Lay summary

‘Healthy Hexagon, Eat less salt’ was a Food Standards Agency (FSA) salt campaign project that worked from March 2007-March 2008 with the staff and residents of Hexagon Housing Association (HHA), a medium sized social landlord in south-east London. The ‘Eat less salt’ project was developed and managed by the charity, The Food Commission.

The framework set out for the ‘Eat less salt’ project was designed to enable the delivery of the key messages set out by the FSA for the third phase of its salt campaign with the addition of messages for housing association staff and residents as follows: 75% of salt comes from everyday foods; check the label and choose lower salt options; cutting down on salt reduces blood pressure, whether or not your blood pressure is high to start with; babies and children should have less salt than adults do; small changes can make a big difference; housing association residents and staff can support each other to cut back on salt; you can get used to eating less salt in a few weeks; and some foods are full of salt even though they do not taste like it.

The project aimed to increase the awareness, motivation and skills of residents with regard to dietary salt reduction and to support them in making changes. It offered information throughout the course of the project to all staff and residents, for example, in the form of: articles about salt in resident and staff newsletters; ‘Healthy Hexagon’ website address with materials; and information packs. More than 150 residents attended specially designed ‘Eat less salt’ workshops that included: store tour, tasting, label reading, cooking in certain instances and salt information. The workshops were run by registered dietitians and were attended on a ‘one-off’ basis in sessions of approximately three hours in length. The project worked with a broad range of staff and residents with the intention to also actively recruit those who might be described as hard-to-reach including: young people living in short-term accommodation and those in care homes for people with longterm mental illness. The workshops were free and attendees received expenses.

The Centre for Public Health Nutrition, University of Westminster, carried out the project evaluation which was done in three stages: an initial evaluation before the intervention began to establish a baseline of information about self-reported salt consumption levels and behaviours; a mid-way evaluation six months into the project; and a final evaluation after the intervention concluded to reassess self-reported salt consumption levels and behaviours. The evaluation gathered information using a quantitative method in the form of a food questionnaire to measure self-reported salt intake on one day and qualitative methods such as one-to-one and group interviews.

The ‘Eat less salt’ project provided an effective focus for engaging staff and residents of a housing association. The relatively high rates of participation in the project were evidence for this. The qualitative data suggested that many felt that they had benefited from the initiative in terms of their knowledge, motivation, and ability to reduce salt intakes. In addition, some respondents intimated that they had made changes to how they shop, cook and consume

food in order to cut salt intake. The qualitative element of the evaluation provided a raft of data providing insights into how best to work with these groups on healthy eating issues, and how to progress work with housing associations in future. However, the food questionnaire failed to demonstrate any measurable impact on salt intakes, and this could be for a number of reasons: low sample sizes; it was a new tool not sufficiently piloted or validated; and the difficulties around self-reported food intakes by individuals with a tendency to under-report unhealthy foods.

Positive changes appear stronger in some groups, for example, older residents who enjoy cooking and who have some experience of ill health. The change appears less strong in, for example, residents with longterm mental illnesses. The evaluation does not suggest that we have provided staff and residents with all of the skills and support they need to change their behaviour, but it does suggest that we have given many people a very good start. There is evidence that HHA will continue to offer some support on an ongoing basis to staff and residents who wish to change their salt consumption habits and who wish to engage with other aspects of healthy eating.

‘Healthy Hexagon, Eat Less Salt’

Final project report

Author: Jessica Mitchell

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Prepared for: The Food Standards Agency, Aviation House, 125 Kingsway, London, WC2B 6NH.

Prepared by: Jessica Mitchell, director, The Food Commission, 94 White Lion Street, London, N1 9PF.

Project partner: Hexagon Housing Association, 130-136 Sydenham Road, London, SE26 5JY.

Evaluation partner: University of Westminster, School of Integrated Health, Centre for Public Health Nutrition, Cavendish Campus, 115 New Cavendish Street, London, W1W 6UW.

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I wish to thank Hexagon Housing Association for giving us the chance to work with staff and residents on the ‘Healthy Hexagon, Eat Less Salt’ project. The commitment of the staff and residents was absolutely wonderful. I wish also to thank our evaluation team from the University of Westminster, Alizon Draper, Pam Schickler, and Jessica Swann, for their valued support and guidance throughout the course of the project. Thanks go to the other salt partner projects for many interesting discussions over the year and for sharing information. Finally, many thanks to the Food Standards Agency, not just for providing a grant to The Food Commission to run the project, but, also to the staff team involved, for their invaluable input to it.

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Executive summary

Background

The ‘Healthy Hexagon, Eat less salt’ project aimed to go right to the heart of addressing core, strategic aims of the Food Standards Agency (FSA) and more specifically of the third phase of its salt campaign, whilst at the same time building on the resources of the project partner organisation Hexagon Housing Association (HHA), a medium sized social landlord in south-east London. The FSA is committed to putting people at the heart of what it does, and to involving diverse communities in behavioural change to improve health. These are also core commitments for Hexagon Housing Association. Both organisations need to deliver effective processes that enable involvement, but that will ultimately be assessed on their ability to deliver genuine change.

The framework set out for the ‘Eat less salt’ project was designed to enable the delivery of the key messages and objectives set out by the FSA for the third phase of its salt campaign with the addition of messages for housing association staff and residents as follows:

- 75% of salt comes from everyday foods
- Check the label and choose lower salt options
- Cutting down on salt reduces blood pressure, whether or not your blood pressure is high to start with
- Babies and children should have less salt than adults do
- Small changes can make a big difference
- Hexagon residents and staff can support each other to cut back on salt
- You can get used to eating less salt in a few weeks
- Some foods are full of salt even though they do not taste like it

Aim and objectives

- To work with diverse housing association residents and staff to improve salt eating patterns in order to drive a reduction in consumption, to leave in place ways of working that are sustainable and to develop good practice methods for involving housing associations in projects to promote healthy eating.

- To broadly categorise salt consumption levels; to explore barriers to changing salt consumption patterns and to explore attitudes to diet amongst 50 housing association residents and staff at the start and conclusion of the ‘Eat less salt’ project through the use of *Salt Food Frequency Questionnaires (SFFQ)* (Appendix 1) and focus groups

• To actively involve approximately 200 residents and staff through the provision of ‘Eat less salt’ workshops (store tour, tasting, label reading, cooking in certain instances and salt information); meeting dietitians and project management

• To provide less intensive support to all Hexagon residents and staff through a range of specifically designed information resources and housing association facilities including Hexagon’s website, Hexagon residents magazines, tenants’ and staff handbooks and staff and tenants’ conferences

•To build project sustainability through partnerships between residents and staff participating in ‘Eat less salt’ exchanges through Hexagon’s time bank ‘My time, your time’

• To propose methods for working with housing associations to support healthy eating

Intervention

The project was managed by the charity The Food Commission. The project delivery period was March 2007 – March 2008. A project team was in place to offer guidance and consisted of: The Food Commission director; four Hexagon staff members including two senior managers; and two residents, one of whom is vice-chair of Hexagon’s Board.

The project offered information throughout the year, in a range of formats, and a programme of ‘Eat less salt’ workshops. The project set out a basic intervention format, in the style of a ‘one-off’ workshop, with the intention that it be developed over the course of the project to meet the needs of particular groups. The majority of the 23 workshops were delivered by state registered dietitians (SRD). The format followed a basic style of: Powerpoint presentation about the role of salt in the diet; label reading exercise; questions and discussion; followed, on some occasions, by a store tour (to practice label reading) or cooking / tasting. Appendix 2 includes workshop format sample plans and materials from workshops.

In total, 152 people attended workshops; 65 visited ‘Eat less salt’ stalls at staff and resident conferences. Another six staff and residents formed a project team and approximately ten more met with project management staff regularly. In the majority of instances, staff and residents attended separate workshops. Some workshop sessions were offered on an open basis to all residents, whereas other sessions were targeted at: young people living in temporary accommodation; people with longterm mental illness living in group homes and members of a residents’ cooking club. The vast majority of workshops were group formats, however, some residents, aged 16-21, in receipt of specialist tenancy support, were targeted with individual workshops.

Information resources distributed to all residents and staff included: *Little Book of Salt* (FSA 2007); *How to look out for salt when you're shopping* (FSA 2007); *Food Shopping Card* (Which? 2007); 'Eat less salt' project posters (Appendix 3) on all staff bulletin boards and all bulletin boards in blocks of flats; *Salt booklet* (Sandwell 2007) (Appendix 4); articles about 'Eat less salt' in every, quarterly, edition of the Hexagon residents' magazine *Home News* (Appendix 5)*; a*rticles about 'Eat less salt' in Care and Support (C&S) team resident newsletters (approximately twice yearly). HHA also developed a specialist area of its website, called 'Healthy Hexagon', along with a logo, which contains information about the project and which enabled residents to submit questions to project staff.

Evaluation

A team from the University of Westminster, Centre for Public Health Nutrition, designed and carried out the project evaluation. The 'Eat less salt' project *Evaluation Framework* (Draper et al. 2007) (Appendix 6) summarises the project aim and objectives, and offers specific guidance about how to monitor the project and to assess its achievements and impact. It specifies the means for gathering and recording information necessary to do that. The evaluation aimed to assess outcomes with regard to salt eating behaviours as well as the operation of the project itself.

The evaluation was carried out in three stages: an initial evaluation at the start of the project, before the intervention began, to establish a baseline of information about self-reported salt consumption levels and behaviours; a mid-way evaluation six months into the life of the project; and a final evaluation after the intervention concluded to reassess self-reported salt consumption levels and behaviours.

The initial evaluation consisted of the following core elements: *SFFQ* (Appendix 1) distributed by email to all staff, approximately 250 in total, and 400 residents, returned by 18 staff and 47 residents; and three focus groups attended by a total of 18 staff and residents. The interim evaluation consisted of: 11 telephone interviews with staff and residents who had attended pilot workshops; two dietitian reports about the workshops and 41 evaluation forms from staff and residents who had attended the workshops. The final stage evaluation consisted of the following core elements: *SFFQ* distributed by email to all, approximately 250 Hexagon staff, and 600 residents, by post, who had had a range of levels of involvement with the project from almost none through to workshop attendance, and returned by 13 staff and 31 residents; three dietitian reports; evaluation of one project notebook; 46 workshop attendees' evaluation forms; two focus groups attended by a total of five people; a project team evaluation meeting with four staff and two residents; and nine telephone interviews with residents. Throughout the course of the project other information relevant to evaluating the process of the project were collected including: information about the number of

leaflets and other materials distributed; data about the socio-demographic profile of residents and information about web hits.

Key findings

The ‘Eat less salt’ project provided an effective focus for engaging staff and residents of a housing association – many who may be considered as so-called hard-to-reach individuals. The relatively high rates of participation in the project were evidence for this. The qualitative data suggested that many felt that they had benefited from the initiative in terms of their knowledge, motivation, and ability to reduce salt intakes. In addition, some respondents intimated that they had made changes to how they shop, cook and consume food in order to cut salt intake (Appendix 7 for photos of residents in workshops).

The qualitative element of the evaluation provided a raft of data providing insights into how best to work with these groups on healthy eating issues, and specifically contextual information regarding their salt behaviours. However, the *SFFQ* failed to demonstrate any measurable impact on self-reported salt intakes within the groups involved in the evaluation, and this could be for a number of reasons: low sample sizes; inability to track the same individuals from the start to end of the project; the *SFFQ* is a new tool that has not been sufficiently piloted or validated; and the difficulties around self-reported food intakes by individuals, with a likely tendency to under-report unhealthy foods..

Evidence is also emerging that HHA intends to devote some future resources to work on healthy eating, using, at a minimum, its ‘Healthy Hexagon’ area of the web to provide links and information. Other housing associations and regulators have begun to express interest in the findings from the project with a view to consider future work.

Key learning

It was very useful to have a specially designed framework for use in evaluating complex community health interventions. This gave confidence throughout the project that it was progressing logically and that information would be available to measure process and outcomes. The importance of conducting initial, and ongoing, qualitative research to inform the design and execution of health promotion initiatives such as this was highlighted within this project. Specifically improvements on the content and delivery of the workshop sessions enhanced the targeting of the intervention.

