

# Appendix 1: Study Methods

## Aims and Objectives of the Study

The aim of this study was to understand the views and experiences of parents, health professionals and retailers across England who used the Healthy Start voucher scheme.

The objective of this study was to identify ways in which processes for applying for and using Healthy Start (HS) vouchers could be improved. This included the management and implementation of HS at national and local level. This was not an impact study, but key stakeholders' perceptions of the value and impact of the scheme were explored.

## Research Ethics:

The study was submitted to the Social Care Institute for Excellence (SCIE) Social Care research Ethics Committee and received a favourable review in January 2011 (REC number 10/IEC08/360). The study also received research and development approval from Western Comprehensive Local Research Network in February 2011, and was adopted by the NIHR Coordinated System for gaining NHS Permission (CSP). Letters of Access were sought through this system from all participating Trusts before any fieldwork started (in practice, we approached 22 Trusts as in many areas health professionals (GPs, midwives and health visitors) were employed by separate NHS organisations). Fieldwork was undertaken between May 2011 and February 2012.

## Study Design:

This was a qualitative study of views and experiences, using in-depth interviews as the main method of collecting data. Interviews were held with four key groups: A) *Target beneficiaries*, including pregnant women and parents of children under 4 years of age. This group also included a sample of non-beneficiaries who either were not eligible, were eligible but had not applied, or were previous users of the scheme. B) *Healthy Start Coordinators*. This group is comprised of those with responsibility for the implementation of HS at the local level, usually as part of a broader remit. C) *Frontline Professionals*. This included health professionals able to counter sign HS claims; those delivering regular health services to pregnant women and families with young children, and other (non-health) practitioners working with families to implement HS, for example, early years professionals and parenting practitioners. D) *Local small retailers*, including (but not limited to) those registered with the scheme and accepting HS Vouchers.

## Sample of 13 PCTs

Participants were recruited from 13 sites purposively selected to achieve a diverse sample across the whole of England. Our sample did not aim to be representative, but rather to reflect a range of criteria likely to influence the implementation of HS. We identified Primary Care Trusts (PCTs) as our primary sampling unit, and considered the following criteria to select these:

- Geographical spread across England
- Level of deprivation
- Average fruit and vegetable consumption in children
- Rural/urban
- Proportion of Black or Minority Ethnic groups in the PCT population
- Percentage take up of HS vouchers (of those eligible beneficiaries)

Geographical spread was achieved by ensuring we sampled at least one PCT from each of the 10 Strategic Health Authorities (SHAs) in England; in three SHAs two PCTs were selected. Within the 13 PCTs we also purposively included two 'Healthy Towns', and four Spearhead PCTs (70 Trusts with the worst health and deprivation indicators in England). Table 2 below shows how the 13 PCTs fit into the sample frame.

Table 2: Characteristics of Selected PCTs

PCT sample criteria		Total PCTs in sample (n=13)
Indices of deprivation <sup>i</sup>	low	5
	high	8
Fruit and Vegetable consumption in children <sup>ii</sup>	Significantly below national average	5
	Same or above national average	8
Urban/rural <sup>iii</sup>	>50% rural	1
	10-49% rural	6
	urban	6
Black and Ethnic Minorities (BME) <sup>iv</sup>	>average non-white	6
	>20% non-white (subgroup)	3
% take-up of HS vouchers <sup>v</sup>	<75%	6
	≥75%	7

<sup>i</sup> We used the Indices of Deprivation 2007 to rank the average score for each PCT. 'High' and 'low' indicates whether they are above or below the mid-rank.

<http://webarchive.nationalarchives.gov.uk/20100410180038/http://communities.gov.uk/communities/neighbourhoodrenewal/deprivation/deprivation07/>

<sup>ii</sup> Taken from *Model-Based Estimates and CIs for the Prevalence of 3+ Daily Fruit and Vegetable Consumption in Children over England*, by PCO developed by the NHS Health and Social Care Information Centre. 'Lower than national average' only refers to those PCTs where the difference is significant.

<sup>iii</sup> Taken from the Urban-rural classification of PCTs (post October 2006 boundaries) published by the Association of Public Health Observatories

<sup>iv</sup> 2001 UK census data

<sup>v</sup> Taken from monitoring data provided by the Department of Health for a 4 week period in Jan/Feb 2011. Uptake ranged between 59-84%, 75% is the point at which approx 1/2 of PCTs are above, and below.

### Sample of Research Sites Within PCTs

Within each PCT we identified a local postcode area<sup>1</sup> from which we recruited professional, parental and retailer respondents. Using post code areas focussed the research on a community and an area that made sense to respondents, such that we could understand the operation of the scheme in a unified way. To achieve the objectives of the study we aimed to select areas where the implementation of HS was working well and less well, and our original intention was to use small area 'take up' rates as a proxy measure of this, using data from the Department for Health on the proportion of those entitled families (on the basis of HMRC records) currently eligible (signed up and in receipt of HS vouchers). However, delays in the receipt of this data meant that selecting on this basis would have introduced an unworkable delay in fieldwork. Instead, the selection of research areas was informed by working with HS contacts within the PCTs to understand the characteristics of the local area, both in terms of the nature of the health and children's services in the area and their account of the local demographics. Research sites were selected that were likely to have high numbers of eligible families and matched as far as possible to the same characteristics that led to the parent PCT being selected according to the criteria outlined in Table 2 above. In some areas local contacts provided additional information that informed the selection of local sites; these included avoiding areas where other research projects were actively recruiting (or had just finished), and selecting some areas where local pilots of universal vitamin provision were underway.

<sup>1</sup> (the first half of the postcode e.g. AB12 though in some areas two postcode areas were used where the proportion of eligible families was lower e.g. AB12 and AB13 (not actual postcodes used))

We provide a brief description of the 13 research areas below:

**SITE 1** was a housing estate bordering a city, comprised mainly of social housing in the form of high rise flats and semi-detached houses. The Children's Centre where most recruitment took place was located in the centre of this estate, and directly opposite a health centre where several health services ran. There were a few local small retailers, and two large supermarkets within walking distance. The majority of the population are white British, and health professionals describe the local population as vulnerable, more specifically having a high incidence of teenage pregnancy, poor parenting skills, single parent families, multiple fathers within a family, domestic abuse, and benefit dependency. The PCT is piloting universal provision of vitamins for pregnant women.

In **SITE 2** we worked on the outskirts of a small seaside town in a largely rural area. The majority of the population are white British though there are also small pockets of Eastern European migrants. There is reasonable access to both small local retailers and several larger supermarkets in the town. Health visitors describe the local area as mixed, with pockets of affluence but their workload is dominated by issues around drug and alcohol abuse, poor mental health and domestic violence. Local health visitors interviewed for the study describe themselves as on 'emergency measures' for the past two years and unable to deliver a standard core offer universally, and we were not able to access the midwifery team.

**SITE 3** included two neighbouring housing estates within a large urban authority. These areas are deprived parts of the authority. Although this PCT is ethnically diverse with a large proportion of the population from BME groups, the respondents recruited were mainly white British. The area has been undergoing some regeneration, with two new main health clinics, and a lot of new housing. However many of our respondents lived in older social housing in need of some repair. There is reasonably good access to small local retailers, large 24-hour opening supermarkets and a market locally, although these latter two were a bus journey away for some of our respondents. There are a few related initiatives around infant health and nutrition going on in the borough run through Children's Centres (diet and nutrition classes, cooking courses etc).

