
627   resource to support local authorities. London2018.
628   25.   Goffe L, Penn L, Adams J, et al. The challenges of interventions to promote healthier food in
629   independent takeaways in England: qualitative study of intervention deliverers' views. BMC public
630   health. 2018;18(1):184.
631   26.   McDaniel PA, Minkler M, Juachon L, et al. Merchant Attitudes Toward a Healthy Food Retailer
632   Incentive Program in a Low-Income San Francisco Neighborhood. International quarterly of
633   community health education. 2018;38(4):207-15.
634   27.   Heart   Foundation.   Healthier   Oils   Program   2018   [Available   from:
635   https://www.heartfoundation.org.au/programs/healthier-oils-program.
636   28.   Health   Promotion   Board.   Healthier   Dining   Grant   2019   [Available   from:
637   https://www.hpb.gov.sg/healthy-living/food-beverage/healthier-dining-grant-schemes/about-the-
638   healthier-dining-grant.
639   29.   Crowe S, Cresswell K, Robertson A, et al. The case study approach. BMC Med Res Methodol.
640   2011;11(1):100.
641   30.   Pinnock H, Barwick M, Carpenter CR, et al. Standards for Reporting Implementation Studies
642   (StaRI) Statement. Bmj. 2017;356:i6795.
643   31.   Cairney P. Understanding public policy: Theories and issues: Macmillan International Higher
644   Education; 2011.
645   32.   Sustain. Good Food For London. How London boroughs can help secure a healthy and
646   sustainable food future2016.
647   33.   Sustain. Good Food For London. How London boroughs can help secure a healthy and
648   sustainable food future2017.
649   34.   International Q. NVivo. 11 ed2018.
650   35.   Liamputtong P. Making Sense of Qualitative Data: Analysis Process.   Qualitative Research
651   Methods. 4th ed. South Melbourne: Oxford University Press; 2013.
652   36.   World Medical Association. WMA DECLARATION OF HELSINKI – ETHICAL PRINCIPLES FOR
653   MEDICAL RESEARCH INVOLVING HUMAN SUBJECTS. 2013.
654   37.   Bagwell S. Designing healthier catering interventions for takeaways in deprived areas. J
655   Environ Health Res. 2015;15(1):38-56.
656   38.   Papadaki A, Alventosa C, Toumpakari Z, et al. Rewarding food businesses that promote
657   healthier and sustainable eating: Lessons learned from the Bristol Eating Better Award evaluation.
658   University of Bristol, Bristol City Council, Bristol Eating Better; 2019 April 2019.
659   39.   Gittelsohn J, Laska MN, Karpyn A, et al. Lessons learned from small store programs to increase
660   healthy food access. Am J Health Behav. 2014;38(2):307-15.
661   40.   Economos CD, Folta SC, Goldberg J, et al. A community-based restaurant initiative to increase
662   availability of healthy menu options in Somerville, Massachusetts: Shape Up Somerville. Preventing
663   chronic disease. 2009;6(3):A102.
664   41.   Dwyer JJ, Macaskill LA, Uetrecht CL, et al. Eat Smart! Ontario's Healthy Restaurant Program:
665   focus groups with non-participating restaurant operators. Canadian journal of dietetic practice and
666   research : a publication of Dietitians of Canada = Revue canadienne de la pratique et de la recherche
667   en dietetique : une publication des Dietetistes du Canada. 2004;65(1):6-9.
668   42.   Hanni KD, Garcia E, Ellemberg C, et al. Targeting the taqueria: implementing healthy food
669   options at Mexican American restaurants. Health promotion practice. 2009;10(2 Suppl):91s-9s.
670   43.   Nevarez CR, Lafleur MS, Schwarte LU, et al. Salud Tiene Sabor: a model for healthier
671   restaurants in a Latino community. American journal of preventive medicine. 2013;44(3 Suppl 3):S186-
672   92.
673   44.   Blake MR, Backholer K, Lancsar E, et al. Investigating business outcomes of healthy community
674   food retail strategies: a systematic scoping review. 2019.