HHA was a very supportive partner in this work. Indications suggest that there is potential for further work in RSLs on healthy eating, but more direction needs to come from housing regulators and central government if Boards and chief executives are going to commit real resources. The development of a healthy

housing association standard, at national level, with associated support, might be one way forward.

The timescale for the project, one year, was somewhat inappropriate for the setting. It required quite intensive work for people with other jobs to do as a priority. It allowed too little time for a weight of interest and awareness to develop amongst staff and residents. Recruitment was time consuming for such a rigorous programme of workshops. Two years would have been more appropriate, however, even more ideal would be some form of ongoing work on healthy eating.

The awareness raising aspect of the project seemed very effective and useful. Some of the most useful methods for this were the lowest cost – word of mouth, bulletin boards and the resident magazines. Residents valued information that was provided to them and commented on the ease of understanding and the quality. One-off workshops seem to have some potential in changing knowledge and motivation across the resident groups towards salt reduction. However, no information is yet available about the longterm maintenance of these changes. Some people need more support than one workshop can offer.

Project management was time consuming and needed face-to-face meetings on a regular basis with all project stakeholders so that coherence and enthusiasm was maintained. A project team involving stakeholders was useful for establishing key contacts who supported the project. Professional workshop staff were invaluable as they needed to deal flexibly and professionally with challenging situations.

Glossary

BME	Black and minority ethnic
C&S	Care and Support
FSA	Food Standards Agency
GN	General Needs
HHA	Hexagon Housing Association
PIF	Participant information form
RSL	Registered Social Landlord
SACN	Scientific Advisory Committee on Nutrition
SFFQ	Salt Food Frequency Questionnaire
SRD	State Registered Dietitian

1. Introduction

Housing associations are under-utilised in terms of their potential to promote healthy eating. Associations are now required by the government's Housing Corporation to promote healthy and sustainable communities by involving diverse residents (Housing Corporation 2006), and are assessed by The Audit Commission in terms of their achievements in this (Audit Commission 2008). All associations will have some form of Resident Involvement / Community Development team in place along with a written 'resident involvement policy' that needs to be impact assessed on a yearly basis. All teams in housing associations are also now directed to consider how to involve residents in their work, including the building of healthy and sustainable communities. Many associations also have Care and Support teams in place to offer particular support to vulnerable residents either living on their own or in supported accommodation.

However, work in this area in still relatively new and has tended to focus upon what are seen as core areas for housing associations – skill building for employment, debt counselling, gardening, DIY and broad involvement skills. Associations can find it difficult to move from delivering simply process to actually documenting impacts and results for communities. Staff tend to be housing experts; for example, HHA staff are not generally professionals drawn from other subject areas but are career housing workers. So, for example, it is less likely that staff would initiate healthy eating projects on their own. There is some difficulty, at times, in attracting funding as it can be assumed that housing associations should simply fund activities out of rent receipts.

There is, however, great energy within the sector and a great desire to become involved in innovative projects. There is much potential for social landlords to be recognised by housing regulators, in terms of awards and inspection results, for innovative work that delivers genuine change for residents. Research for the London Development Agency (Sustain 2004) indicated a great interest by housing associations in becoming more involved in promoting healthy eating and access to healthy foods. There are some examples of housing associations running healthy cooking classes, walking groups and even some evidence of support for local food co-ops. HHA has been involved in a range of these activities, including work with community dietitians on healthy cooking sessions. Diverse Hexagon residents are already involved in a range of resident involvement and community development events (Hexagon 2006, 2007). Hexagon is also recognised under the Investors in People Standard and its Human Resources team supports staff in a range of training and development activities.

Housing associations are a wonderful resource. They have excellent access to hard-to-reach communities. They are required by regulators to collect information about all of their residents on a regular basis. This information covers: socio-demographic characteristics; residents' opinions about their communities and opportunities for involvement; specific translation needs and the profile of involved residents. They have venues in appropriate locations near to communities and these are generally fully accessible. They issue

regular newsletters, web information and handbooks to all of their residents. They have staff, from housing officers to repairs teams to customer services officers, who see or speak to residents regularly and who usually have much personal knowledge of their residents. This type of information is very useful for accessing residents and for planning targeted activities appropriate to communities.

The 'Healthy Hexagon, Eat less salt' project aimed to go right to the heart of addressing core, strategic aims of the FSA and more specifically of the third phase of its salt campaign, whilst at the same time building on the resources of Hexagon Housing Association. The FSA is committed to putting people at the heart of what it does, and to involving diverse communities in behavioural change to improve health. The FSA is committed to working with so-called hard-to-reach communities. These are also core commitments for Hexagon Housing Association. Both organisations aspire to deliver effective processes that enable involvement, but that will ultimately deliver genuine change.

The framework set out for the 'Eat less salt' project was designed to enable the delivery of the key messages and objectives set out by the FSA for the third phase of its salt campaign with the addition of messages for housing association staff and residents. Means, opportunity and motivation (Hutton 2007) were essential elements of the third phase of the salt campaign and of the 'Eat less salt' project.

- 75% of salt comes from everyday foods
- Check the label and choose lower salt options
- Cutting down on salt reduces blood pressure, whether or not your blood pressure is high to start with
- Babies and children should have less salt than adults do
- Small changes can make a big difference
- Hexagon residents and staff can support each other to cut back on salt
- You can get used to eating less salt in a few weeks
- Some foods are full of salt even though they do not taste like it

2. Aim and objectives

2.1 Aim

To work with diverse housing association residents and staff to alter salt eating patterns in order to drive a reduction in consumption; to leave in place ways of working that are sustainable and to develop good practice methods for involving housing associations in projects to promote healthy eating.

2.2 Objectives

1. To broadly categorise self-reported salt consumption levels, at project baseline, in a 50 person sample of Hexagon Housing Association residents and staff recruited to include the broad spectrum of the socio-demographic characteristics of association residents, using an *SFFQ* (Appendix 1)

2. To conduct at least two focus groups, at project baseline, to provide information about resident and staff attitudes to salt, barriers to dietary change, attitudes to support from their housing association and to gather views/reactions to the proposed intervention

3. To broadly re-categorise self-reported salt consumption levels, explore alterations to salt eating habits and examine attitudes to salt consumption at the conclusion of the project in a 50 person sample of HHA residents and staff through an *SFFQ* (Appendix 1) and focus groups (Appendix 8 for final focus group questions)

4. To create an *Evaluation Framework* (Draper et al. 2007) (Appendix 6) with output, outcome and process indicators and to ensure that evaluation is ongoing throughout the lifecycle of the project

5. To actively involve approximately 200 residents and staff through the provision of ‘Eat less salt’ workshops (store tour, tasting, label reading, cooking in certain instances and salt information); meeting dietitians and project management in order to deliver key messages about salt consumption and to overcome barriers to changing salt consumption patterns

6. To provide ‘Eat less salt’ information sessions at the staff and tenants’ conferences

7. To provide information support to all residents and staff through a range of specifically designed information resources to be made available through Hexagon’s website, Hexagon magazines, tenants’ and staff handbooks and staff and tenants’ conferences

8. To build project sustainability through partnerships between residents and staff participating in ‘Eat less salt’ exchanges through Hexagon’s time bank ‘My time, your time’

9. To leave behind good quality information resources in print and on the web

10. To make sure staff and residents know where to go for information on salt reduction and healthy eating in the future

11. To evaluate what worked in terms of recruitment of participants including staff and residents

12. To find out how residents and staff regard the project activities

13. To promote the learning about methods for working with housing associations, to support healthy eating, to other housing associations and interested groups

3. Methods

3.1 Participants and setting

3.1.1 Target audience

The 'Healthy Hexagon, Eat Less Salt' project was carried out with the staff and residents of Hexagon Housing Association. Hexagon is a medium-sized Registered Social Landlord (RSL) based in south-east London.

RSL is the term used for social landlords that are registered with the Housing Corporation (most are housing associations, but there are also trusts and co-operatives) to provide social housing. RSLs run as businesses but do not trade for profit. RSLs are inspected by The Audit Commission.

The project aimed to involve all residents and staff, to some degree, with continued emphasis on accessing the so-called hard-to-reach, with a view to more actively involving approximately 200 people in workshops, meeting dietitians and project management. The profile of those involved was monitored through the administration of *Participant information forms (PIF)* (Appendix 9) distributed at all 'Eat less salt' events.

3.1.2 Hexagon residents' and homes profile

Information about the profile of Hexagon residents is available from a range of sources including from the *Tenants Survey* (unpublished 2005) conducted every three years as required by the Housing Corporation. This document collects a wide range of information including about the socio-demographic characteristics of surveyed residents, along with further information about their attitudes towards the association and the work it does. Specific information on socio-demographic characteristics is collected through tenancy agreements, and is reported regularly to the Housing Corporation which needs information to report who is being housed by RSLs. Communication needs of HHA residents have been assessed through survey of all residents and is regularly updated for new tenants through the tenancy agreement process.

There are some gaps in information, for example, residents are not required to inform the association if they have a partner living with them, or if they have a child and they are not compelled to provide details about ethnicity. Up to approximately 25% of residents have failed to report ethnicity in previous surveys. However, regular informal surveys, and contact by housing staff does keep a regular flow of information into the association.

Many of HHA's residents might be described as hard-to-reach (Draper et al. 2005) including those from low income, disabled and BME groups. There is a standard form used broadly within HHA to collect some socio-demographic information, including about ethnicity, based on categories utilised by the Housing Corporation. BME groups are defined as those describing themselves of the following origins: black or black British from African,

Caribbean or other backgrounds; Asian (variety of origins); mixed (white and black Caribbean, white and black African, white and Asian and other mixed); and Other including Chinese.

Hexagon classes approximately 80% of its residents as general needs (GN). This means that these residents are not in formal receipt of support; essentially they simply rent their homes from HHA which acts as their landlord. This is in contrast to people housed or supported under the banner of Care and Support (C&S), approximately 20% of people. These tenants receive support from specialist housing officers. C&S accommodation at HHA includes: hostels for teenage mums; hostels for teens; flats for recovering alcoholics and group homes for those with longterm mental illness and learning difficulties. The project also aimed to work with young people aged 16-21 in the so-called 1621 Project run by the C&S team. The project works to offer support to vulnerable young people, many coming out of care, living on their own in their first tenancies, but not in HHA properties. These tenancies have a high rate of breakdown.

Some summary characteristics are:

- Approximately 3200 tenancies altogether (some in households with multiple occupants) with the vast majority in Southwark and Lewisham with some in Greenwich and Kent
- Approximately 50% of tenancies are families with children
- Approximately 20% of people in receipt of Care and Support services
- Approximately 40% from black and minority ethnic communities (BME), particularly of black Caribbean or black African origin
- Approximately 65% of tenants are female
- More than 30% report a longstanding illness or disability, with an estimated 30% more with self-identified support needs not being formally met by Hexagon
- Approximately 48% in receipt of housing benefit
- Accommodation includes blocks of flats and houses concentrated on estates, but with the majority dispersed throughout communities at street level
- Fewer than ten with what HHA describes as communication needs – blind or visually impaired, deaf, or unable to read written English fluently
- More than 40% with internet access at home

3.1.3 Staff profile

- Approximately 250 member staff team of which approximately 64% are women and 62% from BME communities

- The vast majority of staff are located at HHA headquarters in south-east London with the rest dispersed to offices in the communities where residents are housed

3.1.4 Recruitment to 'Eat less salt' workshops

Recruitment to staff workshops on salt was through: word of mouth; flyers at the staff conference; email invitation to all staff; staff newsletter; staff intranet and posters on staff bulletin boards. Recruitment to resident workshops was through: web announcements; *Home News* announcements; word of mouth; flyers at the residents' conference; resident bulletin boards and written invitation. Initially, 400, randomly sampled, residents received the *SFFQ* (Appendix 1) through the post in spring 2007 and within this mailing were asked if they were interested in attending workshops. Those who expressed interest were sent a subsequent letter with details of workshops. Another 600 invitations to workshops were sent out to a new database of randomly sampled residents in autumn 2007. The autumn 2007 postal strike disrupted some mailings, so mobile phone text invitations were sent to approximately 100 residents who had previously registered interest in salt and other resident involvement activities. Three 'Eat less salt' workshops took place at existing sessions of the time bank cooking club and so needed no extra recruitment. C&S residents living in permanent and temporary accommodation were also encouraged to attend by support officers working with them.