**SITE 4** was an ethnically diverse ward in the centre of a large city with a high proportion of the population from BME groups over several generations. The PCT is piloting universal provision of vitamins to both pregnant mothers and children in two areas of the city including our research site, in response to recognised rising vitamin D deficiency in the population and the cost of prescribing vitamin D. Parents can collect the vitamins from the GP health clinic in the area, though some of the frontline professionals we interviewed for the study were unaware of this.

**SITE 5** was a residential housing estate close to the centre of a city. The area is renowned locally as very deprived, and largely comprised of social housing, including houses and large-scale blocks of high rise flats. Many of these latter are awaiting demolition though some are still populated. There are limited local small retailers, but reasonable access to supermarkets (within walking distance or a bus journey). The population is mainly white British. Health professionals describe a high incidence of domestic violence, worklessness, drug and alcohol dependency, smoking, formula feeding and poor diet locally.

**SITE 6** was located in an area comprising two ex-mining towns in a largely rural county, which has areas both of affluence and deprivation. The population is almost universally white British. Both towns have large supermarkets and a range of smaller, local shops that take the vouchers. However poor public transport meant some of the parents interviewed for the study had limited access to these.

**SITE 7** was a town in an area characterised by high levels of deprivation. The town is home to a high proportion of people from minority ethnic backgrounds (compared to England averages), some of whom have lived there for over a generation. People's health is mixed compared with the rest of the country; particular challenges for local policy makers include low levels of physical activity across the lifespan, and high levels of adult obesity. Participants reported relatively easy access to big

supermarkets. In the past health professionals had provided cooking and nutrition courses, but felt they no longer had the time or resources for this and were unclear about provision for this elsewhere.

**SITE 8** was a very ethnically diverse ward in a large city. The area is characterised by high levels of social and economic disadvantage and many families are entitled to HS. The population includes a large number of recent immigrants to the UK. There are large supermarkets nearby and many small shops (but only some of these accept the vouchers). The PCT is trialling the provision of universal distribution of vitamins in pregnancy, which are available in the hospital antenatal clinic and through one Children's Centre.

**SITE 9** was an urban town bordering a large city, with a very affluent population and small pockets of deprivation. The proportion of the population likely to be eligible for HS is low compared to the national average. Most health professionals working in the area reported very low numbers of families on their caseload who are eligible for the scheme and it was more challenging to engage them in this research than in other locations.

**SITE 10** was near the centre of a large town, with a high proportion (compared to national averages) of the population from South Asian heritage (both an Asian British population and a proportion of recent immigrants). The PCT is piloting universal provision of HS vitamins to pregnant women, in response to recognised rising vitamin D deficiency in the population. Pregnant women can collect the vitamins from the Children's Centres in the area. There are easily accessible supermarkets and small shops which accept the vouchers.

**SITE 11** was a deprived area of a large market town. Because of the easy availability of private rental properties with very low rents, health professionals report that this results in a very transient population. Health professionals report high incidence of drug use and deprivation. There are many small retailers, most of whom accept the HS vouchers. There is also easy access to a large supermarket (bus or short walk). The population is mainly white British, but with a growing Asian population and recent influx of Eastern European migrants.

**SITE 12** was located on the outskirts of a large town, in an area health professionals described as having a mix of middle and low income families. The area is largely White British but is characterised by a relatively large Asian population and a significant number of Polish nationals. The demographic makeup of the area has caused difficulties for health professionals trying to ascertain the eligibility of families for HS, particularly those under Visa restrictions who professionals know are ineligible for some forms of support. Health professionals also reported difficulties negotiating different cultural practices in relation to women and child rearing. Key issues in the area include Vitamin D deficiency, poor access to larger supermarkets for families without a car and local shops, where many ethnic minority families preferred to shop, not accepting the vouchers.

**SITE 13** was a seaside resort town characterised by a large retired population and a high proportion of young mothers and lone parents. The area is a predominantly rural region of a large county which includes a city and several seaside towns. This area has a mix of affluent areas and pockets of high deprivation. Outside of the urban areas there are problems of isolation, lack of access to amenities and poor transport links. The area is predominantly White British and poverty and unemployment are key issues. Major health concerns reported by professionals include obesity, poor diets, smoking and alcohol use.

## Sampling and Recruitment of Respondents

Specific recruitment practices for each group are described below, but Table 3 below shows in detail the full sample achieved in each of the 13 sites.

Table 3: Respondent Sample Across 13 Research Sites

Site No.	HS coordinator (n=15)	Health Professionals (n=41)	Non-health professionals (n=9)	Retailers (n=20)	Parents (n=107)
1	1	GP (2) Midwife (2) Health Visitor (2)		3	9
2	1	Health Visitor (3) Community Health (1)	Children's Centre receptionist (1) Children's Centre Senior Project Worker (1) Children's Centre Project Worker (1)	1	6
3	2	Health Visitor (2)	Children's Centre Family project worker (1)	2	9
4	1	Midwife (2) Health Visitor (2)		3	6
5	1	Midwife (2) Health Visitor (2)			8
6	1	Midwife (2) Health Visitor (2)		1	12
7	2	Health Visitor (2)		3	9
8	1	Midwife (1) Healthcare Assistant (1) Dietician (1)	Children's Centre Outreach worker (1)	1	4
9	1	Health Visitor (1) Community Staff nurse (1) Community nursery nurse (1)		1	4
10	1	Health Visitor (1) Midwife (1)	Children's Centre manager (1)	1	7
11	1	Health Visitor (2) Community staff nurse (1)	Early years practitioners (2)	1	17
12	1	Health Visitor (2)		2	7
13	1	Midwife (2)	Parent Education Coordinator (1)	1	9

### Healthy Start Coordinators

The Department for Health provided the research team with the named contact for HS in each of the 13 PCTs. We approached this contact by email and telephone with information about the study and a request to interview. In a number of cases the named contact was not the person with local responsibility for oversight of HS and further enquiries were needed to reach the appropriate person. In all sites we identified the local lead for HS implementation. In two sites, the role was shared and two people were interviewed. Information and consent forms were provided prior to interviews taking place (usually via email) and written consent was obtained for all face to face interviews, and

electronically in those cases where these interviews took place over the phone at the interviewee's request. In total, 15 Healthy Start Coordinators were interviewed (see Table 3).

### Frontline Professionals

Once the local research area was identified the HS coordinator usually put us in contact with the team leader for local health visiting and midwifery teams. Details of the research were provided with a request to interview local health professionals working in the area. In some sites, non-health professionals were also approached for interview where these were known to have a key role in HS implementation, for example signposting families to the scheme and/or delivering aspects of the intervention or related interventions (such as the provision of nutritional advice). In each case respondents were provided with information about the research before the interviews were undertaken and written consent was obtained during face to face interviews or electronically where the respondents requested telephone interviews. In total, 50 frontline professionals were interviewed (see Table ).

### Parents

We aimed to speak to families with a range of experiences of the HS scheme; those parents eligible for and receiving HS Vouchers; those who were eligible but failed to apply; applicants not receiving; and previous users, with a target of 10 parents in total from each PCT area. Among those signed up for HS we wanted to gain experiences of different types of users. We split our sample into three key groups based on the age of the youngest child: pregnancy; less than 12 months; and 12+ months. These acted as proxy indicators for voucher use in pregnancy; during breastfeeding, and with toddlers. We also wanted to ensure a range of participants across ethnicity and age (in particular mothers <18 years), and number of children in the household.

