Kent Integrated Adult Healthy Lifestyle

Engagement Event

**AGENDA**

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**10.00-10.15** Registration/Refreshments

**10.15-10.25** Welcome and Introductions

**10.25-10.45** Overview of Public Health Transformation Programme

**10.45-10.55** Resident Voice

**10.55-11.05** Working with Districts

**BREAK**

**11.20-12.00** Proposed Service Model for Adult Health Improvement

- Vision and outcomes
- Service overview and patient Journeys
- Communication

**12.00 - 12.20** Questions

**LUNCH**

**13.20-14.20** Workshop activities

**14.20-14.25** Procurement Timeline

**14.25-14.50** Questions

**14.50-16.00** Networking

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# Kent County Council

Background Document for

*Integrated Adult Healthy Lifestyle Service*

## 1. Background

Public Health is responsible for delivering effective prevention work via Health Improvement Services. During 2015/16, Public Health initiated a Transformation programme to respond to a number of challenges and opportunities. These included clustering of unhealthy behaviours, widening gap in health inequalities, reducing budgets and increasing demand for services as a result of unhealthy lifestyle choices.

There is clear evidence for the effectiveness of healthy lifestyles services that are designed to individuals to address unhealthy behaviours and lead healthier lives. NICE 2014 have provided guidance on individual approaches to behavioural change, which makes recommendations on individual level interventions aimed at changing health-damaging behaviours among people aged 16 or over. It includes a range of approaches, from single interventions delivered as the opportunity arises, to planned high-intensity interventions that may take place over a number of sessions. The behaviours covered relate to alcohol, diet, physical activity, sex and smoking. NICE guidance 2007, Behaviour Change to Reduce Health Inequalities showed that the following principles should be considered when tackling behaviour change in target populations;

- Base interventions on a proper assessment of the target group, where they are located and the behaviour which is to be changed;
- Work with other organisations and the community itself to decide on and develop initiatives;
- Build on the skills and knowledge that already exists in the community, for example, by encouraging networks of people who can support each other;
- Take account of and resolve problems that prevent people changing their behaviour (for example, the costs involved in taking part in exercise programmes, language barriers or buying fresh fruit and vegetables, or lack of knowledge about how to make changes);
- Base all interventions on evidence of what works;
- Train staff to help people change their behaviour.

The review of the healthy lifestyle services provided Kent County Council a thorough understanding of the potential and the limitations of the current services which include; Health Trainers, Health Checks, Stop Smoking Service, Physical Activity and Healthy Weight, in the context of new legislative obligations and guidelines. This has presented a clear case for change and has identified opportunities for a new, more integrated approach. Kent will join many other Local Authorities that are intending improved service models that deliver a more integrated and holistic approach to health improvement services, with the aim of helping residents' live healthier lives, with the appropriate support to make difficult lifestyle changes. At times of reducing budgets and increasing demand for services it is essential that services are effective and equitable and make use of things that already exist in communities to support people to live healthy lives.

## 2. Why tackle Unhealthy Behaviours

Buck and Rossini (2012), in a King's Fund report, argue that 70% of the population still have two or more unhealthy behaviours, which would equate to 827,470 adults in Kent. With those from more deprived communities, in unskilled manual labour or without qualifications having an increased risk of having all four risk behaviours. With 40% of all the deaths in England

are being related to people's behaviour, this contributes towards a widening gap in health inequalities and early death amongst deprived populations.

Helping adults make lifestyle changes today can have a positive impact on their health, now and in the future which can prevent conditions like type 2 diabetes, cancer, heart disease and reduce the risk of suffering a stroke or living with dementia, disability and frailty in later life. Living healthily in middle age can increase life expectancy and double the chances of being healthy at 70.

**3. Key Drivers for Change**

As Health and Social Care services face increasing pressure to treat people with long-term conditions, there is a growing rational for supporting people to make positive lifestyle choices earlier in life and screening for risk factors which may lead to poor health. As well as key drivers set out in the Care Act, Five Year Forward View and KCC Outcomes Framework.