The aim for all workshops was to predict the numbers of people likely to attend in order to limit attendance to a maximum of eight. Those who wished to attend were asked to return confirmation slips in freepost envelopes. However, as recruitment methods to workshops included such a range of entry routes, it was not always possible to predict attendance accurately. For example, verbal requests relayed by HHA staff to The Food Commission were also accepted as confirmation of desire to attend workshops. Workshop staff were required to plan flexibly for workshops and were asked not to turn people away if they came without prior, written confirmation.

Staff received no incentives for their attendance. Residents received a variety of incentives which were decided in discussion with HHA staff. Basically, the project aimed to generously cover the expenses of participants, with £10 of shopping vouchers the typical offering. Care home adult residents received no incentives as they did not need to travel to events. However, young people in hostel accommodation received the shop vouchers as an encouragement to come. In one instance, the shop voucher was supplemented by HHA with the provision of a sandwich grill pan. Young people in care homes also need to take part in a cooking activity in order to progress towards permanent housing; participation in an 'Eat less salt' workshop was viewed to count as that activity.

Hexagon residents with communication needs were offered the opportunity to request materials in different formats and for specialist provisions at workshops. All venues were fully accessible, and events were held in a range of locations appropriate to staff and residents with the vast majority being Hexagon owned locations and therefore requiring no payment. The aim was to keep all events in neighbourhoods familiar to attendees, with events requiring no transport between venue and locations for store tours.

3.2 Project management and involvement context

The project was managed by Jessica Mitchell, director of the charity The Food Commission. Quarterly reports were provided to the funder, the Food Standards Agency, throughout the lifecycle of the project and quarterly meetings were held with the FSA, in the presence of all salt partner projects.

A project team was in place consisting of: the director of The Food Commission; four Hexagon staff members including two senior managers; and two residents, one of whom is vice-chair of Hexagon's Board. The project aimed to hold quarterly meetings with the project team with all meetings being minuted. The staff members of the management team were in place to ensure that HHA delivered on it responsibilities with regard to the project. The resident participants were paid £250 for their attendance at five meetings and for their regular attention to the project over the year.

Meetings were held with key staff members and managers for all of the different resident groups before the intervention began. A meeting was also held with the human resources manager at the start of the project. The chief executive also met with The Food Commission to approve the project. Hexagon's Board approved the project and regular project updates were provided to the Board during scheduled reports to the Board by managers of Hexagon staff teams involved in the project.

HHA has a range of opportunities in place for residents to become involved in the activities of the association, in line with Housing Corporation requirements. Staff from all teams are required to cooperate with the specialist Resident Involvement and Community Development teams in enabling this work.

The 'Eat less salt' project aimed to take particular advantage of one of Hexagon's involvement mechanisms, 'My time, your time' - the resident time bank. This is a project that operates similarly to a local exchange trading scheme; residents can become members, help other residents with a range of services for no payment except time credits which they can then redeem for services for themselves. The project particularly relied upon the support of staff central to the Resident Involvement team and the C&S team.

3.3 Timescale

The project began in March 2007 and project activities finished in March 2008. Workshops and other activities were scheduled throughout the year in discussion with Hexagon staff members in order to fit in with the regular plans of the association.

3.4 Budget

The project received £54,000 plus VAT. Hexagon Housing Association was provided with £5,750 for 'disturbance' of staff. The University of Westminster

received £7,500 for evaluation work. The rest of the money was distributed to staff and running costs.

3.5 Intervention

3.5.1 Plan of action

The 'Eat less salt' project was designed to enable all residents and staff of HHA to participate in some way in the project, whilst more actively engaging 200. In order to accomplish this, the project offered information throughout the year, in a range of formats, and a programme of workshops. The intervention was open to all staff and residents at the request of HHA. The intention was to build on the sense of community and involvement that the association is always working to enhance. However, staff and residents were invited to separate workshops, except in the instance of some C&S workshops where there was joint attendance. C&S workshops were targeted at particular groups of residents, for example young people and those with longterm mental illness.

It was not the intention to recruit a representative sample of staff or residents to participate in the project, due to the resources this would have required. It was the intention to ensure a 'spread' of participants from people representing the diversity of characteristics of those housed and employed by HHA. It was also the intention of the project to actively target residents from certain so-called hard-to-reach groups such as young people in temporary accommodation and those with longterm mental illnesses.

The project piloted workshops in the spring/summer of 2007 which were evaluated by written participant forms and detailed 'exit' interviews with some participants. Discussions were also held with staff from relevant teams to gather their opinions on the workshops. Redesigned workshops were then offered in autumn 2007 / winter 2008.

3.5.2 Information provision

The following information sources were distributed to all staff and residents:

- *Little Book of Salt* (FSA 2007); *How to look out for salt when you're shopping* (FSA 2007)
- *Food Shopping Card* (Which? 2007)
- 'Eat less salt' project posters (Appendix 2) on all staff bulletin boards and all bulletin boards in blocks of flats
- *Salt booklet* (Sandwell 2007) (Appendix 4)
- Articles about 'Eat less salt' in every, quarterly, edition of the Hexagon residents' magazine *Home News* (Appendix 5)
- Articles about 'Eat less salt' in C&S resident newsletters (approximately twice yearly)

Residents and staff who attended workshops received a collection of information in specially designed 'Salt and health' folders (Appendix 10) that included:

- *Little Book of Salt* (FSA 2007); *How to look out for salt when you're shopping* (FSA 2007); *The Eatwell Plate A5 card* (FSA 2007); *Food Labels: More Informed Choices* (FSA 2007)
- *Salt booklet* (Sandwell 2007)
- *The Food Magazine* (various editions) – the majority of editions that came out during the project had an article about salt (Appendix 11 for sample article)
- *Food Shopping Card* (Which? 2007)
- Powerpoint presentation designed for their session (Appendix2)

HHA also developed a specialist area on its website, called 'Healthy Hexagon', which contains information about the project and links to other organisations including The Food Commission and the FSA.

3.5.3 'Eat less salt' workshops

Basic format, organisation and staff

The project set out a basic intervention format (Appendix 2), in the style of a 'one-off' workshop, with the intention that it be developed over the course of the project to meet the needs of particular groups. The format followed a basic style of: Powerpoint presentation about the role of salt in the diet; label reading exercise; salt quiz; questions and discussion; followed, on some occasions, by a store tour (to practice label reading) or cooking / tasting. The project 'philosophy' was to offer knowledge and skills around salt consumption in order to build motivation for change in the context of a social support structure. There is evidence from a range of health interventions that one-off workshops with store tours are a successful method (Baic 2007; Baic and Thompson 2007) and that community and social support structures are vital (Sullivan 2007; Kok 1993).

Sessions had to be run to times and styles appropriate to that available to staff and residents and to the concentration level of those involved. For example, residents of care homes for the longterm mentally ill needed shorter sessions and were unable to do store tours. C&S staff came to these sessions, including cooks in some instances, with a view to supporting residents with further work in future. All workshops were group formats, except for young, C&S 1621 Project residents living alone in their first tenancies; these were targeted with individual workshops.

The majority of the 23 workshops were delivered by SRDs. Two sessions were facilitated by an experienced community food worker with an MSc in Nutritional Medicine and one cooking workshop was led by a professional chef with an MA in Food Policy and experience in teaching. The staff designed materials for the workshops which were approved by the FSA.

Some form of catering was offered at all events, depending upon the style, length and format of the workshop. Two catering services provided fruit, juices and sandwiches. Discussions were held with both in order to ensure that offerings were lower salt choices. Hot food was not provided, except at workshops that included cooking.

General Needs resident workshop formats (Appendix 2)

- Workshop 1

General needs residents in a 'one-off' 2 ½ to 3 hour workshop including: Powerpoint presentation; label reading exercise; salt quiz, and store tour.

- Workshop 2

Time bank members of a monthly cooking club received a total of three sessions in order to facilitate their knowledge and confidence to do 'Eat less salt' style exchanges with other residents in future. The sessions covered: three recipes with no added salt; Powerpoint presentation; salt quiz, and label reading exercises. There was no store tour.

Staff workshop formats (Appendix 2)

- Workshop 3

Staff in a 'one-off' 2½ to 3 hour workshop including: Powerpoint presentation; label reading exercise; salt quiz, and store tour.

- Workshop 4

Staff in a 'one-off' 1½ hour workshop including: Powerpoint presentation; label reading exercise; salt quiz, and no store tour.

- Workshop 5

C&S staff in a 'one-off' 2½ to 3 hour workshop designed to get them thinking not just about their own salt intake, but about how they could bring information and activities about salt into their work with residents. The workshop included: Powerpoint presentation; label reading exercise; salt quiz and, store tour.

C&S resident workshop formats (Appendix 2)

- Workshop 6

C&S residents and support staff in homes for those with longterm mental illness in a 'one-off' 2 hour workshop including: Powerpoint presentation; label reading exercise; salt quiz, and no store tour. The cooks in the homes provided a low salt meal.

• Workshop 7

C&S residents and support staff in temporary hostels for young people aged 17-21 in a 'one-off' 2½ hour workshop including: Powerpoint presentation; label reading exercise; cooking, and no store tour.

• Workshop 8

C&S residents and support staff in temporary hostels for young people aged 16-21 in a 'one-off' 2½ hour workshop including: Powerpoint presentation; label reading exercise; salt quiz; but with no cooking, and no store tour.

• Workshop 9

C&S residents living on their own in their first tenancies through the 1621 Project. Individual workshop plans for sessions of approximately three hours were drawn up for each participant according to his or her needs but aiming to include: store tour; salt information, and label reading exercises (Appendix 12)

Conferences

• Staff

An all day stand staffed by an SRD with opportunities for staff to visit built into the timetable of the day. Staff could ask questions, practice label reading and take away information.

• Residents

An all day stand staffed by an SRD with opportunities for residents to visit built into the timetable of the day. Residents could ask questions, practice label reading and take away information.

Table 1. 'Eat Less Salt' workshop programme

'Eat less salt' workshops	Type of workshop	Location & time
General Needs residents		
• June 2007	• Workshop 1	• HHA HQ; morning
• July 2007	• Workshop 1	• HHA HQ; lunch to early afternoon
• July 2007	• Conference	• Greenwich Maritime Museum; all day
• September 2007	• Workshop 2	• East Dulwich Community Centre (EDCC); evening
• October 2007	• Workshop 1	• HHA HQ; evening
• October 2007	• Workshop 2	• EDCC; evening
• November 2007	• Workshop 2	• EDCC; evening
• November 2007	• Workshop 1	• HHA HQ; evening
• November 2007	• Workshop 1	• Redriff Estate SE16; morning
Staff		
• June 2007	• Workshop 4	• 1621 Project office; afternoon
• July 2007	• Workshop 5	• HHA HQ; morning
• July 2007	• Workshop 3	• HHA HQ; morning
• July 2007	• Workshop 3	• HHA; lunchtime
• November 2007	• Workshop 3	• HHA; lunchtime
• November 2007	• Conference	• HHA HQ
C&S Residents		
• July 2007	• Workshop 8	• Hostel for young men, women & teen mums; evening
• October 2007	• Workshop 6	• Townley Road Home
• November 2007	• Workshop 6	• Newstead Road Home
• November 2007	• Workshop 6	• Woodcote Road Home
• December 2007	• Workshop 7	• Highshore Road Hostel
• January 2007	• Workshop 9	• Various Southwark
• December 2007	• Workshop 9	• Various Southwark
• February 2007	• Workshop 7	• Peckham Road Hostel

3.6 Evaluation

3.6.1 Evaluation framework

A team from the University of Westminster designed and carried out the project evaluation. The lead evaluators were members of the Centre for Public Health Nutrition. The 'Eat less salt' project *Evaluation Framework* (Draper et al. 2007) (Appendix 6) summarises the project aim and objectives, guided by recommendations from the Charities Evaluation Services (CES 2007), and offers specific guidance about how to monitor the project and to assess its achievements.