Our primary recruitment method was face to face recruitment of parents attending services for young families. We worked with our health and non-health professional contacts in each research area to recruit parents, by advertising for volunteers in Children's Centres and Well Child Clinics, and other groups held in health or Children's Centres where eligible parents were likely to be in attendance (these included well child clinics, toddler groups, weaning classes, teenage pregnancy support groups, and nutrition classes in health and Children's Centres). In these circumstances researchers approached parents discreetly to enquire about their knowledge and use of HS and if appropriate ask if they wanted to take part in the research. We also asked midwives and health visitors to distribute information about the research and the researchers' contact details so parents could opt in by contacting the research team directly. In all cases, parents were provided with information about the research and given an opportunity to ask questions about the study before being asked to give signed consent to take part. Interviews were carried out face to face and digitally recorded. Interviews took place either in the health or baby clinic/group where parents were recruited, or arrangements made to visit the parent at their home to undertake the interview.

Our secondary recruitment method was to purposively recruit groups under-recruited via convenience sampling described above. Midway through the fieldwork period we reviewed our achieved sample and implemented a second recruitment strategy to access 'harder to reach' families who were infrequent users of health and children's services and who had not been recruited using the methods described above. We applied to the Department for Health for information on HS applicants held on a national database. The data is held centrally by a contractor employed by the Department of Health. There is a notice on the HS application form which reads "From time to time we or our researchers might invite you to tell us how the scheme is working for you, to help us improve it." The Department of Health confirmed this approach has been used to recruit HS recipients for a range of other commissioned studies, and that our proposed approach met their data protection standards. We specified selection criteria specific to recruitment progress in each PCT and requested data, including name and contact details, beneficiary status (current beneficiary, previous beneficiary and

unsuccessful applicant), number and age of children in household for up to 100 parents per research area who met these criteria. In all cases we only requested contacted details for families who had registered a phone number. DH provided us with contact details for 1,080 families, noting that only 11% of the records in the post code sectors we asked for had provided phone numbers.

In the first instance we sent a letter and information sheet about the study to 20 potential respondents per site, with contact details for the research team (text and telephone number as well as address) with instructions on how participants could opt in or out at this stage. As outlined in the letter, we then followed up with a telephone call from the research team, providing further information about the study and requesting consent to arrange an interview over the phone. This process was repeated until our recruitment target was reached.

All families who took part in an interview were given a £5 shopping voucher in thanks for their time.

In total, we interviewed 107 parents; 80 were recruited face to face at health or Children’s Centres, one through health professionals, and 26 via HS records. 23 parents were approached in health or Children’s Centres who met our selection criteria but chose not to take part when they were followed up at a later date. Table 4 below illustrates our achieved sample frame. The rows describe three sub-samples based on the age of the youngest child; pregnancy, less than 12 months, and 12+ months. The columns describe further sub-groups according to age, ethnicity, ‘success’ in use of HS vouchers and the number of children in the family. There is overlap between groups for families because column categories are not mutually exclusive. Most of our sample is comprised of those who at the time of interview received and used HS vouchers (70); but also included are 11 who we believed were eligible but failed to apply, 8 who applied but had not received vouchers (for reasons of ineligibility or other) and 18 past recipients (either through ineligibility or dissatisfaction with the scheme).

We found pregnant women challenging to recruit for a range of reasons, including lesser attendance at Children’s Centres and well baby clinics (unless with older children). Nevertheless, we achieved 14 in our sample, proportionally higher (13%) than the proportion of pregnant HS beneficiaries nationally (7%). There was a similar challenge recruiting under-18s and we achieved 8 in our sample (7.5%); nationally 1.7% of HS beneficiaries are under 18.

Table 4: Breakdown of Parent Recruitment by Sampling Criteria

	<18 years (n=8)	BME (n=17)	White, non British (n=4)	Eligible users (n=70)	eligible non applicants (n=11)	applicants not in receipt (n=8)	previous users (n=18)	2+ children including pregnancy (n=56)
Pregnant (n=14)	0	5	0	10	2	0	1	10
Parents of ≤12 months (n=50)	7	5	2	29	4	7	10	24
Parents of 12+ months (n=43)	1	7	2	30	5	1	7	22

We used a family descriptor sheet to collect demographic information about parents interviewed for the study (including respondent age, ethnicity, age and number of children, relationship status, qualifications and employment).

### Retailers

We wanted to speak with smaller retailers rather than large multiples (e.g. well-known supermarkets) because the equality impact review of HS <sup>1</sup> highlighted the importance of independent and franchised

retailers to some groups of parents, and evidence that suggests small shops offer better choices than major supermarkets in communities in areas of high deprivation<sup>2</sup>. We aimed to recruit independent retailers serving the communities from which parents and professionals were recruited by approaching in person several local shops in a subsample of our research areas, recruiting until 20 retailers were included. However, this method alone was found to be insufficient since researchers had to initiate multiple contacts and refusal rates were high. Therefore, a purposive method was adopted to supplement this sample. The Department of Health uses an independent contractor to maintain a database of retailers signed up to HS and record their reimbursements. We requested data on retailers signed up to the scheme in each of our sample PCTs, including trading name and address, number of vouchers claimed (and first and last claim date) and what the retailer was registered as selling (fruit, vegetables, milk, dry milk, frozen fruit and vegetables, usually a combination of some or all of these). Retailers were recruited from 12 of our 13 postcode areas through this combination of cold-calling (when carrying out fieldwork in the area) and telephone recruitment. Store managers were provided with information about the research and asked for signed consent to take part. Eight interviews were carried out face to face, twelve by telephone, and digitally recorded. Table below shows our achieved sample of retailers, and Table 6 describes their further characteristics.

Table 5: Retailer Sample by Retailer Type

Retailer Type	Number (n=20)	Research sites
Independent Convenience/General Store	9	2, 3, 4, 7, 10,12
Newsagent/Post Office	4	1, 6, 7, 8
Food Cooperative	2	1, 4
Dairy Services	1	11
Grocery Chain	1	1
Independent Pharmacy	1	4
Franchisee	2	9, 12

Table 6: Description of Retailers Interviewed

Retailer number	PCT Number	Description	Time Registered	Average number of vouchers reimbursed per month
1	4	Dry milk only	4 years	8
2	7	Dry milk, Fruit & Veg	4 years	10
3	7	All except frozen	3 years	11
4	12	All except frozen	3 ½ years	16
5	3	Fresh and dried milk	4 years	19
6	4	F & V	3 ½ years	26
7	11	Fresh milk only	4 years	34
8	13	All except frozen	3 years	35
9	9	Milk, Dry milk & Fruit	4 years	36
10	12	All except frozen	4 years	39
11	3	Fresh milk, F & V	4 years	55
12	7	Fresh milk only	4 years	58
13	8	All except frozen	4 years	77
14	10	Milk & Fruit only	3 ½ years	82
15	1	F & V	4 years	93
16	6	All items	5 years	101
17	4	Dry Milk F & V	3 years	182
18	1	All except frozen	Unknown	N/A
19	1		Not registered	N/A
20	2	All items	< 3 months	N/A

## Qualitative interviews and Analysis

Detailed topic guides were developed for use with HS coordinators, health and non health professionals, parents (four separate guides dependant on eligibility status) and retailers. Interviews with coordinators and frontline professionals focused on their experience of managing and implementing HS, including knowledge and views about the scheme, reaching HS-eligible families (and barriers to doing so), use of HS resources, experience of HS continuing professional development materials, the impact of the scheme on their other work, and potential impact on beneficiaries. The topic guide for families included questions about their knowledge of the HS scheme, how they found out about it, the application process (if appropriate), use of vouchers, health and nutrition advice received, family diet and nutrition, and their views about the scheme and its impact.