**4. Delivery Model**

A proposed model outlining an integration of healthy lifestyle services was tested with the public through a consultation process. There were three elements to the consultation including an online consultation, insight work and focus groups to investigate further into people's attitudes to services and a behavioural insight study which focused on developing our understanding of why those people with the unhealthiest lifestyles are least likely to engage with our services. The findings showed support for an integrated model and highlighted a number of key themes;

- The importance of self-motivation as being key to success and there are limits as to what any service can offer.
- Mentors could potentially have a key role in influencing positive lifestyle change.
- Unhealthy behaviours are incredibly accessible and are often default coping strategies for dealing with more acute challenges, offering a way to exert choice and control.
- Unhealthy habits reinforce one another through 'negative snowballing', which indicates that an integrated model may be more likely to support people to make a sustained change.
- Identity is strongly tied to local friends and family and the area around where people live.
- People perceived health to be about both their physical and mental health.
- A high proportion of respondents felt that services should be allocated based on need.

**5. Vision and aims of the new service**

The aim of the service is to improve population lifestyles that will positively impact on the health and wellbeing of the Kent adult population. Other aims include preventing the prevalence of a number of long-term conditions, improving healthy life expectancy, reducing health inequalities and improving health outcomes for the people of Kent to reduce future demands on services.

A number of principles have been developed for the model. These include;

- Integrated - People can get all the help they need to be healthier from one service.
- Targeted - Aimed at people who need help most but still available to everyone.
- Motivating - Encouraging people to be healthier.
- Promoting independence – Helping people to be healthier so they don't need to rely on a service.
- Flexible – Meeting the needs of local people creating better choice.

**6. Scope**

**Adult Healthy Lifestyle Service – Lot 1**

The Integrated Adult Healthy Lifestyle Service will integrate healthy weight, smoking cessation, physical activity, Health Trainers and outreach health checks it will also include an element of alcohol brief intervention, with mental and emotional wellbeing underpinning the whole service delivery. The service will support individuals to address a range factors that might be affecting their lifestyle choices. Individuals will be referred, or self-refer to a central hub which will assess suitability to the programmes offered. It will also aim to address any barriers faced by individuals have in changing their unhealthy behaviours. This approach looks beyond individual behaviours, seeking to improve the overall health and wellbeing of the person. It will save the individual needing to visit a range of different services, as it is integrated, rather than individual services for a particular condition e.g. smoking or excess weight. There will be simple access and referral pathways to individuals to access the most appropriate services quickly, reducing the need to visit multiple services. The service will deliver interventions that have an evidence based approach demonstrating good practice, although this should not stop innovation and creativity to meet the specified outcomes.

Lot 1 will also include sub-contracting arrangements to GP, Pharmacy and any other qualified provider.

**Health Checks Service – Lot 2**

The nationally mandated NHS Health Check programme gives an opportunity to help people to live longer, healthier lives. It aims to improve health and wellbeing of adults aged 40-74 years through the promotion of earlier awareness, assessment, and management of the major risk factors and conditions driving premature death, disability and health inequalities in England.

The vision of the NHS Health Check service is to provide an equitable, high quality programme with greater accessibility, choice and flexibility to increase uptake of health checks resulting in improved outcomes for Kent residents.

The principles for the service are to:

- Take a Universally Proportionate approach to reduce health inequalities
- Deliver an equitable service to the population
- Person centred, flexible and promotes independence

- Evidence based, intelligence led approach following best practice
- Maximising Impact –by working with a range of other partners, considering social value and using opportunistic prevention and making every contact count to make the most of the resources available.
- High quality service- clinical effectiveness, safety and patient experience

It is expected that the service will be delivered through a range of subcontracted providers, both in primary care and other third party providers in order to deliver the service across the county and offer choice.

**Expected Benefits**

There are a number of benefits to the proposed approach. These include:

- Improved outcomes for individuals
- A consistent set of outcomes which will lead to a level of support designed to promote sustaining healthy lifestyles
- More effective use of resources by removing duplication between services
- Services that are person centred and co-designed
- The ability to measure the impact of the services by robust performance management frameworks.

**7. Partnership**

There will be a need to work in a flexible way to meet new demands, align delivery to evolving health structures and drive efficiency's over the life of the contract. It is anticipated that the provider will need to work closely with Kent Districts who may have similar outcomes as the Integrated Health Improvement service

**8. Making Every Contact Count**

MECC is about helping to enable change, both within organisations and with individuals, reaching as many people as possible with key health messages, and to guide individuals to support and help. The purpose is to create a healthier population; reduce NHS and social care costs; improve health outcomes and reduce health inequalities. Building upon the MECC agenda the development of the service across lifestyle issues would have the potential to impact upon individual behaviours and community involvement to improve health outcomes and, if targeted appropriately, reduce health inequalities.