The *Evaluation Framework* (2007) breaks the overall aim of the project, to improve salt eating patterns, into its component objectives. It then specifies process and output indicators that should be used to provide information relating to those objectives. It also specifies the means for gathering and recording information to monitor project work. The process of the evaluation takes us from initial measurement to establish baseline indicators through to ongoing monitoring activities and then on to assessing the quality of the outcomes of the project. The evaluation aimed to assess outcomes with regard to salt eating behaviours as well as to provide insight about best practice and project replicability.

The Food Commission ensured the management aspects of the evaluation, in collaboration with HHA staff, such as: the organisation of focus groups; the distribution and collection of *SFFQ* (Appendix 1) and collection of other information necessary for ongoing monitoring of the project as outlined in the *Evaluation Framework.* The Food Commission also actively contributed ideas to the evaluation process due to its responsibilities under the *Evaluation Framework* and as a result of its close involvement with all aspects of the project. During the course of project delivery, many informal visits and conversations took place with staff and residents; the director of The Food Commission attended some of the workshops.

SFFQ

The evaluators designed the individual elements of the evaluation. The team designed the *Salt Food Frequency Questionnaire* (Appendix 1) to estimate self-reported salt consumption levels of staff and residents. The *SFFQ* estimated salt intake of individuals through assessment and characterisation of food habits relevant to salt intake and specifically through taking account of the frequency of consumption of high salt foods and significant contributors to salt intake. The *SFFQ* measured a single day's consumption (the previous day was specified) of high salt foods and significant contributors to salt intake. The *SFFQ* analysis then categorised people into low (0-6 grams (G) a day), medium (6.1g to 9g a day) or high consumers (more than 9g a day).

The *SFFQ* was pilot tested with twelve staff and residents and adjustments were made. The FSA approved the final design. *SFFQ* were distributed to residents and staff of the HHA prior to the start of the 'Eat less salt' project

and again at its conclusion (Section 3.6.2). It was not possible, within the resource constraints of the project, to ensure follow-up of the same group of residents and staff from project start to project end, to allow comparisons of salt consumption and behaviours. The *SFFQ* was, however, distributed to approximately the same group of staff and residents, with some additions and some losses in the form of staff and resident changes.

The *SFFQ* was designed to quantify an individual's self-reported salt intake over one day as accurately as possible. The *SFFQ* was a tool in the evaluation designed to offer a baseline measure of self-reported salt consumption levels at HHA at the project start so that it could be compared to a measure taken at the project's conclusion. The *SFFQ* was distributed to a random sample of residents, and to all staff, with the understanding that sample numbers of returns were likely to be so low that it would not ultimately be possible to make meaningful statistical observations about sub-groups of staff or residents or of those groups as a whole. It was not the intention to recruit a representative sample of staff or residents to fill in the *SFFQs*, due to the resources this would have required. It was the intention to collect a 'spread' of *SFFQs* from people representing the diversity of characteristics of those housed and employed by HHA.

In order to encourage the return of *SFFQs*, a prize draw for £25 of high street vouchers was offered to residents.

Focus groups and depth interviews

The team also set out the parameters for focus group discussions and individual participant interviews in discussion with The Food Commission. The focus group discussions were recorded and then transcribed before being analysed for key points identified in the evaluation framework. Detailed information about socio-demographic characteristics of attendees was not gathered, however attendance lists were kept.

In order to encourage attendance at the focus groups, residents were given a £10 shop voucher plus expenses and those who were interested were provided with a free year's subscription to *The Food Magazine*.

3.6.2 Stages of the evaluation

The evaluation was carried out in three stages: an initial evaluation at the start of the project before the intervention began to establish a baseline of information; a mid-way evaluation six months into the life of the project; and a final evaluation after the intervention concluded.

The initial evaluation consisted of the following elements:

- *SFFQ* with *Participant information form* distributed to all, approximately 250, Hexagon staff members by email and to 400 residents (a random sample) by post with a target response rate of 50 in total

• Three focus groups: one for staff; one for GN residents; and one with young people living in C&S hostels in temporary accommodation. All residents were offered expenses for attending workshops in the form of a high street shopping voucher. See Appendix 7 for an outline of information gathered in initial focus group sessions.

• Notebooks provided to members of the project team to record ideas over the course of the project

• Notebook kept by Jessica Mitchell of The Food Commission

The interim evaluation consisted of:

• 11 telephone interviews with staff and residents who had attended pilot workshops with the aim of recruiting five of each group. These 'exit' interviews asked participants what they thought about the workshops including: information about practical aspects such as the venue, timing, food, expenses; information about the length of events; their thoughts about the content of the session, materials and workshop co-ordinator; their thoughts about whether they believed it would help them to change their salt consumption habits.

• 2 dietitian reports about the workshops

• 41 evaluation forms from staff and residents who had attended the workshops

The final stage evaluation consisted of:

• *SFFQ* (Appendix 1) distributed to all Hexagon staff members by email and to 600 residents by post, the same group who had received these at the start of the project, with 200 extra a mix of people who had a range of levels of involvement with the project from almost none through to workshop attendance

• Two focus groups: one for GN staff; and one for residents

• Project team evaluation meeting

• Nine telephone interviews with residents invited to focus groups who indicated that they could not attend but would prefer phone contact. Interviews were done with C&S and GN residents

• 3 dietitian reports about the workshops

• 46 evaluation forms from staff and residents who had attended the workshops

• Notebooks provided to members of the project team to record ideas over the course of the project were requested but had not been filled in

• Notebook kept by Jessica Mitchell of The Food Commission analysed by herself in discussion with the University of Westminster

• Data required by the *Evaluation Framework* (Appendix 6) collected including: number of leaflets distributed; newsletter articles; number of time bank resident exchanges; web usage information; P*articipant information forms* and attendance sheets analysis

3.7 Ethical issues in project operation and data usage

Although the 'Eat less salt' project did not need ethical approval to go ahead, the project aimed to proceed essentially in line with ethical guidance for qualitative research. The project aimed to respect anonymity and confidentiality of all participant information and to respect the rights of Hexagon staff and residents to opt out of participation in the project. The project aimed to ensure that consent to participate was informed, with all residents and staff provided with full information about the project prior to active participation. It was thought unlikely that harm could result from the project, for example an increase in salt consumption. However, the project requested funding to allow it to proceed with high quality staff and procedures so that it was delivered to achieve positive outcomes. All contributions by staff and residents to evaluation processes in the form of written content was done anonymously; and contributions to focus groups and interviews were conducted by the external evaluation team and results were analysed anonymously.

In practice, confidentiality and anonymity can be slightly more difficult to ensure in projects with participatory elements; for example, residents or staff may choose to take part in public presentations at FSA or dissemination events. Where a participant chose to give up their anonymity, implications of this were discussed in advance with the participant.

4. Findings

The information presented in this section relies upon the data sources outlined in Section 3.6.2 of this report. The evaluation of such information has been done with reference to the project aim and objectives. Section 4.1 considers objectives 1 through 3 (Section 2.2) relating to the salt knowledge, attitudes and behaviour of participants and any changes resulting from the actions of the 'Eat less salt' project. Sections 4.2 through 4.8 consider objectives 4 through 13 (Section 2.2) relating to the overall operation of the project and the processes it used.

4.1 SFFQ and self-reported salt consumption

Descriptive information about the SFFQ and respondents

The initial stage (round 1), prior to the start of the 'Eat less salt' project, of the *SFFQ* aspect of the evaluation, saw the return of 47 questionnaires by residents and 18 by staff. At the project conclusion (round 2), 31 *SFFQ* were returned by residents and 13 by staff. The returns in both rounds, for staff and residents, represent something of the diversity of those groups. Table 2 gives socio-demographic details for those residents who returned the *SFFQ* in both rounds. Table 3 gives socio-demographic details for those staff who returned the *SFFQ* in both rounds. Note that, with regard to ethnicity categories, respondents were able to define themselves in further subcategories including, for example, Chinese, but these categories were excluded in the table if there were no respondents from the ethnic group.

Data analysis has not been done with regard to socio-demographic sub-groups of staff and residents and self-reported salt intakes. The numbers in each sub-group were too small to be meaningful in terms of statistical analysis. The evaluation team analysed the *SFFQs.*

Table 2: Descriptive statistics of the resident sample prior to engagement with the activities (round 1) and the end of the project (round 2)

	Round 1		Round 2	
Variable	Number	Percentage	Number	Percentage
Sex				
Male	12	25	7	23
Female	28	60	23	74
Not identified	7	15	1	3
Total	47	100	31	100
Ethnic group				
White British	19	40	14	45
Any other white	0	0	3	10
Irish	0	0	1	3
African	7	15	8	26
Caribbean	7	15	5	16
White & Caribbean	4	9	0	0
White & Asian	1	2	0	0
Asian	1	2	0	0
Not identified	8	17	0	0
Age range				
16-24 years	8	17	3	10
25-34	8	17	4	13
35-44	9	19	6	19
45-54	7	15	9	29
55-59	1	2	4	13
60-64	2	4	3	10
65-74	0	0	2	6
Over 75	5	11	0	0
Not identified	7	15	0	0

The information from those residents who filled in the *SFFQs* indicated that people from a range of ethnicities and ages responded in both rounds 1 and 2. People from BME communities responded as a greater proportion of the sample than they make up in the overall HHA resident profile (approximately 40%). The BME respondents were also, in the main, members of the BME communities that HHA houses. The data also indicated that more females than males responded in both rounds, but males do make up approximately a quarter of respondents in both rounds. Approximately, 35% of Hexagon tenants are male. There is also no fully reliable data about the age profile of all of the HHA residents, but the respondents to the *SFFQ* are quite broadly spread between 16-75 years of age.

The information from those staff members who filled in the *SFFQs* (Table 3 see below) indicated that people from a range of ethnicities responded in both rounds 1 and 2 but members of BME communities did not respond in as great numbers as they make up in the overall staff profile (approximately 62%). The data also indicated that more females than males responded in both rounds, but males do make up more than a quarter of respondents in round 1 and 44% in round 2. Males make up approximately 36% of Hexagon's staff. There is also no publicly available data about the age profile of all of the HHA staff, but the respondents to the *SFFQ* are spread between the categories from 16-75 years of age. There is a concentration in age groups from 35-54.

Table 3: Descriptive statistics of the staff sample prior to engagement with the activities (round 1) and the end of the project (round 2)

	Round 1		Round 2	
Variable	Number	Percentage	Number	Percentage
Sex				
Male	5	28	4	44
Female	13	72	9	56
Not identified	0	0	0	0
Total	18	100	13	100
Ethnic group				
White British	9	50	8	61
Any other white	0	0	1	8
Irish	0	0	0	0
African	1	5.5	1	8
Caribbean	1	5.5	2	15
White & Caribbean	5	28	0	0
White & Asian	0	0	0	0
Asian	2	11	1	8
Not identified	0	0	0	0
Age range				
16-24 years	0	0	1	8
25-34	1	6	1	8
35-44	8	44	4	30
45-54	7	39	6	46
55-59	2	11	1	8
60-64	0	0	0	0
65-74	0	0	0	0
Over 75	0	0	0	0
Not identified	0	0	0	0

Analysis of the SFFQ

The *SFFQ* estimated information about salt consumption as reported by the individuals who filled these in and then categorised people into low (0-6 grams a day) (g/d), medium (6.1g to 9 g/d) or high consumers (more than 9g/d). Salt intake information was self-reported data based on people's recall of their own food intake in a single 24 period.

The information gathered from the analysis of the *SFFQs* for staff and residents suggested the following: both groups reported that they consumed less than population averages of salty foods; on average, staff reported consuming less salt than residents; there were individuals that reported consuming high levels of salt in both groups and there was no significant change in levels of consumption of salt between the project start and conclusion for either group.

Table 4 (see below) shows the spread of self-reported salt consumption from low to high for residents who returned the *SFFQ* in both rounds. 21% of those who returned the *SFFQs* in round 1 were classed as high consumers of salt and 26% in round 2. The Table 5 (see below) analysis of this data shows that, overall, the average intake of salt for residents was low at 7.2g/d for both the pre intervention and post intervention groups. According to urinary sodium analysis research (FSA 2007), the average daily population intake for men is 10.2g and 7.6g for women.

The statistical tests carried out suggest that there was no significant difference between the rounds with respect to the intake of salt. The P value (a judge of statistical significance) was 0.966 suggesting that there was no statistically significant difference between the two rounds with respect to the self-reported information from residents about salt in their diets.