The interviews with retailers focused on their experience of administering HS vouchers. We also explored perceptions of the aims and impact of the scheme and practical issues arising from accepting HS vouchers.

Two examples of types of topic guides used in the study are included below. The topic guide for parents was piloted with the parent representative on our advisory panel before use with respondents, and those for HS coordinators piloted with another member of the advisory group. The research team also made minor amendments to the guides after use with a small number of respondents.

All interviews were digitally recorded to ensure accuracy and allow later review. They were not transcribed verbatim, but rather the recordings reviewed by the research team and detailed notes typed up, including verbatim quotes where these were illustrative of the key issues in the research. Following a review of the notes, we developed a set of draft analytic frameworks that included the key themes and sub-themes that emerged from the data. The frameworks were driven by and emerged from the data, bearing in mind that they also needed to fit the study objectives and ensure we could address our research questions<sup>3</sup>. Separate frameworks were used for data from parents, coordinators and health professionals, and retailers. The draft frameworks were tested by all of the research team with a small number of interview data and amended as necessary until we were confident that the frameworks emerged from and 'fitted' the data.

Once the analytical frameworks were finalised, they were used to code the data, assigning both verbatim quotes and detailed notes to one or more theme or sub-theme. Once all the interviews were coded, we had a detailed and accessible overview of the data populating each theme and sub-theme from every respondent. This data management approach affords the possibility of exploring the data by both theme, and respondent-type, so we might better *describe* the data (through for example listing key elements of a theme or sub-theme) and to *explain* the data through the identification of patterns and associations across and between themes and respondent-types<sup>4</sup>.

## Appendix 2: Interview Guide – Healthy Start Coordinators

### 1. Introduction

- Introduce self
- Introduce study:
  - funded by Department of Health
  - qualitative study of Healthy Start focusing on the experiences of health professionals and retailers
- Digital recording – check OK, and reassure re: confidentiality
- How we'll report findings
- Reminder of interview length – (60-90 mins) check OK
- Any questions/concerns?

### 2. Background and context

I'm going to start by asking a few questions about your role in general, before moving on to Healthy Start.

- Can you confirm your job title, and tell me a bit about your role and responsibilities?
- And what is your role with regard to the Healthy Start vouchers scheme?
  - How long have you had this role?
  - If appropriate, is it a new role or has someone performed it previously
  - How does it 'fit' with wider role and responsibilities
- Is there a local steering group for the HS scheme?
  - If appropriate, who sits on it
  - remit
  - How long it has been in place
  - How often it meets
  - Whether the right people/services are represented, and at the right level
  - Is it 'working'?
- (if not respondent) Who is responsible for local management/coordination of the HS scheme?
- Where do they sit in the local PCT structure?
- Who else is involved?
- Are these the same people who were involved when the scheme was originally rolled out?
  - If not, prompt for changes and why.
- Is this management/coordination structure working?
- If yes, what makes it work; or, why not and what needs to happen

### 3. Aims of the scheme and links with other initiatives

- What would say are the main aims of the HS scheme?
- And what do you think of these aims?
- How do they link with other priorities within your PCT?
- Does the HS scheme link with any other initiatives within the PCT or local authority?
  - If so, which
  - Other initiatives – managed by same person/team?
  - How are links between initiatives made at the strategic level e.g. planning
  - And at the 'front line' – do initiatives join up?
  - Does the HS scheme add value to these initiatives?
  - If so, how; or why not.
- Are there any barriers in the HS scheme that make its 'fit' with local priorities/initiatives more problematic.

- Prompt – eligibility and access;

#### 4. Local implementation of HS

Moving on to the implementation of the Healthy Start scheme, can you tell me a bit about how it works?

- Which groups of professionals are involved e.g.
  - Health professionals e.g. midwives, nurses, GPs
  - Local authority-funded teams e.g. Early years professionals, family/parenting practitioners
- For each group, what is their role in the HS scheme
- Do you have all the teams/professionals involved you think you need to make HS work effectively?
- Does the level of commitment to the aims of HS vary between teams?
  - If yes, prompt for effect of this
- What impact has involvement in the HS scheme had on those practitioners' day-to-day work?
  - Prompt especially midwives and other health professionals
- How is the HS scheme promoted to those professionals who need to know about it?
  - Is this working?
- Is there any training provided for professionals?
  - Prompt – on being counter signatory; signposting or providing nutrition advice etc
  - How often is this training offered?
  - What has the take-up been?
  - What has been the feedback on this training?
  - Are there plans for further training?
- Is anyone responsible for promoting the scheme amongst local retailers?
  - If yes, who are they, what is their role
  - What work have they done with local retailers
  - Prompt for successes and barriers
  - How is this work funded?

#### 5. Impact and Monitoring

Do you monitor the implementation of HS in your PCT?

- Prompt for take-up by eligible families
- Impact on those families
- If yes, how is this done?
- Who sees the monitoring data?
- Have you made changes to how HS is implemented as a result of this?
- Is the 'take up' rate by eligible families what you expected?
- Is this rate monitored closely?
- If appropriate, is the PCT taking any specific action to raise take up?
- Who would you say are the 'hard to reach' groups in your area, and is HS reaching them? Are you aware of any gaps in coverage?
- What would you say are the main barriers to take-up by eligible families?
- Is there any work being done locally to address these barriers?
- How successful has this been, and how do you know?
- In your experience has it been a scheme that's been easy for families to use?
  - Why/why not? What makes it difficult?

- What would make it easier?
- Prompt for finding out about the scheme, understanding it, eligibility, application, receiving vouchers, spending vouchers in the local area
- In your experience is it a scheme that families like?
  - Why/why not? What makes it disliked?
  - What would improve this?

## **6. Their Perceptions About Benefits of HS**

- Can you tell me what you think are the main benefits of the scheme for families?
- Healthy Start aims to encourage families to eat more healthily by making it easier for those on low incomes to buy healthier food.
  - Do you think it is working?
  - Can you explain your answer?
  - Prompt could it work better and how?
- Do you see any additional benefits to HS?
  - Prompt for encouraging families to purchase healthy food
  - whether Healthy Start creates opportunities to talk about breastfeeding, diet, other health promotion activities
  - to increase interactions with vulnerable families.
- Do you think perceptions about HS have changed since it was first introduced? In what ways?

## **7. Improving the HS Scheme**

- What would you say are the things that help the scheme work well in your local area?
- Can you tell me if anything could be done to improve the Healthy Start Scheme?
  - Prompt for changed to national scheme
  - Changes in local implementation
- What would improve take up of the scheme? (distinguish vouchers and vitamins)
- Are there any other ways that you would change the scheme if you could?

Those are all the questions I wanted to ask you. Is there anything you want to say about HS that I haven't asked about?

Have you got any questions for me?

Thank you for your time

Remind them about arrangements for hearing about results of the study.

# Appendix 3: Parents Interview Guide (Eligible, in receipt and using HS vouchers)

## 1. Introduction

- Introduce self
- Introduce study:
  - funded by Department of Health
  - qualitative study of Healthy Start focusing on the experiences of health professionals, parents and retailers
- Digital recording – check OK, and reassure re: confidentiality
- How we'll report findings
- Reminder of interview length – (45-90 mins) check OK
- Any questions/concerns?