The Provider must develop and maintain an organisational plan to ensure that staff utilise every contact that they have with service users and the public as an opportunity to maintain or improve health and wellbeing, in accordance with the principles and using the tools comprised in MECC Guidance. We want the provider to ensure that their workforce is trained to deliver the MECC agenda.

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# Results from Public Health Improvement insight and consultation

## October 2015 – March 2016

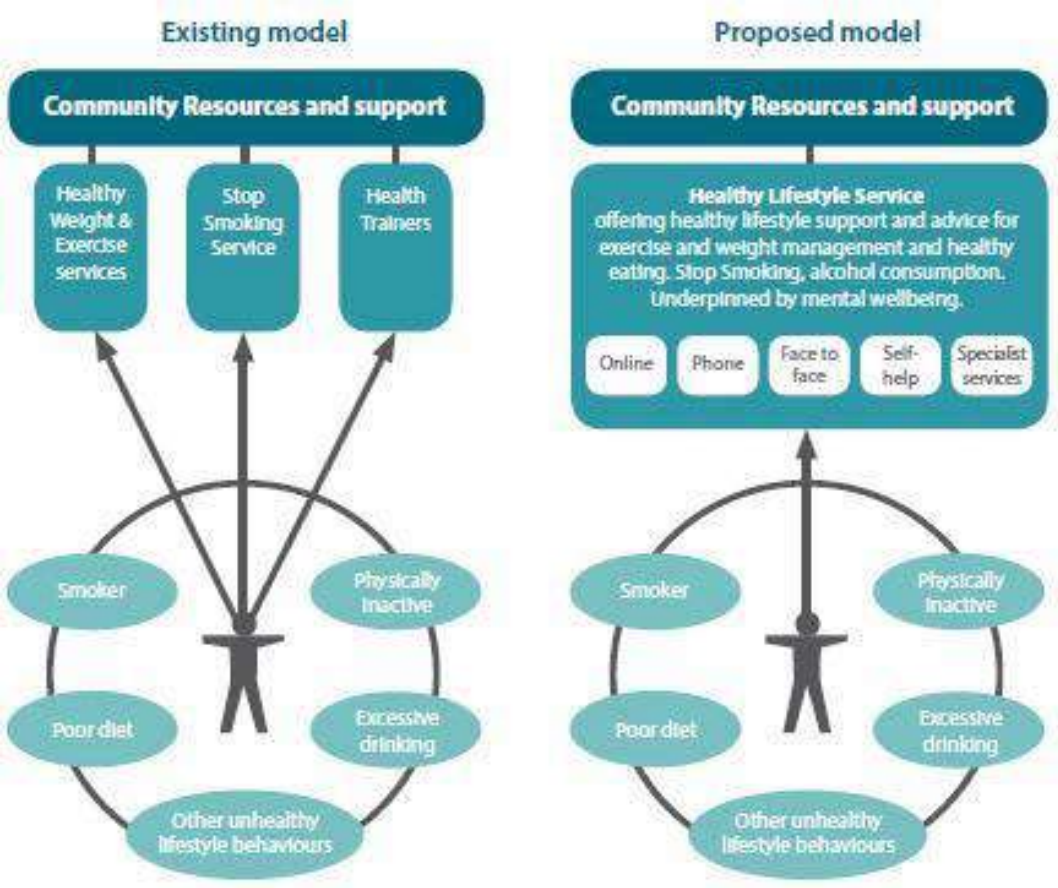
**Background**

Public Health is responsible for delivering effective prevention work via Health Improvement Services, in April 2015 KCC began a review of the use of the public health grant and the programmes commissioned through the grant. The review has provided a thorough understanding of the potential and the limitations of the current services, which include; Health Trainers, Health Checks, Stop Smoking Service, Physical Activity and Healthy Weight, in the context of new legislative obligations and guidelines. This has presented a clear case for change and has identified opportunities for a new, more integrated approach. Kent will join many other Local Authorities that are proposing improved service models that deliver a more integrated and holistic approach to health improvement services, with the aim of helping residents' live healthier lives, with the appropriate support to make difficult lifestyle changes. At times of reducing budgets and increasing demand for services it is essential that services are effective and equitable and make use of things that already exist in communities to support people to live healthy lives.

**Proposed Model**

Public Health have proposed the following model in order to integrate the current separate healthy weight, smoking cessation, physical activity and health trainer service which includes elements of health checks, alcohol mental wellbeing and sexual health services.

It is envisaged that the proposed service model will look beyond individual behaviours and seek to improve the overall health and wellbeing of the person, with mental and emotional wellbeing underpinning the whole service delivery.