675   45.   Boelsen-Robinson T, Blake MR, Backholer K, et al. Implementing healthy food policies in health
676   services: A qualitative study. Nutr Diet. 2018.
677   46.   Bagwell S. Healthier catering initiatives in London, UK: an effective tool for encouraging
678   healthier consumption behaviour? Crit Public Health. 2014;24(1):35-46.
679   47.   Lindberg R, Sidebottom AC, McCool B, et al. Changing the restaurant food environment to
680   improve cardiovascular health in a rural community: implementation and evaluation of the Heart of
681   New Ulm restaurant programme. Public health nutrition. 2018;21(5):992-1001.
682   48.   Martinez-Donate AP, Riggall AJ, Meinen AM, et al. Evaluation of a pilot healthy eating
683   intervention in restaurants and food stores of a rural community: a randomized community trial. BMC
684   public health. 2015;15:136.
685   49.   Valdivia Espino JN, Guerrero N, Rhoads N, et al. Community-based restaurant interventions to
686   promote healthy eating: a systematic review. Preventing chronic disease. 2015;12:E78.

687

688

689   **TABLES AND FIGURES**

Role (environmental health qualifications)	Organisation	Team within local Authority
HCC* Officer	Local Authority 1	Public Health
HCC Coordinator (EHO**)	Local Authority 2	Environmental Health
HCC Officer (EHO)	Local Authority 3	Environmental Health
Senior Practitioner	Local Authority 3	Public Health
HCC Coordinator (EHO)	Local Authority 4	Environmental Health
Public Health Lead	Local Authority 4	Public Health
Environmental Health Lead	Local Authority 5	Environmental Health
Public Health Strategist	Local Authority 5	Public Health
Public Health Strategist	Local Authority 6	Public Health
HCC Officer	External Organisation delivering HCC to Local Authority 2 and 6	N/A
HCC Officer	Local Authority 7	Environmental Health
Public Health Lead, PH	Local Authority 7	Public Health
HCC Officer (EHO)	Local Authority 8	Environmental Health
Public Health Strategist	Local Authority 9	Public Health
Public Health Officer	Local Authority 9	Public Health
HCC Officer	Local Authority 10	Environmental Health
Senior Policy Officer	Supporting Organisation	N/A
Manager	Supporting Organisation	N/A
Manager	Supporting Organisation	N/A
Manager	Supplier involved in HCC	N/A
Manager	Evaluation Organisation	N/A

| | Manager | Industry Group | N/A |

*Healthier Catering Commitment
**Environmental Health Officer

690   *Table 1: Participant characteristics*

691

Themes (stage of logic pathway to HCC implementation)	Sub-themes emerging from open coding under a priori themes, organised into facilitators, barriers, and further resources		
	Facilitators	Barriers	Further resources and actions to enhance implementation
Uptake of HCC by local authority	• Existing scheme easy to pick up	• Limited funding for delivery • Additional workload to environmental health officers	• Making HCC mandatory for all new businesses • Having dedicated HCC officer in each borough
Local authority chooses resourcing and targeting methods	• Existing relationships between environmental health and food businesses • Flexible delivery plays to strengths of local authority • Partnership between environmental and public health draws on expertise • Sharing resources capitalises on existing knowledge • Strategic targeting to make efficient use of time	• Resource and time intensity of delivery • Sometimes weak existing relationships between environmental and public health	• Creating more centralised resources
Adoption by food businesses	• Incentives to join • Increased customer interest in health • Checklist easy to understand and accessible	• Owners fear loss of business due customers not accepting smaller, healthier portions	• Consistent promotion to increase awareness of scheme for

	• Some businesses only had small changes to make to meet criteria • Feasible, culturally acceptable and tailored way to deliver to different businesses	• Communication and contact with food business owners • Eligibility criteria to join excludes some businesses • Challenges exacerbated for businesses in areas of deprivation	businesses and customers • Providing further incentives to businesses for joining
Effectiveness of changing food offer at outlets	• Delivering tiered scheme encourages businesses to go above and beyond • Public recognition of success through award ceremony • HCC as the first step of many towards creating healthier food environments	• May mislead customers to perceive all food options in business as 'healthy' • Little measurement of maintenance of HCC • More difficult for unhealthy businesses in areas of low deprivation to join	• Additional funding to conduct evaluation of change in food environment • Online map for customers to identify participating businesses
Perspective of supplier involved in HCC	• Supplier perceived as being a leader in the restaurant supply industry • Positive health impact on customers • Long-term outlook essential	• Rest of supply industry perceives they don't have the responsibility • Other suppliers not acting in the space	• Identifying what products are healthy at a manufacturing level

692 *Table 2: Summary of barriers and facilitators emerging from participant interviews*

693

694

695 **Appendix I: Interview guides**

696 **Interview guide for local authority participants**

697 - Can you tell me about your role at *your local authority*?