Table 4: Salt intake defined as high, medium and low categories of a sample of residents of Hexagon Housing Association (round 1) before engaging in activities (round 1) and after the project (round 2).

	Round 1		**Round 2**	
Category of salt intake (g per day)	**Number of respondents**	**Percentage**	**Number of respondents**	**Percentage**
Low 0-6 g/day	18	38	13	42
Medium 6.1-9 g/d	19	41	10	32
High over 9 g/d	10	21	8	26
Totals	47	100	31	100

Table 5: Results of statistical tests carried out on the self-reported salt intakes from a sample of residents in 2 rounds (round 1 before intervention and round 2 after workshops and events)

	Round 1	Round 2
Mean salt intake g/d	7.25	7.29
Standard deviation	3.659	4.53
Confidence intervals 95% confidence	6.207-8.299	5.77 – 8.814
P value of t-test		0.966

Table 6 (see below) shows the spread of self-reported salt intakes for the staff members indicating that 6% were categorised as high salt consumers in round 1 and 15% in round 2. The analysis in Table 7 (see below) shows a similar pattern to that in residents, of lower than population average salt consumption, but the recorded mean intake of salt was lower, at 5g/d, before the intervention, and 5.1 at the end of the intervention period. The statistical tests on the staff data did not show any significant difference between the values from the *SFFQ* filled in at the beginning of the project and at the end.

Table 6: Salt intake defined as high, medium, and low categories of a sample of staff members of Hexagon Housing Association (round 1) before engaging in activities and (round 2) after the project.

	Round 1		Round 2	
Category of salt intake (g/d)	Number of staff	Percentage	Number of staff	Percentage
Low 0-6 g/d	13	72	9	70
Medium 6.1-9 g/d	4	22	2	15
High over 9 g/d	1	6	2	15
Totals	18	100	13	100

Table 7: Results of statistical tests carried out on the self-reported salt intake from a sample of staff in 2 rounds (round 1 before intervention and round 2 after workshops and events)

	Round 1	Round 2
Mean salt intake g/d	5.01	5.12
Standard deviation	1.811	3.57
Confidence intervals 95% confidence	4.174-5.848	3.17-7.56
P value of t- test		0.924

The *SFFQ* also asked some questions about salt behaviours including: addition of salt at the table or while cooking; and the use of low salt products or salt substitutes. However, the information for staff and residents showed no clear patterns at all.

4.2 Salt knowledge, skills, attitudes and behaviour

4.2.1 Resident focus groups and evaluation interviews

Attendance sheets were kept for the focus groups, but detailed socio-demographic information was not gathered. Notes about participants were relayed in reports from the focus groups, but this data is not fully reliable with regard to ethnicity or age. Gender and broad ethnic group were easiest to relate in focus group reports and from attendance sheets.

Twelve residents attended the two focus groups at the start of the project. Four were young people living in C&S temporary accommodation. Of the residents, eight were from BME communities. Seven attendees were female and five were male.

Seven telephone interviews were done with residents after the pilot, so-called interim, stage of the project. Approximately half of the group were female. No other information is available about the participants.

Twelve residents also participated in the evaluation interviews, project team meeting and focus group at the end of the project. No information is available about the participants but the evaluator reports a mix of males and females.

4.2.2 Staff focus groups and evaluation interviews

Attendance sheets were kept for the focus groups, but detailed socio-demographic information was not gathered. Notes about participants were relayed in reports from the focus groups, but this data is not fully reliable with regard to ethnicity or age. Gender and broad ethnic group were easiest to relate in focus group reports and from attendance sheets.

Six staff attended the focus group at the start of the project. Three were from BME communities; two were male.

Four staff participated in telephone interviews after the pilot stage of the project. No information is available about the participants but the evaluator reports a mix of males and females.

Eight staff participated in the focus group and project team meeting at the end of the project. HHA members of the project team consisted of three white men, and three women, one from a BME community.

Salt knowledge and skills at baseline

Information gathered in focus groups and from dietitians' reports suggested that, overall, staff and residents began the project with an awareness that salt was the focus of a health campaign. Overall, there was the knowledge that salt consumption at high levels was linked to ill health effects. However, less than a majority were clear about the recommended intake levels for adults and children. Young people and those with longterm mental illnesses in particular were uncertain about recommended levels of salt consumption and were also less likely to be aware of health campaigns in this area. Young mums and pregnant teens were not aware of recommended levels of salt consumption for babies and children but did report that they knew salt was not good for children.

There was some knowledge about sources of salt in the diet, but this was limited in all groups. Again, this was particularly true for young people and those in care homes. Participants named obvious sources such as salty snacks and smoked meats and fish. They also regularly mentioned salt added while cooking and to food once it was cooked. However, there was much less knowledge about sources of salt in a wider range of processed foods, and very limited awareness of the significant role processed foods play in salt in the diet. Participants, for example, did not know that many tinned vegetables or beans had added salt. Participants did not realise that even if you could not taste the salt, it might still be in the foods. There was almost no understanding about the differences between sodium and salt.

Dietary messages were also somewhat confusing to participants as they came from random sources. Many had heard the publicity about salt and bread, and noted that they were avoiding bread. Many were shocked that we had offered sandwiches as part of lunch.

Participants made mixed suggestions about their label reading skills; many staff and GN residents suggested they could read labels if they wished to, but did find them somewhat time consuming and confusing. Dietitians for the project suggest that reported label reading skills were higher than actual skills. Young people and those with longterm mental illnesses did not on the whole indicate that label reading was a skill they had mastered.

Staff members and older consumers were more likely to know where to go for information about healthy eating, or to feel confident that they could find out such information. Many participants did note a lack of knowledge about alternatives to salt – other flavourings, methods of cooking and snacks.

Changes in salt knowledge and skills

At the end of the project awareness regarding levels about salt amongst workshop participants seemed very high. HHA staff and residents reported a high level of awareness that the association was engaged in work to promote healthy eating around salt. It is difficult to be certain about the extent to which the 6G a day maximum for adults had permeated through to all residents and staff, but those who had attended workshops reported a higher recognition of this and other key messages of the campaign. Many staff and residents commented that anything with numbers put them off, and that they wanted more visual messages.

Staff and residents also developed a clearer sense of where to go for information about the role of salt in the diet. There was an awareness that Hexagon could be approached for guidance in this area – residents and staff noted materials they had been sent which provided information and also guidance about where to go for further information. Staff noted that they were committed to progressing this work by communicating about it to residents. This was true for staff working in C&S and also for staff working with GN residents. Since the cessation of the active work of the project, requests have come from two staff teams, including the 1621 project for further materials relating to salt and a balanced diet.

Those who had come to workshops reported enhanced skills with regard to label reading. Dietitians reported that residents, on the whole, were able to understand the principles of label reading in order to choose lower salt options after they had attended a workshop. Some residents noted that label reading could still be confusing and that the traffic light system was the most helpful. There was still minimal indication that either staff or residents were entirely clear about salt versus sodium.

Many participants noted that they had learned about ideas for alternative ways of flavouring foods and ideas for low salt snacking. They noted using materials given out in workshops for this. However, some did note that they would like further and ongoing suggestions in this area; some noted that the publication of a low salt HHA recipe book would be useful.

Attitudes and behaviour at baseline

At the start of the project, staff and residents were surprised and pleased to see HHA becoming involved in an innovative project. Participants noted that HHA seemed very committed to resident involvement and to staff and residents developing new ways of working together. There was some surprise that the association was focusing upon healthy eating, as most noted that they had not heard of many housing associations working in this area.

There was some surprise that the focus of work was on salt. Many staff and residents noted some interest, but more expressed a desire to learn about broader aspects of healthy eating. Many also noted that ideally they would like to be able to choose from a range of workshop and information options on a variety of healthy eating topic areas.

Participants suggested an openness and a willingness to take part in the project. There was generally a – give it a go – attitude. Many also noted that they hoped the focus of the work would be to treat them as adults – noting that they disliked moralising health campaigns. Participants noted that it would not just be a matter of changing their own attitudes and behaviour – but of motivating their families too. Many predicted that they would face resistance if they tried to alter their family diets. Some noted that this would actually be easier with young people, as they could enforce changes, but noted that they felt older family members would be likely to be more resistant to change.

Many staff and residents, except for young people and those in care homes, noted that they had already been trying to make some changes to their diets, including with regard to salt. This had been motivated by health campaigns. Many noted that this was obviously a high priority for government these days. It was also motivated, for many participants, by feelings of getting older and by seeing relations and friends develop high blood pressure or other diet related conditions. There was also a general sense that it was important to do something positive in this area for the younger generation.

There was some sense that making changes to diet, particularly with regard to salt, could be unpleasant and time consuming. Participants did not like the idea of having to do label reading too much – which they felt to be time consuming and confusing. They also noted that lower salt foods might not taste so good, and that they needed some convincing of this.

Young people and those in care homes on the whole did note that they cared about healthy eating and were happy to participate. For young people under C&S, this was a concern of lower priority than finding permanent accommodation, eating on a low budget, eating out with friends at take aways and not enjoying shopping and so trying to get it over with quickly. C&S staff in homes for those with longterm mental illness noted that resident interest would need to be backed up with significant and regular staff support.

Changes in attitudes and behaviour

Overall, participants maintained their support for HHA becoming involved in healthy eating work. A few noted mixed feelings about how core a priority this should be for housing associations. Many participants noted that the social side of the project was very important, this included those who actively participated and those who had not. They suggested that the chance to meet people at workshops who had similar interests was great, and that it felt good that HHA cared about the health of staff and residents. Some commented that is was good to have staff and residents working together on the same project and that it built the sense of community.

Staff at HHA indicated that more support should have been forthcoming from those most senior at the association and from government housing regulators. They suggested that any lack of internal support was not likely to be down to lack of interest, more to time pressures of other work priorities.

The majority of those interviewed at the project conclusion noted that they were trying to make changes to lower their salt consumption and to eat more healthily in general. The articles in *Home News* and the workshops were noted as motivating. Some care home cooks noted that they were already producing lower salt meals and that they had removed salt shakers from the table. Many participants did note that the dietary shift was important to them but that it was difficult to make permanent changes due to time and family pressures. They noted having skills, knowledge and desire to change, but that they often stumbled due to these other pressures. Many noted that positive and regular reinforcement would be useful. Participants who had taken part less actively noted that they too were taking on board messages about behaviour change and that the importance of this was increasing in their lives.

The young people reported interest and warmth about the workshops along with a sense that they would like to put what they had learned into operation in future when their lives were more stable.

4.3 Participants and setting

4.3.1 Setting

HHA was regarded as an excellent salt project partner by all but a few residents and staff members. One resident, who attended a workshop, felt that the nanny state had gone a step too far in involving housing providers in the promotion of healthy eating. The resident noted that this type of information was widely available, and that she would prefer not to be made to worry about healthy eating by her landlord. The staff member felt the link between housing and health was tenuous. The overall positive view of the project was supported despite the fact that only a couple of residents, and only a handful of staff actively involved in organising the project, were aware that HHA had been provided with a fee for participation.

Some residents and staff noted that in future it would be a good idea to do more workshops out in community locations. Those who mentioned this noted that it would ensure wider participation, with one resident noting that she felt HHA head office was too formal. Three members of the project team noted that working in partnership with other RSLs would be useful in terms of boosting attendance, and increasing the range of free, community venues on offer.

There is some evidence emerging that the project will contribute to policy making with regard to healthy eating and RSLs. The report has been requested by a senior member of the management team at The Housing Corporation and the director of The Food Commission has been asked to participate in policy discussions about supported housing and healthy eating, as part of work with the charity, The Foyer Federation.