## 1. Background

I'm going to start by finding out more about you and your family, before moving on to the HS scheme. I just want to know what you think about the Healthy Start Scheme and your experiences of using vouchers. If anything isn't clear just let me know, or if you want to skip a question you can. (NB to researcher, if any questions are refused please ask why, explaining that it will help us to improve the interview in future if we know).

## Use 'Family Description' sheet with interviewee

### 1. General knowledge and awareness

- How long have you been using Health Start?
- Can you tell me what you get from the HS scheme?
  - Prompt for vouchers, vitamins, use of other resources such as website, recipes etc.
- Can you tell me what else you know about Healthy Start?
- Why do you think it was set up?
- Who do you think it's aimed at?
- Where have you seen it advertised?
- 

### 2. Applying for HS

- How did you find out about HS?
  - Did anyone suggest you apply, or did you decide for yourself?
  - Did you talk it over with your midwife, health visitor or GP when you applied? Which ones?
  - Did they give you any information? What was this?
  - Were they helpful? Why/why not?
  - Can you remember what you thought about the scheme when you first heard about it?
  -

Can you tell me about applying for HS

- when did you apply
- How long have you been getting them for now?
- How easy was it to find the forms you needed to fill in?
- Did you have any problems filling in the forms?
- How did you feel about putting information about the benefits you receive on the application form? Do you understand why they asked about this?
- Were you confident that you would be eligible for healthy Start? (and why)
- Did you have any problems getting the forms signed by HP? Which HP signed your form? Had you met them before?
- Could anything about the application process be improved?

What happened next?

- How long did you wait for an answer? Till you got vouchers/drops?
- How did you feel when you got the letter to say you'd be getting vouchers?
- How do you feel when the vouchers arrive now?
- Do you remember ever getting any information or advice with your vouchers?
  - What was it?
  - How did you feel about this?
  - Was it helpful?
  - What sort of information would you find most helpful?
  - In what format (online, sent in the post with vouchers etc)

### **3. Using vouchers**

I'd like to understand a bit more about how you use the vouchers, and how useful they are to you

#### **For those pregnant:**

In order to help me understand about the kinds of things you might use the HS scheme for, can you tell me...

- How far into your pregnancy were you when you began getting vouchers?
- What do you use the vouchers for?
- Has receiving the vouchers changed your diet in any way?
- What are the main benefits to you of the vouchers?
- Do you receive vitamin drops? What do you think of these?
- 

#### **For those with an infant < 12 months – infant feeding questions**

In order to help me understand about the kinds of things you might use vouchers for can you tell me...

- Are you breastfeeding, bottle feeding or mixing the two?
- did you ever breastfeed? For how long?
- would you like to have Breastfed for longer? Why was that?
- Is he/she on solids? When did he/she begin on solids?
- If on solids, what is his/her favourite food? (prompt for brand or if home made)

- How far into your pregnancy/how old was your child were you when you began getting vouchers?
- What do you use the vouchers for?
- Has receiving the vouchers changed your diet in any way?
- What are the main benefits to you of the vouchers?
- Do you receive vitamin drops? What do you think of these?

#### **For those with an infant >12 months**

In order to help me understand about the kinds of things you might use vouchers for can you tell me...

- How far into your pregnancy/how old was your child were you when you began getting vouchers?
- What do you use the vouchers for?
- Has receiving the vouchers changed your diet in any way?
- Your child's diet?
- What are the main benefits to you/your child of the vouchers?
- Do you receive vitamin drops? What do you think of these?
- 

#### **4. Using the vouchers**

- How easy is it to find a shop that accepts the vouchers?
- Is there a local shop that accepts the vouchers?
  - Is this somewhere you normally shop?
  - Where (else) do you use your vouchers?
- Do you always use your vouchers?
  - If not, why not?
  - How often do they go unused?
  - What do you do with the vouchers you don't use?
- Is there long enough to use them before they expire?
- Do you have a fixed budget for FOOD (RESEARCHER TO MAKE EXPLICIT IF THIS IS DAILY, WEEKLY, MONTHLY)? Do you mind telling me how much you spend? How much difference to this do the vouchers make?
- What do you usually use your vouchers to buy?
- Are they enough for that purpose? E.g. are they enough for formula
  - what happens when your fruit and veg cost too much or too little?
- Has anything made it difficult for you to use the vouchers?
- Can you buy things that are useful/that you need with the vouchers?
- Can you buy things your family likes to eat with the vouchers?
- Are there other things that you think you SHOULD be able to buy with the vouchers but you can't.

I'm wondering what happens when you go to the shops and you want to use the vouchers, but the things you want to buy cost more or less than the amount of vouchers you have?

- What are shop assistants like about that?
- Are they helpful?
- Are some shops better than others about being helpful?
- What sort of helpful things do they do?

I know it's difficult to ask I want to know about what it's really like to use these vouchers, good and bad. So I'm wondering if you've ever heard of anyone swapping their vouchers with someone else – maybe so they could buy something they really wanted instead of the things they're allowed to buy. (Reassure them we're not employed by HS, they are completely anonymous). Can you tell me a bit more about this?

## 5. Changing behaviour or relationships

We've talked about the practical things about the HS vouchers. Now I'd like to talk about how you felt about applying for the vouchers, and whether you think they've made a difference to you at all.

Thinking first of all about the health care workers you're in contact with – your midwife, HV and GP.

- Do you think it's ok that its midwives and health visitors are involved in HS?
- Why?
- How often to you see your midwife/HV?
- Do you get on with your midwife/HV?
- Have they talked to you about food and diet? Prompt for more information if answer is yes.
- Have they talked to you about breastfeeding? Prompt for more information if answer is yes.
- Is he/she helpful to you? In what ways?
- Has your MW, HV or GP ever talked to you about HS since they signed your application?
  - Has having the vouchers changed your diet?
  - Your children's diet?
  - In what ways?
  - Do you think the restrictions on the vouchers have changed the sort of things you buy – do you buy things you didn't used to? Is that a good or a bad thing for you?
  - What would you say has been the main impact of receiving HS vouchers on you and your family?
  - Did anyone ever talk to you about HS vitamins?
  - Prompt who/when etc
  - Do you use them? Why/why not?

Is there anything you want to say about HS that I haven't asked about?

Have you got any questions for me?

Thank you for your time

Remind them about arrangements for hearing about results of the study.

## Appendix 4: Recording Food Purchasing and Consumption; an Exploration of Possible Methods to Use with Low-Income Families

Healthy Start aims to improve the health of low-income pregnant women and families, and key measures of success are likely to be food purchasing behavior and nutritional intake of both low income parents and their children. The current study was not an impact assessment of HS, but the commissioning brief requested that we consider the potential to record family food purchasing and consumption habits to inform any future impact evaluation (including economic impact) of the scheme.