698 - Can you tell me a bit about the work you do in relation to the Healthier Catering
699   Commitment?

700 - How have you approached retailers to involve them in these initiatives?

701 - Have you had any challenges in working with retailers or engaging them in healthy food
702   initiatives? If so, please explain what they have been.

703 - How did you find was the best way to overcome these challenges?

704 - Are there any tools or resources that you rely on to implement these initiatives? (Either within
705   or outside of the local authority)

706 - Were there any additional resources or tools that would have been useful in addressing these
707   challenges?

708 - Did you have anything else you wanted to add?

709 - Is there anyone else at your local authority or other local authorities that you think might be
710   interesting to talk to?

711 **Interview guide for supporting organisations**

712 - Can you tell me about your role at *your organisation*?

713 - Can you tell me a bit about the work you do in relation to the Healthier Catering
714   Commitment?

715 - How does your organisation support the delivery of the Healthier Catering Commitment?

716 - Have you had any challenges in supporting the Healthier Catering Commitment delivery? If
717   so, please explain what they have been.

718 - How did you find was the best way to overcome these challenges?

719 - Are there any tools or resources that you provide to local authorities to support the delivery of
720   the Healthier Catering Commitment?

721 - Were there any additional resources or tools that would have been useful in supporting the
722   delivery of the Healthier Catering Commitment?

723 - Did you have anything else you wanted to add?

724   •   Is there anyone else at your organisation or other local authorities that you think might be
725   interesting to talk to?

Interview guide for supplier involved in HCC

727   •   Can you tell me about your role at *your organisation*?

728   •   Can you tell me a bit about how your organisation is involved in the Healthier Catering
729   Commitment?

730   •   How did the involvement with the Healthier Catering Commitment come about? Please step
731   me through the process.

732   •   What kind of products to you supply?

733   •   Who are the main food service outlets that you supply?

734   •   What kind of considerations did you think about when starting this work with the Healthier
735   Catering Commitment? For example, did you consider any potential impact on your
736   businesses profits?

737   •   What do you think the outcomes for your business have been as a result of your involvement
738   with the Healthier Catering Commitment?

739   •   Why do you think your company has become involved in the Healthier Catering Commitment
740   when other suppliers haven't?

741   •   Are there any challenges that you have experienced or foresee in promoting and selling
742   healthier options?

Interview guide for evaluation organisation

744   •   Can you tell me about *your organisation* and your role here?

745   •   Can you tell me a bit about how your organisation is or has been involved in the Healthier
746   Catering Commitment?

747   •   What are some of the other healthy food service or food retail strategies or evaluations that
748   you have been a part of?

749   •   Have you had any challenges in working with retailers or engaging them in healthy food
750   initiatives? If so, please explain what they have been.

751   •   How did you find was the best way to overcome these challenges?

752   •   Are there any tools or resources that you rely on to implement these initiatives? (Either within
753   or outside of the local authority)

754   •   Were there any additional resources or tools that would have been useful in addressing these
755   challenges?

756   •   Did you have anything else you wanted to add?

757   **Interview guide for industry group**

758   •   Can you tell me about *your organisation* and your role here?

759   •   Can you tell me how *your organisation* sees the role of your industry in healthy eating?

760   •   What are the kinds of initiatives that your industry has implemented to promote healthy
761   eating?

762   •   What do you think is the role for other organisations and sectors involved in the food
763   industry?

764   •   What do you think are the most important factors that influence consumer choice? How does
765   health factor into this? How might this be different from 5 or 10 years ago?

766   •   There are often comments made about how unhealthy food is cheaper – could you comment
767   on that?

768   •   What do you think the role of the government should be in supporting healthy eating?

769   •   Did you have anything else you wanted to add?

770

771

772