4.3.2 Information: print and web

The project aimed to involve all staff and residents in some way, and the following resources were distributed in quantity to all staff and residents:

• 3500 copies each of the following: *Little Book of Salt* (FSA 2007); *How to look out for salt when you're shopping* (FSA 2007); *Food Shopping Card* (Which? 2007); *Salt booklet* (Sandwell 2007); articles about 'Eat less salt' in every, quarterly, edition of the Hexagon residents' magazine *Home News; and* articles about 'Eat less salt' in C&S resident newsletters (approximately twice yearly)

In addition, 'Eat less salt' project posters (Appendix 3) were provided for all 25 staff bulletin boards (at head office, hostels, care homes) and for 75 bulletin boards in blocks of flats. All of the residents and staff (152) who attended workshops were also provided with: 'Eat less salt' Powerpoint presentations; *The Eatwell Plate* A5 card; and a copy of *The Food Magazine.*

The website provided some information about the project from its start, including the facility to send questions about salt and the project to The Food Commission. A web address www.hexagon.org.uk/healthy was developed a few months into the project and promoted to all residents in *Home News* along with a 'Healthy Hexagon' logo. On average, 6 residents a month logged into the project area. Nineteen residents submitted questions to The Food Commission and had these answered. Three residents downloaded information from the project available on the site.

Staff were slow to add material sent by the 'Eat less salt' staff team to the website; the staff responsible noted that this was simply due to time pressures of their own work. The staff also noted that Hexagon had not really begun to properly consider its website as a service to residents, and so were not in the habit of developing it and promoting its use. The project team noted that all members considered that the web was a very important resource for HHA and that it should be much more actively developed and promoted in future.

The staff intranet did not develop during the period of the project; according the HHA staff, this was true for all aspects of the intranet, a new service, not just for the 'Eat less salt' project.

No materials or communications were requested in special communication formats such as CD or other languages.

4.3.3 More actively involved residents

The project intended to more actively involve approximately 200 staff and residents beyond simply being recipients of information. The project did not promise to involve a representative sample but the intention was to focus particularly upon accessing the hard-to-reach and to involving a broad spectrum of staff and residents.

The total attendance at workshops for the project was 152: of this number, 38 were staff attendees and 114 were residents, of which 46 were C&S residents. A total of 15 residents and approximately 50 staff interacted with project staff at conferences as follows: fifteen residents and five staff visited the project stall at the residents' conference and were able to ask questions, take the salt quiz and try label reading with the products on the stall; approximately 45 staff visited the project stall at the staff conference and were able to ask questions, take the salt quiz and try label reading with the products on the stall. The six project team members were also actively involved; all attended workshops as well as undertaking other activities. Five staff and residents submitted recipes to the project and nineteen submitted questions to the project. At least ten staff members did not attend formal workshops but participated in various planning meetings for the workshops and read materials related to the project.

Participant information forms were filled in only sporadically at staff and resident workshops; attendance forms were completed, but it is difficult to be certain of full names (and therefore gender) in all cases due to the quality of the handwriting. Information has also been collected in discussion with dietitians and HHA staff. The information available for residents suggests: just under 50% of attendance was from BME communities; and approximately 65% were female. Overall, approximately 40% of Hexagon residents are from BME groups and 65% are female. Of the GN residents who attended workshops, the vast majority came from postcodes nearest to Hexagon Head Office – SE23 and SE6. Workshops at head office attracted these residents and fewer from further afield. The workshops open to GN residents mostly attracted residents over the age of forty; with very few under this age. However, 25 young people aged 16-21 did attend workshops, but all of these were under the banner of the C&S team. Just three residents attending GN workshops were disabled, but 21 residents with longterm mental illness attended workshops, again through work with C&S residents. One deaf resident requested a sign interpreter for a workshop, but did not respond to requests to suggest a date possible for attendance at a workshop.

Around 1/3 of staff attendance was for men, and approximately 40% was BME staff. The workshops therefore attracted a slightly lower percentage of males and a considerably lower percentage of BME staff members than these groups make up in the overall profile of HHA staffing.

4.3.4 Recruitment

Details were not kept about how specific residents or staff members had heard about 'Eat less salt' workshops so it is not possible to completely understand the best methods for recruitment. However, participants suggested that they had heard about the project through a range of means including word of mouth, or *Home News* and were then more motivated to attend a workshop if they received a direct invitation by letter.

Recruitment of GN residents was resource intensive in the form of staff time and postal costs. More than 1000 residents were invited directly to workshops by letter. Expressions of interest were followed up by post and phone, but not all who expressed interest eventually attended workshops. Almost all of the GN residents interviewed by evaluators had heard about the project and knew generally that activities were on offer even if they had not come to workshops. When the postal strike delayed letters, HHA staff provided mobile phone numbers for residents who had previously taken part in resident involvement activities so recruitment could be boosted. This form of recruitment had a response rate of approximately one in twenty, lower than the rate of around one in fifteen for letter. However, it also was cheaper and faster. HHA was keen that it be used sparingly, as residents are often not happy to have their personal telephone numbers used by their landlord except for urgent issues.

Recruitment to time bank workshops was not time consuming. The workshops ran as part of an ongoing programme of monthly cooking workshops. The workshops were also promoted to the broader membership of the time bank with the support of the coordinator. The staff support and established format enabled recruitment.

Staff recruitment was not time consuming or resource intensive. Group email to all staff members, staff noticeboards and word of mouth spread the word very easily. Awareness of the project was very high amongst staff in head office; 'Eat less salt' staff who entered the building reported many HHA staff making comments to them about salt. The project team felt that staff participation could have been further facilitated if the chief executive, directors and Board members had made the effort to come to sessions. The team also suggested that the Human Resources team could have been more involved in promoting the workshops as a high priority benefit for staff.

Workshops for C&S residents were well attended, with many of the residents in the hostels and homes where they took place turning up to them. HHA staff attributed this attendance to the encouragement of C&S staff, who heavily promoted the usefulness of the workshops. Workshops for young residents in hostels were well attended due to the active promotion of HHA staff who have

very regular contact with residents as staff offices are generally located in or very near hostel accommodation. One to one workshops with 1621 residents did not actively take off; staff suggested that residents in this project prioritised other forms of support on offer as they have many other priorities in working to maintain their first tenancies. These residents are also spread through a wider geographical area, and see less of C&S staff. However, the 1621 Project has requested further information about healthy eating from The Food Commission and has indicated it would like to continue to be able to offer some form of support in this area to tenants.

The time bank workshops conducted as part of the regular cooking club had good attendance through the three sessions despite much disruption in the Community Development team. There has not been the time to see if resident exchanges will take place as the project is coming to an end. Those who attended suggested that they would like to share what they learned with other members of the time bank through exchanges.

Workshops conducted in the daytime had higher attendance than those held in the evening. However, the evening workshops seemed to attract younger people. Workshops which covered a basic £5 expenses had no lower attendance than others; just one resident took up the offer made on publicity of a higher level of expenses for longer travel or extended childcare.

4.4 Project management and involvement context

4.4.1 Project team

The project team met quarterly with excellent attendance from all members. Project team members used their different roles within the association to facilitate access for 'Eat less salt' staff and to promote the project to staff and residents. Access to the many staff teams at the association was time consuming to coordinate. The project team facilitated this access on many occasions. The project team was a very useful source of 'inside' information in terms of how the 'Eat less salt' project was regarded by staff and residents.

None of the project team filled in the 'reflective' notebooks they were given, noting that they felt they had other means of contributing ideas about the project, but they spoke to the project evaluators and also had an evaluation meeting with The Food Commission. Their observations are included within the different sections of the Findings (Section 4) of this report. The members regarded the project team as a very useful aspect of 'Eat less salt' but noted that quarterly meetings of a maximum of 1½ hours was enough if supplemented by regular phone and email contact. All members of the project team also participated in other aspects of the project including: workshop attendance; article writing for *Home News*; organisation of workshops for staff teams; reports to the Board about the project; reading evaluation reports; review of publicity materials; organising mailings to promote the project and submission of material to the web. In total, the members of the project team committed an estimated 28 days to the project

over the year. The project simply would not have happened without their commitment.

The members of the project team noted that it would have been useful to work in partnership with other housing associations based in similar areas. The team noted that this would have facilitated attendance at workshops and also would have allowed the sharing out of organisational responsibilities.

4.4.2 Other Hexagon Housing Association staff

Many other staff at Hexagon were essential to the implementation of the project, even if they were not directly members of the project team. In the vast majority, they were very responsive to the needs of the project. The chief executive and the human resources manager met with The Food Commission, supported the project and made it clear to managers that staff could attend 'Eat less salt' meetings and workshops during working hours, with no need to make up time for this attendance. The project received priority for room bookings and all staff were cooperative about enabling access for those participating in workshops. The Customer Services team, which answers all phone enquiries to HHA, has a manager that ensured the team understood the project and what was on offer. More junior managers of staff teams, including in, for example, hostels and care homes, took part in meetings and discussions to plan workshops. The staff member in charge of the website also met with project staff on more than one occasion.

The association took ownership of the project, which was time consuming to deliver, and those doing the delivery had every support to make the project work. The planning and organisational elements were very time consuming. The offer of workshops to all staff and residents meant that many teams needed briefing. A range of forms of workshop promotion also had to be done in a range of styles. Each workshop needed to be designed to fit the needs of very different groups, and this required significant planning and discussion with staff teams. The project also needed to operate within the 'living' environment of an association conducting its primary business – offering housing. For example, the Community Development team underwent significant reorganisation during the year, and this impacted on the organisation of 'Eat less salt' workshops with the time bank, with other teams at HHA needing to step in to offer support.

4.4.3 Food Standards Agency

The relationship with the FSA was an important one for the project. The project manager, The Food Commission, has noted that this was a positive relationship. In particular, the good points of the relationship were: ease of access to decision making staff at the FSA; an awareness by the FSA of project timescales, so staff could move quickly to approve materials and articles for newsletters, but also, staff could accept that some planning took longer than expected due to the demands of community based and public sector timescales; care by FSA staff to meet the material needs of projects in terms of sorting out delivery of salt phase three resources; constructive

support in meetings and access to an experienced project manager at arm's length from the FSA; and low level requirements in terms of paperwork and reporting.

The only 'negative' aspects of the relationship were: fast timescale at the start of the project delivery (Section 4.3); lack of certainty over how the findings from the best practice work might be project funded at the conclusion of the year; and no speeches from project partners at the salt phase three launch event in March 2007.

4.5 Timescale

The project was delivered in the expected timescale. It was the view of The Food Commission, project dietitians; the project team and senior Hexagon staff (including the chief executive) that a more extended timescale, perhaps of two years, would have been more useful. The project team noted that they felt this would not necessarily have involved much more in the way of resources, simply that the same amount of activity could have been spread over a longer period. The team noted that this would have allowed: more time for the word to spread amongst staff and residents; more allowance for the timescales of a public sector organisation; more time for healthy eating initiatives to become accepted as part of the culture of the housing association; more time for staff to disseminate information about the work at national conferences and events; and more time for salt project partners to share materials.

HHA and Food Commission staff also noted that the project had a very short period from confirmation of funding to start date. This made the start of the project a rush, with too much happening at once.

4.6 Budget

The project was delivered within budget but involved The Food Commission director and some Hexagon staff in more days of work than had originally been expected. The demands of project management were more time consuming, and required more face-to-face meetings than had originally been predicted.

The project also met with some unexpected obstacles that had not been allowed for in the budget. There was a rejigging of staff in terms of project dietitians and money had to be found to enable a new dietitian to plan and develop materials. The postal strike impeded recruitment to workshops and involved staff in a range of activities to inform residents about events.

The project met its budget partly due to the support of HHA. Hexagon received £5,750 to cover 'disturbance' including staff time and use of facilities. The fee was not supposed to cover direct costs such as postage or paper. Staff members of the project team contributed approximately 28 days to the project and in total, staff of HHA contributed at least another ten days to the delivery of 'Eat less salt', not including time spent attending workshops. If 38

days were costed at £125 a day, staff contributed £4,750 in time. Approximately twenty, fully accessible venues with full IT facilities were provided for free, with staff support for participant access. Hexagon also did not charge for the following: mailings to more than 1500 residents (including stationery, printing, freepost envelopes, several days work for temporary staff to stuff envelopes, postage); support for access to their website; and photocopying of materials for workshops.

The project became 'cheaper' as the year moved on. Significant resources went into design of the intervention, including materials, and initial project management aspects. Once staff and residents knew about the project, and the delivery package was in place, costs reduced with dietitian fees the most significant aspect. Recruitment was also a significant cost, but word of mouth, the web and *Home News* began to be more useful in terms of recruitment of residents as the project wore on.