In order to seek the views of service users, the public and partners, Public Health has delivered various stakeholder engagement sessions, commissioned some Insight work with target groups and carried out a public consultation on the proposed model.

## Stakeholder Engagement

During September and October the Public Health team engaged with a range of stakeholders to gather their input to the process, including Local Health and Wellbeing boards, the Local Pharmaceutical, Council, potential providers and GPs.

**Stakeholder Findings**

A number of themes have come out of the stakeholder engagement, including discussion at the majority of Local Health and Wellbeing boards, which will inform some of the core principles for the approach moving forwards.

- Health promotion across the population
    - Communications play a significant role in supporting people to take responsibility for their health, and that the approach to public health messaging could be hugely strengthened and coordinated much more with partners.
    - There is a need for a highly proactive approach to increase the coordination of campaigns, social marketing and communication channels across partners to produce high profile, high impact messages.
- A focus on health inequalities
    - A key theme has been to further identify the opportunity to enhance public health work in those communities where there are the highest health inequalities in Kent. It is clear that better use of data and intelligence and customer insights can be used to target communities with high health inequalities. Work has now begun to produce a new Kent Health Inequalities strategy - “bridging the Gap” ( note the previous strategy was ‘Mind the Gap’”). The work will support more effective targeting of health inequalities in the top 10 % most deprived areas in Kent, using data from the recent release of the updated Indices of Multiple Deprivation.

- Locally flexible services
    - The current approach has been based on a one size fits all model across Kent.
    - Future procurement should include local representation to ensure a model which varies according to local priorities. The service models in development must enable better alignment with local population need. Local representatives are welcomed to be involved in developing this model.
    - A key element of work moving forward will be to work with local community assets to support people to develop and maintain healthy lifestyles, recognising that services alone are not enough to meet the health challenges faced across Kent.

## Customer Insights

Public Health commissioned The Behavioural Architects (a specialist behavioural science agency) to conduct research into understanding drivers and barriers to health improvement among people who engage in multiple unhealthy lifestyle behaviours, specifically; smoking, risky drinking levels, a poor diet and a lack of activity. Behavioural insight was required to inform the specification and design of a new Health Improvement Service offer, and development of social marketing and health promotion campaigns in the county, aimed at this key target audience group.

The Behavioural Architects focused on developing Public Health’s understanding of why people with the unhealthiest lifestyles are least likely to engage with commissioned services. The key role of this study was to further Public Health understanding of the issues raised in The King’s Fund report ‘Clustering of unhealthy behaviours over

time - Implications for policy and practice' (August 2012). The report showed that people with no qualifications were more than five times as likely as those with higher education to engage in all four poor behaviours.

**Customer Insight methodology**
The behavioural Architects worked with twelve people over a course of two weeks to understanding their daily choices, and the influences on their behaviour.

**Customer Insight Findings**
The following themes have were identified in the Behavioural Architects work;

- Unhealthy behaviours are incredibly accessible and offer a way to exert choice and control
- Unhealthy behaviours are often default coping strategies for dealing with more acute challenges
- Identity is strongly tied to local friends and family and the area around where people live
- Consistent habit loops for all four behaviours enables them to be used interchangeably
- Unhealthy habits reinforce one another through 'negative snowballing'

The key points clearly indicate that an integrated model would be more likely to support this group of people to make a sustained change.

## Public Consultation

The proposal model was put out to public consultation over the period Monday 2nd November to Monday 14th December (inclusive).

**Consultation Findings**

160 people responded to the consultation

- The proposed model was generally well received. Three-quarters (75%) of respondents agreed with the proposed model, and only 9% disagreed.
- The level of agreement was slightly higher amongst members of the public than amongst 'Others', which comprised of users of current services (past and present), people responding on behalf of an organisation, and people responding in a professional capacity.
- All of the 5 options behind the model were felt to be important and there was little difference in the average scores given to them. The first two on the list ('Integrated' and 'targeted') received slightly higher scores than the other three.
- Respondents were somewhat divided on whether the Health Improvement Services should be 'open to everyone on a first come first served basis', 'by referral only', or 'allocated based on need, so that those with the highest levels of need get treated first'. Just over half (54%) felt that they should be allocated based on need, with the remaining respondents stating that they should be open to everyone (19%), 'by referral only' (18%) and 'other' (9%).
- The most preferred way of delivering the service was felt to be face-to-face, supported by a website/online information and telephone advice.
- The most preferred venues were GP surgeries, dedicated buildings and existing venues such as libraries and Leisure Centres. Pharmacies were least preferred by everyone.
- The main pre-requisites for the location were that it should be easily accessible, and have sufficient space to be able to provide privacy, and accommodate different types of work.
- Opinions were also divided as to whether the centres should be provided in a health related setting, with some feeling that they should, and others feeling that GP surgeries suggest illness rather than lifestyle, and that a non-health related venue would be better. Having the right ambiance so that people feel comfortable was also felt to be important.