Dietary assessment of HS beneficiaries is likely to present methodological challenges regardless of the methodology used, for a range of reasons. Firstly, current evidence about the nutritional intake of low income households is largely based on national surveys where the representation of low income households is low. Low income households also have a higher incidence of poor literacy, numeracy and language skills making written assessment methods more challenging, additionally they are also more likely to face challenges resulting from drug and alcohol abuse, domestic chaos and stress factors than the general population<sup>5</sup>. Standard methods of collecting such data, such as the Food Frequency Questionnaire (FFQ) require respondents to read a lot of dense text, and complete a long questionnaire. All of these factors increase the burden of self-reported dietary assessment and are likely to affect both participation in such studies, and their accuracy. This is further exacerbated by the parental status of HS beneficiaries, who are either pregnant or parenting small children (or both). During pregnancy, mothers' food intake may vary according to the stage of pregnancy and also be affected by nausea, sickness or and/or food cravings<sup>6</sup>. In addition, because the children who are beneficiaries of HS are under four years of age and not developmentally ready to self-report, parents will be collecting data on behalf of their children. Recording or recalling their child's diet places an additional burden on a parent already recording their own food intake. Some children may spend some of their day with alternative carers (either formal or informal care such as nurseries or grandparents) and these carers will be responsible for providing the child's meals for some of the time, making it more difficult for parents to know with any accuracy what their child was offered or consumed.

The current study afforded an opportunity to pilot innovative methods of collecting food purchasing and/or consumption data with HS beneficiaries that might inform any future evaluation of the scheme. We wanted to test out methods which were designed to be light-touch and easy for families to implement and return given the challenges outlined above. Measures designed to determine the impact of HS might usefully measure food purchasing patterns (e.g. does the provision of vouchers impact on food choice in the supermarket?) or consumption patterns (e.g. does the scheme impact on the nutritional intake of parents and their children?). After a review of the literature, we designed a pilot of two innovative methods intended to capture each of these. The first method was the use of a disposable camera for parents to record their own and their children's food intake over 48 hours by photographing all food and drink before consumption. The second was a collection of till receipts as the primary record of food purchases supplemented by a diary record of purchases not covered in itemised receipts.

Our aim was to use the current study as an opportunity to test the acceptability of these innovative methods by comparing them with a more standard approach. We wanted to assess which method of collecting purchasing and food intake information was preferred by our respondents, what the likely return rates might be, and the quality of the data returned. Our aim was *not* to make conclusions about the accuracy of any of the data recorded; both new methods rely on self report and we chose not to attempt to validate against established methods because of the burden that completion of two methods would place on our respondents. If our innovative methods proved acceptable to

respondents and appeared to yield useful data, validation would be the recommended next step. The pilot was designed to:

- Develop a method for collecting family food intake from HS families using disposable cameras;
- Develop a method for collecting family food purchasing data from HS families using till receipts and diaries;
- Compare acceptability and completion rates for these innovative methods with a standard method (FFQ) used to collect data on one adult and one child (the youngest) in the family.

We reviewed more standard methods for dietary assessment to identify one for use as a comparison for our two innovative methods. Food Frequency Questionnaires (FFQ) are comprised of a list of common foods and drinks and ask participants to estimate the frequency with which they consume them over a defined period of time. Our pilot study uses a FFQ as the comparison methods for a range of reasons. Firstly, it was preferred by parents in a Food Standards Agency (FSA) study comparing validity and acceptability of assessment methods<sup>5</sup>. Secondly, our primary data collection method was a qualitative interview for the current study, and we wanted to limit the additional burden on our respondents. Filling in a FFQ for one parent and one child and posting back to the research team was, we felt, a more convenient and flexible approach than say, a method such as the structured recall of foods consumed over the previous 24 hours over the telephone at a fixed time (24-hour recall method). Many of our respondents were interviewed in clinics and Children's Centres and posting back data was less intrusive than requesting a telephone number for the 24-hour recall method. It was also more closely aligned to our innovative methods as both required return of data by post. Furthermore, an FFQ was used in the one before-and-after impact assessment of HS that we have been able to locate<sup>7</sup> based in Sheffield. In common with that study we used the FFQ selected was that used in the Avon Longitudinal Study of Parents and Children<sup>8,9</sup>. The questionnaire lists 40-70 items in formats suitable for adults or for children of different ages (1, 6, 15 and 24 months of age)

### **Photo diary using disposable cameras**

The photo diary method asked parents to record their own and their youngest child's food intake over 48 hours by taking a photograph of the food prior to consumption. Parents were given a disposable camera, an instruction sheet (included below), ID cards (anonymised cards for use in the photographs that would identify the respondent to the research team) and an envelope to return the camera to the study team. Parents were asked to take photographs of everything they and their youngest child ate and drank (unless pregnant in which case only the mother participated), including main meals as well as snacks and drinks. If the parent was breastfeeding a baby we requested only photos of bottle feeds or solids that they also gave to the infant.

Our aim was to determine the acceptability of the approach as well as an initial understanding of the quality and completeness of the returned data. This approach would need refinement if it proved acceptable to parents. Parents were asked to photograph food prior to consumption; this approach does not record what was actually consumed (e.g. what was left uneaten on the plate) nor is likely to yield data that satisfactorily identifies all food and drink stuffs and estimate portion sizes<sup>10</sup>.

### **Till receipts and purchasing diary**

The diary method asked parents to collect till receipts for food items bought by all members of the household in a shop or restaurant etc for two week days and two weekend days. This was supplemented by a food purchasing diary for items bought but not covered by an itemised receipt. The instructions for this method are included below. The purchasing diary was informed by those used in previous studies<sup>11,12</sup> and asked for details of the food items bought, whether HS vouchers were used, total cost of the shopping and whether or not non-food items were included in the cost.

This method would also require further refinement and will only ever provide aggregated data for the family purchasing the food rather than individuals. However such data can be more economical to collect and has been shown to be a valid estimate of fat and energy intake, particularly in low income groups who may eat out less often and waste less food <sup>13</sup>.

### Pilot design

Sixty-two of the parents we interviewed in the HS vouchers study were also invited to complete a study of food consumption or purchasing. Those interviewed over the phone (n=26), and in cases where circumstances meant researchers felt it was not appropriate to explain this additional component of the research study (eg recruitment in very busy setting) were not included in this part of the study. Each of the two innovative methods was compared with the standard method (FFQ). The photo diary method was piloted with parents in six of the research sites (36 parents in total), the purchasing diary in the remaining seven sites (26 parents in total). The methods pilot was introduced in detail after the end of the interview and parents were given the choice of either the FFQ or photo diary, or the FFQ or purchasing diary, or no method at all.

Parents were provided with instructions for the method selected, a stamped addressed return envelope, and a questionnaire asking how they felt about the method. This was a short questionnaire asking parents to comment on the acceptability of the method including ease of completion, accuracy (of recording data for themselves and their children), time taken, and any concerns about the method. Parents who provided a mobile number were sent a text message after one week reminding them to return their materials.

Table 7: Preference for Method of Data Collection

	Photo diary vs. FFQ (n=36)	Purchasing diary vs FFQ (n=26)
Camera	7	n/a
Purchasing diary	n/a	3
FFQ	29	20
refusal	0	3

### Camera vs. FFQ

Thirty-six parents recruited across six PCTs were given a choice between a disposable camera or a FFQ to complete. The majority, 29 (81%), chose the FFQ, 7 (19%) chose the camera, and none refused either option (see Table 7). The main reason given for choosing the FFQ over the camera was concern that they might lose the camera. A few thought the FFQ would be easier. A couple of the parents also felt that the camera option was strange. One commented: *'The idea of taking pictures of what my daughter is eating and sending it off to some stranger is a bit odd'*. One parent thought that it would be too embarrassing taking photos of all the food she shouldn't be eating. The parents who chose the camera all did so either because they thought it seemed like good fun or because it sounded easier than the FFQ. One mother thought it would be easier for her than the FFQ because she was a Polish speaker.