Interviews with residents at the start, middle and end of the project indicated that they were unclear that Hexagon had been provided with a fee for participation in the project. However, all but a few interviewees noted that it was a project that it was useful for HHA to be involved in.

4.7 Intervention

4.7.1 Materials

The materials distributed to everyone at Hexagon were viewed almost entirely positively by HHA staff and residents and by dietetic staff of the 'Eat less salt' project. In particular, staff and residents noted that the *Little Book of Salt* (FSA 2007) was clear and simple to use. The *Food Shopping Card* (Which 2007) was regarded as very useful for shopping trips, except by some young, C&S residents who did not think they would carry it with them as they did not use wallets, and would not remember it. Residents and staff noted on the whole that it did not occur to them to use the website for information, but noted that they did use *Home News* including trying out low salt recipes. The materials distributed in workshops were also reviewed positively with staff and residents noting clarity and quality of production.

The residents in care homes for those with longterm mental illnesses were somewhat less interested in the materials packs. Staff in those homes did suggest that the materials were useful and that they would work with residents to begin to use them in their staff supported shopping trips and cooking sessions.

The production, collation and delivery of materials to locations was a time consuming aspect of the project.

4.7.2 Workshops

Basic format, organisation and staff

Overall, the format of the sessions was well received by HHA staff and residents and by 'Eat less salt' dietetic staff. There were strong themes with regard to positive and negative aspects, but not 100% agreement on all factors. Positive aspects noted by almost all participants were: single sessions of not more than 2½ hours length; flexibility with regard to workshop format so sessions could be designed with participant needs in mind; a chance during sessions to ask questions and practice label reading; a social aspect with time to meet other participants; a chance for tasting low salt foods; materials to go away with and support on offer for future questions; a knowledgeable person delivering the workshop who seemed to know a lot about all aspects of healthy eating. The young participants were particularly keen that the person delivering the workshop was lively and that cooking and tasting was on offer.

Negative aspects were noted as: salt as the main focus of sessions with a view that broader aspects of healthy eating should be the focus of work; any need to travel by car during a workshop, for example, to get to a supermarket; catering not tasty enough or healthy enough; more foods needed for tasting during workshops if no store tour or cooking was involved; more clarity at the point of recruitment about the exact objectives of the workshops. Salt was a difficult recruiting point for young residents in particular. Most participants did not indicate that they wanted to cook in sessions, just that they wanted to taste delicious low salt food.

There were some dissenters on issues; for example, some participants felt refresher sessions at future dates would be useful; a couple felt that sessions could be longer than three hours; a few staff were very resistant to the idea of store tours even at very local venues. The staff who objected felt the tours took them away from work for too long and also that they felt a bit childish – as if they were participating in a children's television programme noted one participant. Care home staff suggested follow up workshops would be useful, as residents are unable to cope with long sessions and need regular reinforcement.

SRDs needed to be very flexible and had to have the ability to work sensitively with diverse participants. Workshop formats varied and sessions could be unpredictable. It was not always possible to know how many residents would come to a session and not possible to turn them away once they had arrived. Despite efforts to be clear about the purpose of the workshops, people came who were interested in many aspects of health other than salt consumption.

The SRDs on the whole noted positive views about the workshops including: committed participants; well organised facilities; helpful HHA staff. More negative comments were: uncertainty over numbers attending workshops; attendance of some participants who seemed more interested in other

aspects of healthy eating, not salt; the challenge of being constantly aware of the need to consider low budgets of participants; and the mixed nature of interests in the GN residents and staff groups.

Some of the dietitians and project team members suggested that staff and GN attendees were, in the majority, people, no longer young, who had begun to worry about their diet and health, perhaps through seeing older relatives develop diet related diseases. The SRDs also mentioned the challenge of running workshops with very diverse mixes of ethnicities, genders and age. Some suggestions were made that it would be good to target workshops more closely towards particular ages or risk groups or ethnicities.

General Needs workshop formats

The basic Workshop 1 formula was well reviewed by the vast majority of residents. The pace of the workshop, with the three hours divided into a range of activities was viewed as interesting, and not boring. Fun was noted as important – socialising, asking questions, tasting nice food.

Workshop 2 was the session delivered to those who attended time bank workshops. The sessions were well reviewed. Participants noted that the workshops fitted in well with the regular cooking club. However, participants noted the limited amount of time, with cooking and information provision being a lot to cram into the sessions. The stability of the sessions enabled dietitians to plan recipes and purchasing.

Staff workshop formats

Staff who attended the three hour Workshop 3 with travel to a superstore felt that the session was too long. Staff did not like travel to the store which involved a five minute drive. Some staff also commented that the store tour felt a bit childish. Staff suggested that time might be better used if products were brought in to sessions so they could practice reading without leaving head office. Staff also felt that the food provided in the session needed to strongly reflect healthy eating values. Staff noted on the whole that the person delivering a session of this length should be lively and have a sense of humour.

Staff who attended the shorter Workshop 4 format rated it more highly. The staff appreciated that the session did not include a store tour, but included label reading practice with products at the workshop.

C&S staff who attended Workshop 5 rated all aspects of it very highly. The SRD was regarded as well informed, responsive to questions and it was noted that the store tour was well organised and the short walk to the shop was appreciated. C&S staff noted that they felt they would be able to use the knowledge gained in their future work with residents.

C&S resident workshop formats

Young people enjoyed workshops that involved cooking, tasting and socialising (Workshop 7) and were more negative about any form of long presentation without cooking and tasting (Workshop 8).

One to one sessions (Workshop 9) were reviewed positively by those who took part with flexibility and personal attention valued.

Workshops in care homes were viewed positively by residents and support staff. There is a desire for short but repeated workshops that maximise attention span of residents.

Conferences

The conference sessions were busy, with HHA staff and residents engaging in a range of activities. The sessions were useful for: giving specific, individual information and guidance; sparking interest through the salt quiz and quick label reading practice; and allowing some individual discussion of ideas in project materials.

4.8 Evaluation

The evaluation process was completed as set in the original project design and methodology, with some failures of information collection.

It was difficult to manage some of the diverse data streams. For example, so many staff were involved in handling mailouts, and in form filling in that sheets could become detached from one another. Much information came back to the project that staff and resident participants did not enjoy filling in the forms, for example, the *Participant information form*. These were usually left to the end of sessions when participants were keen to get away; some participants noted that the request for information could be intrusive in a community type event. Workshop staff noted that forms (including attendance sheet, shop voucher signing and handout, *PIF*, evaluation form) could take up valuable time in short sessions. Limited information is available, but some residents and staff suggested that they were also somewhat confused by the *SFFQ* due to its unfamiliarity, and this may have deterred people. As the *PIF* was often not filled in at workshops, it led to somewhat scattered information being available about the socio-demographic characteristics of participants.

The initial evaluation saw the return of 65 *SFFQs.* Three well attended focus groups were held, involving diverse residents and staff, and information from these was used to inform project design. Notebooks were distributed to the project team to record their thoughts over the course of the project.

The interim evaluation provided information used to redesign some elements of the project. Eleven detailed exit interviews were conducted with staff (four) and residents (seven) as well as interviews done with the project team. The project dietitians also submitted reports from workshops which gave their

thoughts about the work. Evaluation forms were collected from workshop participants in many instances, but not all. *Participant information forms* were filled in more sporadically, with attendance forms filled in at all workshops.

After the interim evaluation, the following actions happened: staff workshops were shifted to extended lunch periods; store tours were moved to a more nearby location that meant a smaller store, but only a two minute walk; catering was made more healthy; level of expenses provided to residents was reduced; a project staff member was replaced with someone more experienced at working with young people; new materials and workshop style were developed for work with young people; meetings were held again with C&S teams, including the 1621 project, to explain the project further and to correct misunderstandings about what was on offer; the importance of the *Participant information form* was emphasised; the 'Healthy Hexagon' logo and website address were developed and promoted; a workshop was arranged for a housing estate location.

The final evaluation saw the return of 44 *SFFQs*, when the desired response rate was fifty. Two focus groups were held and nine telephone interviews were done. Phone interviews were conducted as these were offered as an alternative to attending focus groups; more people expressed interest in extended phone interviews than in attending groups. Interviews were done with the project team. Notebooks distributed at the start of the project were requested, but only the director of The Food Commission had filled one in. Numerical information was collected including data about distribution of materials and workshop attendance. *Participant information forms* were analysed, but again, had been filled in sporadically. Where possible, HHA staff looked at attendance lists from workshops and provided information requested on the *Participant information form* including postcode, gender, ethnicity and age category.

The *SFFQ* did not register changes in level of salt consumption, as outlined in Section 4.1.1.

4.9 Ethical issues in project operation and data usage

The project was not able to document a change in the salt intake of staff and residents through the *SFFQ*, but the qualitative information collected did indicate increased awareness, better motivation and improved reported salt behaviours in almost all of those who took part. There has been no indication of harm to any participants and the project has been reviewed almost universally favourably.

The anonymity and confidentiality of those who took part has been maintained with regard to the *SFFQs* and to the evaluation process. The project made particular efforts to ensure willing and informed consent of participants. The communication needs of residents were a part of the project design. Vulnerable residents – young people and those with mental illnesses – were supported in their participation through HHA C&S team members. All materials and formats were approved with HHA staff before workshops went

ahead. The piloting process and interim evaluation allowed changes to be put into place and the views of HHA were taken into account. For example, a change of workshop staff was made after this review. No compulsion was applied, and expenses were provided to support participation.

5. Discussion and key learning from the project

5.1 Discussion

Salt in the diet

The 'Eat less salt' project provided an effective focus for engaging staff and residents of a housing association – many of whom may be considered as hard-to-reach individuals. The relatively high rates of participation in the project were evidence for this. The qualitative data suggested that many felt that they had benefited from the initiative in terms of their knowledge, motivation, skills and ability to reduce salt intakes. In addition, some respondents intimated that they had made changes to how they shop, cook and consume food in order to cut salt intake. In addition, the qualitative element of the evaluation provided a raft of data providing insights into how best to work with these groups on healthy eating issues and specifically contextual information regarding their salt behaviours. However, the *SFFQ* failed to demonstrate any measurable impact on salt intakes within the groups involved in the evaluation, and this could be for a number of reasons.

The *SFFQ* might not actually have been a sensitive enough tool to measure self-reported salt intake accurately. Analysis actually showed average levels of salt intake at considerably lower than population averages; it would be unwise to take these measurements as reliable data. The tool is a newly developed one, and due to resource constraints (time and money) it was not possible to pilot it with a large group of staff and residents or to ask staff and residents their opinion about its ease of use, or how well they felt it captured their dietary habits. It was also not possible to validate the *SFFQ* against urinary sodium concentrations and it is generally accepted that urinary sodium is the most valid way to measure sodium intake. The project did not have the budget to do this sort of validation, but it was mentioned to HHA. Senior staff at the association and the project team noted that they would not have become involved in the project if it had had such a requirement, as they believed this would have been too intrusive. They noted that they felt it would be inappropriate for a community style project in a housing setting.

It is also notoriously difficult to accurately measure dietary intake of foods. Self-reported intakes of foods, unsupported by validated information (for example, urinary sodium, blood tests), are highly questionable for many reasons. For example, the *SFFQ* was designed to measure salt intake on one day, and as such it is not possible to say anything about the typicality of salt intake in the residents. In addition, it is possible that there are day of the week factors that might influence salt intake; that is, residents may well eat more convenience and processed foods during the weekdays meaning that any measure of salt that is only based on one day will not capture the variation in a person's intake. It is also possible that participants filling in the *SFFQ* both at the start and finish of the 'Eat less salt' project were very likely to be aware of the intention to work on reduction of salt consumption. Due to the tight scheduling around the start of the project, the evaluation time period coincided to some extent with the launch of the project. The *SFFQ* also asks

some very obvious questions about salt in the diet. It is a failing of self-reported food intakes that people may choose to paint their diet in a healthier light, in this instance, choosing to report the lowest possible salt intake or to avoid mention of consumption of highly processed foods.