### Food Purchasing Diary vs. FFQ

In seven other PCTs, 26 parents were given the option of either a FFQ or of completing the purchasing diary. Three refused either option, three chose the purchasing diary and 20 chose the FFQ (see Table ). The main reason given by parents who chose the FFQ over the purchasing diary was that that the FFQ seemed like it would be quicker or easier than the purchasing diary. A few simply didn't like the idea of sharing purchasing information, and one parent felt that a diary was 'too intrusive'. Of the three parents who chose the purchasing diary, two felt that it was an easier option than the FFQ.

## Rate of return

Data regarding rates of return are provided in Table below. Just over a quarter (18) of the 59 parents given one of the food diary methods returned them. Of the three parents who chose the purchasing diary, no one returned them. Two of the seven parents who chose the camera method returned them to the research team. Of the 49 receiving a FFQ, 15 (31%) returned them completed and a further one returned the FFQ blank.

Table 8: Rate of Complete Return for Each Method

Method	Number Distributed	Returned
FFQ	49	15 (31%)
Camera	7	2 (29%)
Till Receipts diary	3	0 (0%)
Any	59	17 (29%)

## Acceptability of Method

Of those 15 parents who returned the completed FFQ, 12 also returned a completed questionnaire concerned with the acceptability of the method. We acknowledge that this group is self selecting, and are likely to be more positive about the methods than those who did not return their data. Eleven of the parents found the FFQ easy to complete with only one agreeing that it was difficult. All agreed (some strongly) that it was an accurate record of what they, and their child, ate. Three respondents agreed with the statement that the FFQ would miss out some of the foods their children ate, while two agreed it would miss out some of their own food. The one respondent who commented further wrote '*dietary needs*' suggesting the FFQ did not capture the foods required for special diets. No respondent said they were tempted to cheat when completing the questionnaire, though four agreed with the statement that completing the FFQ made them change what they ate. One wrote further that the FFQ '*made me aware of what I should and shouldn't be eating*', another that '*I eat too much junk*'. One agreed that the FFQ made them change what they gave their child to eat but did not comment further. Two respondents agreed (strongly) that the FFQ took too much time, with one of these feeling that it was not ok to ask mums to complete the FFQ. The remainder of the respondents agreed that asking mothers to complete a FFQ was ok. No respondent said they were 'worried' about the questionnaire.

Both the respondents who returned the camera also returned the acceptability questionnaire. Both of these parents found the instructions easy and enjoyed the method. Both also agreed that it was an accurate method of what they and their child ate, although the respondents also agreed that it would miss out some of the foods they and their child ate. One commented further saying both her and her child's drinks were taken 'outside' and she forgot. One respondent admitted she was tempted to cheat when completing the photo diary, stating '*because I think I eat sometimes too much, for example I made photos of some ice cream but I actually ate 3. :).*' Neither felt the camera would change what they or their child ate. Both respondents were positive about the time taken for this method, and that asking mothers to maintain a photo diary was fine. Neither had concerns about the method.

## Conclusions

This small scale exploration of methods for collecting food consumption and purchasing data was an 'add on' to a qualitative interview and was not the main data collection technique for which the parents were recruited. This may have impacted on the returns of the methods we were testing, for example researchers were conscious that families had often already spent considerable time with us and didn't

feel it was appropriate to approach some families. However, our response rates confirm previous studies showing that data return from this group is likely to be low.

This exploratory work found that our innovative methods (the camera and the till receipts diary) were less popular than the established FFQ survey method with this group of parents. The small sample means that any conclusions about return rates and acceptability should be treated with great caution. There did not appear to be a difference in rate of return between different methods, but very few families selected cameras or till receipts. Acceptability of both the FFQ and camera was good, but we would note that this was a self-selected sample: this represents a group who had chosen this method above another and was in a minority in returning their materials.

Although we believe these methods could be improved by, for example, a dedicated pilot study that worked with a user panel to develop these innovative tools further, the return rates achieved here confirms previous research that this is difficult data to gather. Well validated, resource intensive methods for collecting food intake data already exist, and these options which required less input from respondents did not appear to increase response rates.

The high proportion of HS food vouchers used in supermarkets suggested that an alternative strategy worth pursuing might be gathering purchasing data directly from these sources.

# Photo Food Diary Instructions



## Photo Food Diary - Instructions

As part of the Healthy Start Vouchers Study we are trying out different ways of asking families to record what they eat. Taking photos is one way we think might be useful, so thank you for agreeing to help us with this work.

You should have in this pack:

- A Disposable camera with 27 exposures
- A card with a code on it and your name/your child's name
- A padded envelope
- A large envelope with Bristol University's address on it
- A piece of paper with questions on it.

### What do you have to do?

We would like you to take a photograph of everything you and your children eat for the next two days, starting on the morning after the researcher's visit (tomorrow). After you have done this for two days, you can post the camera back to us and we'll develop the photos.

### Who is involved?

We would like photos of food and drink for you and **one child (the youngest)**. This will be

Parent.....

Child .....

We do not want photos of any food to be eaten by other adults, or older



babysitters, and nursery etc. and even when you are there, there is not always time to take a photo. We will ask you how complete you think your diary is. However, we are hoping that what you send us is enough to give us a good idea of what children eat so please try and take pictures of as much as you can.

If you have any concerns or problems, please call or text Tricia on 07896 575194 and we will call you back.

Thank you

### When the two days are over:

Please complete the short questionnaire enclosed with this pack. There are 11 questions about your experiences taking photos of you and your child's food and drink - we are really interested in how you found it.

Once you have done that, please place the camera in the padded jiffy bag, and put this with the name cards and the questionnaire in the envelope addressed to Tricia at Bristol University. It is FREEPOST - you do not need to pay for postage.

If you have any queries about any of this you can text or call us on 07896 575194 and we will call you back.



### What will the photos look like?

For every piece of food or drink given to your child, please take a photo before they eat it. Please do the same for everything you eat or drink. For food prepared on a plate, please place the plate next to the card with your name, or your child's name on it like the photos on the pages attached.

Please do this for breakfast, lunch, and evening meal and any other meals that you and your child have during the next two days.

Please also take photos of food and drinks NOT served on plates e.g. snacks such as fruit, sweets or biscuits and any drinks provided. There are some examples with this pack. In all of them, we try and make the food or drink as clear as possible and ALWAYS have the name card in the picture.

### When do I start?

Please start tomorrow as soon as your day begins. This will probably mean you start taking photos at breakfast time. If possible, we would like you to take photos of everything you and your child eats and drinks for two days.

### Do you want photos of all food and drink?

Yes please. This will usually mean:

<b>Day 1</b> Breakfast Lunch Evening meal Snacks and drinks provided during the day Bedtime snacks or drinks Etc.	<b>Day 2</b> Breakfast Lunch Evening meal Snacks and drinks provided during the day Bedtime snacks or drinks Etc.
---	---



### Drinks



### Snacks

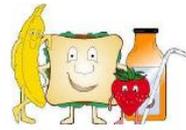


### Plates of food





School for Policy Studies  
Healthy Start Vouchers Study



**Food for babies and small toddlers**

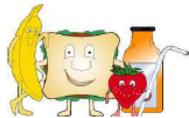


Please do NOT take photos of people (children or adults). We will make sure that we don't keep any photos taken by mistake.

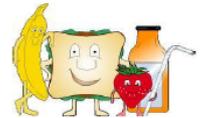
# Till Receipts and Purchasing Diary Instructions



Healthy Start Vouchers Study



Healthy Start Vouchers Study



## Till receipts and purchasing diary - Instructions

As part of the Healthy Start Vouchers Study we are trying out different ways of asking families to record what they eat. We think one useful way of doing this will be to keep till receipts and fill in a diary of food and drink bought. Thank you for agreeing to help us with this work.

You should have in this pack:

- A food and drink purchasing diary
- A piece of paper with questions on it
- A large reply envelope with our address on it. This has pre-paid postage.

### What do you have to do?

First of all, we would like you to collect all the till receipts whenever **anyone in your household**

- buys food or drink items from a market or shop
- food and drink items from a restaurant, café or takeaway

We would like you to do this for 4 days in total. We want you to do this for 2 week days (Monday-Friday) and 2 weekend days (Saturday and Sunday).

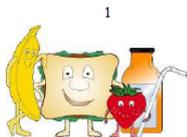
The days on which we would like you to collect receipts or fill in the food purchasing diary are:

Day 1: \_\_\_\_\_  
 Day 2: \_\_\_\_\_  
 Day 3: \_\_\_\_\_  
 Day 4: \_\_\_\_\_

After you have done this for these 4 days, we would like you to post all the receipts back to us using the pre-paid envelope we have given you.



Healthy Start Vouchers Study



Healthy Start Vouchers Study



### When the 4 days are over:

Please complete the questionnaire enclosed with this pack. There are questions about your experiences of collecting till receipts and filling in the diary - we are really interested in how you found it.

Once you have done that, please place all the till receipts, food purchasing diary and the questionnaire in the envelope addressed to Meg at the Social Sciences Research Unit. It is FREEPOST - you do not need to pay for postage - just pop it in the post box!

If you have any queries about any of this you can text or call Katie on 07759 355 314 or Meg on 07944 615 386 and we will call you back.

Thank you

If you buy any food or drink items but don't get a receipt, or if the receipt you get does not name the items you bought then we would like you to fill in the short food purchasing diary. An example of the kind of receipt we need, that lists the items you bought, is below. Details of how to fill out the diary can be found on the front page.

TESCO	
MUSSELS/100g	4.80
LOTTO BOTH	4.80
CHOC DIGESTIVE 4	0.25
CHOC DIGESTIVE 4	0.25
BUTTER	0.25
CHEEKED HAM	0.25
CHEEKED HAM	0.25
POTATOES	0.15
PEAS/100g	0.25
BANANAS	0.73
PIZZA	0.25
COLDEN	0.60
CHIPS	0.60
CHANGEBLUE	0.25
-----	
ELECTRONIC STATEMENT	
CLUBCARD NUMBER	8882828
QUALIFYING SPEND	2.72
POINTS THIS SPEND	272
-----	
Lacey Ticket Conc. 1	1096.66021.100.00251
-----	
10942000	11.47 2310 001 094

### Who is involved?

We would like till receipts or diary information about food or drink purchased by **any member of the household**

### Do you want till receipts or diary information about all food and drink?

Yes please. This means if you buy food or drink from a store (market stall, local shop, supermarket) or if you eat or drink out (restaurant, café, takeaway).

We are interested in all food and drink purchases no matter how big or small, from a chocolate bar to a big weekly shop.

## How to fill in the food purchasing diary



You only need to fill in the diary if you bought food or drink items and **did not get a till receipt or did not get a receipt that lists the individual items you bought**. You only need to do this for 4 days (2 weekdays and 2 weekend days).

1. Write down the date that you bought the food or drink
2. Write down all the food and drink items purchased
3. If you used any Healthy Start vouchers to buy any of the items then write Y (yes) or N (no)
4. Write down the total cost of ALL the items that you bought at this shop (this total may include non food or drink items you purchased e.g. nappies, washing up liquid)
5. We'd like to know if any non food or drink items were included in your purchase, please write Y (yes) or N (no)
6. Tick the type of retailer where you brought the food/drink from

Please use a separate row each time you or a household member went to a different shop or restaurant, even if this was on the same day.

So you don't forget, please fill out the diary as soon as possible after you get home. Snacks, soft drinks and food from restaurants are easily forgotten. Please check with members of your household at the end of each day to ensure all food and drink purchases are recorded, either by a till receipt or in the diary.

The first page of the diary has been filled out with an example so you can see how we'd like you to complete it.



Healthy Start Vouchers Study

Please return your diary, till receipts and completed questionnaire to the following address using the FREEPOST envelope:

Meg  
Social Science Research Unit  
18 Woburn Square  
London  
WC1H 0NR

**Thank you!!!**

## Appendix 5: Summary of Retailers Data

Table 9: Number of Registered Retailers in England (April 2011), and Proportion of Vouchers Spent Over Scheme Lifetime

	Number of Registered Suppliers	Proportion of Vouchers Redeemed
Multiple Retailer (non-franchised)	541	72.9%
Independent Retailer	10299	13.5%
Milk Delivery Services	2509	5.8%
Independent Chemist	1002	0.5%
Multiple Retailer (franchised)	623	1.3%
Market Trader	302	0.3%
Food Co-Op/Box Scheme	299	0.2%
Multiple Chemist	173	4.5%
Wholesaler	115	1.0%
Total	15863	

Table 10: Top Ten Individual Claimants in England (April 2011) over Scheme Lifetime

Top Ten Claimants	% of total redeemed
Tesco Stores Plc	22.3
Asda Stores Ltd	18.0
Independent Retailers	13.5
Wm Morrison Supermarkets Plc	8.4
J Sainsbury Plc	8.4
Milk Delivery Services	5.8
CWS Ltd	4.9
Boots The Chemists Ltd	3.7
Somerfield Stores Ltd	2.7
Iceland Frozen Foods	2.5
Others	9.0

Table 1: Number of Each Retailer Type Registered in Research Areas (PCT) (February 2012)

	Total across all areas	Average Number per PCT, range in brackets
Multiple Retailer – Groceries	779	57.2 (15-171)
Independent Retailer (Grocer/Convenience Store)	598	44.9 (6-114)
Multiple Retailer - Pharmacy	420	30.5 (8-113)
Franchisee	141	9.8 (0-36)
Independent Pharmacy	87	6.3 (0-15)
Dairy Services	57	3.8 (0-12)
Other (eg Post Office, Forecourts, Farms, market traders)	152	11.6 (0-31)
All types combined	2234	171.8 (43-369)

Table 12: Proportion of Active Small Retailers per PCT Area (excluding multiples) February 2012

PCT No.	Total number of registered small Retailers	Number Newly registered (< 3 months)	Never claimed Number (%)	Total No of Vouchers per PCT over HS lifetime	Average of No of Vouchers Reimbursement per Retailer per Month**
9	16	0	0	138.7	3.3
6	96*	15	0	208.0	0.4
4	96	4	0	96.5	0.7
8	148	6	0	95.1	0.4
5	97	4	0	44.2	0.4
3	158	12	1 (0.6)	17.0	0.8
1	79	7	3 (3.8)	162.1	1.0
13	43	5	2 (4.7)	229.9	0.8
7	43	2	2 (4.7)	51.1	0.7
11	35	0	2 (5.7)	386.3	2.0
10	62	0	5 (8.1)	686.4	0.7
2	150	13	20 (13.3)	169.5	0.1
12	12	1	4 (33.3)	57.7	9.1
Grand Total	1035	69	39 (3.8)	2,342.6	1.6

\*all figures in bold above average

\*\*estimated using time since first claim and vouchers submitted to date

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