Again, due to resource constraints, the *SFFQ* part of the evaluation was not designed to track individuals from the start to finish of the project. Thus, the sample of people who filled in the *SFFQ* at the start and finish are different. A tracking process would have allowed for comparisons, for example, of how individuals with differing levels of involvement in the project changed their consumption habits. Efforts were made to attempt to recruit the same individuals; the *SFFQ* was sent to the same database of residents and to all staff at the start and finish of the project. However, the time was just not available to track people down to ensure the same ones filled in forms and there was no system in place to enable that tracking. It is also important to remember that the project was essentially a community one; the same type of methodological rigour that might be required of an academic research project was not applied. The participants were not subjects; they were all free living community members under no pressure to see a study through to the end.

The sample sizes of those who returned the *SFFQ* were very small, despite more than 1500 being distributed in total, and far too low to allow any form of sensible statistical analysis. The project aimed for at least 50 returns at the start and 50 at the finish; it exceeded this at the start with 65 returns and failed at the end with just 44. However, this is to a large degree irrelevant; 50 was a somewhat random target, driven by resource constraints and not by statistical imperatives. The *SFFQ* was something of an experiment, and it was hoped that it would offer data that was more reliable. There is some indication that there was consistency in measurement, with intakes for staff and residents similar in both rounds. Perhaps the tool is measuring coherently, but not very sensitively.

It would be unwise to be drawn into detailed comment on the raw data collected either with regard to levels of salt intake or dietary patterns. The samples are so small overall, and sub-groups within them are even smaller. It would seem to compound possible error to turn a not sensitive enough quantitative tool into a not very sensitive or detailed qualitative one.

The focus groups and interviews provided interesting descriptive information about salt consumption motivation, knowledge and skills. It was important that this information was backed up by the array of other information streams, including: dietitian reports; project team insights; evaluation forms; meetings with staff. The numbers attending focus groups was just not high enough on its own. Detailed information gathered in face-to-face and phone interviews was more useful than the information on evaluation forms.

Working with housing associations

Housing associations definitely offer excellent potential for work on future healthy eating projects. The reasons for beginning this project were proved to

be good ones by the end. The association contributed hugely in terms of resources in the form of staff, money and knowledge. There is no doubt that HHA enabled access to a diverse spectrum of people and that further work could be done to better target interventions using available data. Hexagon developed a 'Healthy Hexagon' logo and area of its website during the course of the project and it hopes to pursue work on healthy eating. Requests for materials and advice have come from staff since the finish of the project.

Outside of HHA, Interest in the work has already been expressed by a senior staff member at the Housing Corporation and by other organisations involved in housing work, including The Foyer Federation, under money from the lottery Well Being programme. Two other housing associations have requested meetings to discuss the project.

However, it is unclear how easily or quickly or comprehensively work will progress on more closely uniting social housing and health initiatives. HHA staff have already noted their limited budget for community work. Although this is somewhat difficult to measure, it is approximately 1/3rd less in total than the entire budget of this project. Staff have suggested that joining up groups of RSLs might be a positive approach in terms of maximising resources, boosting attendance at sessions and avoiding support staff project fatigue.

The project was resource intensive due to its broad nature. It may have been more effective if a particular resident group had been targeted. RSLs can do this to some extent through their databases, for example, picking out males over the age of fifty who are unemployed. In this case, a single intervention could have been developed and perfected. Recruitment could have been more directly targeted towards a particular group. Many fewer meetings would had to have been held which were almost a time consuming aspect of this project. The project also did not suit the timescale of the housing association; staff noted that they would normally have run the number of 'Eat less salt' events over two years. The project would then have had time to become more well known and talked about. Staff would not have felt the organisation of events as such a pressure. Workshops could have arisen out of resident requests rather than through project demands.

Recruitment was a regular pressure and concern. The mailings to residents were not ideal as they were costly. Most people reported very positively about reading about the project in the residents' magazine which is read by a large majority of the tenant group. Word of mouth also worked well for recruitment; it was particularly used for staff sessions and C&S sessions. Word of mouth is also cheaper than mailings, what it takes is the time to make personal contacts. It was very noticeable that one meeting was not enough with staff teams in order to explain what 'Eat less salt' was all about. It took at least two face-to-face meetings to work out how both 'sides' could best work together. Face-to-face work is one of the most easily and regularly disregarded methods for recruiting the so-called hard-to-reach or what we might better call the hard-to-hear (Draper et al. 2005). Community work is community work, it means getting out of your office and talking to people.

There is not enough data from this study about the role of incentives in recruitment. HHA offers incentives in some instances for resident participation and always offers expenses at a generous level. However, HHA is also trying to wean residents off the expectation of a financial incentive and there is some evidence that that is proving entirely possible. In Draper et al. (2005) the role of incentives did not seem particularly critical in community settings, but more useful when recruiting people with no connection to a project or organisation. Expenses are critical, however, and it was useful that these were not connected to receipts, but offered at a generous flat rate, as is usually the case at HHA. Informal incentives were the subject of active comment in this project and discussion of these arise regularly in community development approaches. HHA staff and residents liked to meet other people, to get out of the house, to be offered tasty food in a pleasant venue and to feel they were participating in something useful (Sullivan 2007).

Recruitment was hindered by the fact that there is also still not enough official backing for work in this field. The Board and senior staff at HHA were keen on the project, and allowed resources to be diverted towards it, but are unlikely to pursue work in this area actively, and continuously unless there is more official direction or support from regulators. A national healthy housing association standard, similar to that in schools, could be effective if backed by resources. The 'Eat less salt' project team, which included a resident Board member, indicated that they believed the work had an uncertain future despite the fact that the association regarded the work very positively.

Salt as a topic

Many staff and residents questioned the utility of the single issue focus of workshops. Some people attended workshops hoping to discuss other aspects of health and diet in more depth. Younger people were less attracted to the issue. Some residents could see the applicability of skills, for example, label reading, across healthy eating topic areas. Others suggested they would need more support in this. The fact that community SRDs were running the workshops was useful in this matter. They are experienced at coping with running sessions on particular aspects of diet and health.

However, the project showed that there is certainly demand for workshops on broader aspects of healthy eating

Evaluating a complex community intervention

The 'Eat less salt' project commissioned the School of Integrated Health to design an appropriate evaluation framework. The rationale of the final *Evaluation Framework* (2007) was to help the project to consider whether its intervention actually worked, how it actually worked, or not, in order that the project would be more likely to be replicable. The framework also supported the project in developing measurable indicators of effectiveness. The framework was very useful throughout the project and at the end in guiding work and writing up this report. It enforced the consideration of a range of data and information streams and of an overall project rationale; the rationale

being a movement starting with raising awareness of the issue; to increasing people's knowledge and motivation with regard to salt reduction behaviours to support for the implementation of change. This rationale was pursued in all of the diverse aspects of the project.

The 'Eat less salt' project is very typical of many types of complex, community based food and healthy eating interventions. It was very diverse, and in many ways, several interventions in one. For example, residents of care homes for those with longterm mental illnesses needed a different approach to recruitment and workshops than staff or teenage mums in temporary accommodation. Yet, these people were pulled together by the same project and by an essentially similar workshop format. 'Eat less salt' takes the view that it had a quality intervention with built in flexibility, well researched, supported by partners and participants with the offer to comment during the project lifecycle. It had a core rationale and stuck with that throughout the project lifecyle and has gathered and analysed a range of evidence to support belief in the effectiveness of the project. It raised awareness, built skills and motivation and offers the support of a community development type approach, by connecting itself to the wide 'tentacles' of the Hexagon community.

The whole topic of just how to evaluate interventions such as 'Eat less salt' is a huge one; and the question of replicability outside of the original setting is still something of a mystery (Draper 11th October 2007). It is not the job of this paper to establish the absolute principles of evaluating community interventions. The 'Eat less salt' project was commissioned by the FSA and hired experts to offer guidance in the matter of effective evaluation. However, some contributions can be offered (Section 5.2).

One off workshop format

There is not enough actual data to formally evaluate the effects of the different levels of interventions upon salt consumption and behaviours. It is also not possible to completely understand the reasons people may have accessed different levels of intervention. It could be that some staff and residents were very well informed and just needed a small knowledge boost to pursue active change, others may have needed a workshop. The information from the qualitative evaluation supports a trend towards increased knowledge, skills, motivation and behaviour change as does some of the information from the *SFFQ.* This change appears stronger in some groups, for example, older residents who enjoy cooking and who have some experience of ill health. The change appears less strong in, for example, residents with longterm mental illnesses.

The evaluation does not suggest that we have provided staff and residents with all of the skills and support they need to change their behaviour, but it does suggest that we have given many people a very good start. There is evidence that HHA will continue to offer some support on an ongoing basis to staff and residents who wish to change their salt consumption habits and who wish to engage with other aspects of healthy eating.

5.2 Key learning from the project

• Evaluation – process and outcomes

The project was an effective focus for engaging hard-to-reach groups which nonetheless took considerable effort to engage participants. The qualitative element of the evaluation suggested that most participants felt they benefited and their perceived knowledge, motivation and practices to reduce salt had improved. However, the *SFFQ* failed to demonstrate any measurable impact on salt intakes within the study group included within the quantitative element of the evaluation and this could be for a number of reasons: low sample sizes; the *SFFQ* is a new tool that has not been sufficiently piloted or validated; and the difficulties around self-reported food intakes by individuals with a tendency to under-report unhealthy foods.

It was very useful to have a specially designed framework with academic theory behind it. This gave confidence throughout the project that it was progressing logically and that information would be available to measure process and outcomes. This project benefited from setting a rationale for change that was expected to lead to a hoped for outcome. Measurable indicators were set and reviewed over the course of the project to see how it is progressing.

The *SFFQ* did not perform as expected and it is questionable what it added to this project. However, it is an interesting tool which could be developed further for salt intervention projects.

Evaluation was time consuming, with the need to set up meetings and interviews. Evaluation does not happen naturally or instinctively and requires considerable data management. The importance of conducting initial, and ongoing, qualitative research to inform the design and execution of health promotion initiatives such as this was highlighted within this project. Specifically improvements on the content and delivery of the workshop sessions enhanced the targeting of the intervention.

• Setting and participants

HHA was a very supportive partner in this work. The project fit quite well with the philosophy of a housing association and was able to make great use of the association to aid recruitment of diverse people. Indications suggest that there is excellent potential for further work in RSLs on healthy eating, but more direction needs to come from housing regulators and central government if Boards and chief executives are going to commit real resources. The development of a healthy housing association standard, at national level, with associated support, might be one way forward.

There was considerable willingness across resident and staff groups to participate in the project. Keenness was expressed in further work in this broad area. Recruitment was time consuming and needed to be pursued continuously using a range of methods.

- Resources

The timescale for the project, one year, was somewhat inappropriate for the setting. It required quite intensive work for people with other jobs to do as a priority. It allowed too little time for a weight of interest and awareness to develop amongst staff and residents. Two years would have been more appropriate, with roughly the same level of resources. However, even more ideal would be some form of ongoing work on healthy eating. The HHA website was under-utilised in this area, and staff suggest that they believe there is more potential in this as a means of keeping up some engagement with healthy eating.

HHA and other associations, except for the largest, are unlikely to have enough resources on their own to pursue healthy eating workshops very actively. Partnerships between associations could be a way of maximising resources.

- *Workshops and information*

The awareness raising aspect of the project seemed very effective and useful. Some of the most useful methods for this were the lowest cost – word of mouth, bulletin boards and the resident magazines.

Residents valued information that was provided to them and commented on the ease of understanding and the quality. The work of the FSA on standardising and clarifying messages and in reviewing materials was invaluable.

One-off workshops seem to have some potential in changing knowledge and motivation across the resident groups. However, no information is yet available about the longterm maintenance of these changes. Some people need more support than one workshop can offer. Flexibility is important because some attendees were very opposed to the idea of attending workshops longer than a few hours or on more than on occasion. It is important to pay expenses and to provide decent venues with some social aspect to the event, perhaps through food tasting.

- Project management

This is time consuming and needs face-to-face meetings on a regular basis with all project stakeholders so that coherence and enthusiasm is maintained. A community project such as ‘Eat less salt’ is complex, involves large numbers of diverse individuals and takes place over considerable time. People can drift off the focus if strong management is not maintained. A project team involving stakeholders is useful for establishing key contacts who can support and direct the project more efficiently.

Professional workshop staff are invaluable as they need to deal flexibly and professionally with challenging situations. Participants quickly lose

confidence in staff who do not seem up to the job and this reflects badly upon the project.

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