To review the full consultation and summary please go to;
http://consultations.kent.gov.uk/consult.ti/Healthimprovement/consultationHome

**Focus Group to support the Public Consultation**
Public Health commissioned a provider, Ipsos MORI to provide a qualitative research study as part of a wider consultation, to include public survey and behavioural insights study, and it focused on securing in depth feedback through workshops with the target audiences which we wish to engage with the proposed service model.

The specific research objectives for this study were as follows:

▪ To understand how the target audience feels about the proposed service model for Adult Health Improvement Services.

▪ To identify suggested improvements to the proposed model and seek opinions on how to encourage access and engagement with it.

▪ To provide enhanced and more detailed feedback on the proposed service model which compliments that being collected through the public consultation.

**Focus Group Methodology**
Ipsos MORI delivered 12 workshops with participants reflecting the demographic make-up of Kent. The workshop took place throughout the Consultation Period (2nd November – 14th December), one in each district in Kent. Each of the workshops lasted three hours. Within the deliberative workshop approach facilitators 'set the scene' with initial high-level discussion of what healthy lifestyles are and what public health services exist, before going into more detail on specific aspects of service transformation, and conducting a series of activities to aid discussion and the development of emerging ideas and points of view.

Kent County Council and Ipsos MORI collaborated to develop activities and the use of case studies to use as stimuli, and to inform research participants about pathways into public health services. Each case was selected to inspire discussion of a range of different variables which might affect attitudes towards the proposed service transformation, such as using different types of communication channels to access health trainer support and maintain motivation.

**Focus Group Findings**
The 12 workshops showed that participants considered wellbeing to be about both their physical and mental health, the wider determinants of poor health and people are acutely aware that health inequalities exist. People recognised the limits to what Council services can and should do given that adults are in control of whether they engage in unhealthy behaviours. This suggests that the message about self-motivation as being key to success must. There is strong support for the major changes suggested by proposed service model – indeed many participants spontaneously suggested elements of the proposed model when critiquing the current model.

The workshops identified the following themes;

- It will be less disjointed and more convenient and that individuals don't have to attend separate services to address multiple health issues
- It will provide a more holistic approach to account for the underlying attitudes and outlooks of individuals which potentially contribute to their unhealthy behaviours
- It will have better follow up support to maintain discipline – put in place from the start
- It needs to be flexible of different support settings and delivery channels to suit personal preferences
- It needs to incorporate group sessions were important as can connect with people and reduce isolation
- One health trainer offers less opportunity for conflicting advice

There were some challenges which were identified including;

- Access – some worried about undersupply and some over demand

- Addressing multiple behaviours at once – too much for individuals?
- Potential generalisation of the health trainers' skills
- Consequences of not getting on with that particular health trainer
- Potential loss of services or service quality in the transition period
- Risks of using language around mental health – making reference to it being a potentially stigmatising term
- More costly than current service model

## Conclusions

The insight, engagement and consultation work that has been delivered has shown that support for an integrated model and highlighted a number of potential advantages. Addressing the concerns will be thought through the model development. The findings of the work so far allow Public Health to develop an outcome based service specification based on the needs identified. This piece of work will be conducted during summer 2016, alongside engagement with partners, and Kent residents to ensure that local needs are built into the service, and that the service will work with the wider health and social care system to provide a joined up experience for the people of Kent, supporting them to improve their lives.

It is clear that the future approach needs to look beyond services to address the issues identified and there is an opportunity to make better use of behavioural science to promote healthy lifestyles, positively influence lifestyle choices at key life stages and improve the coordination and dissemination of health messages.

There will be a greater emphasis placed on utilisation and signposting to the vast range of activities available to those living in Kent. By motivating people to access opportunities within their existing communities and build on the assets available, demand on services can be reduced and people will be better equipped to sustain behaviour changes.

There is clear scope for partners (including health commissioners and district / borough councils to work in partnership to drive better integration of services that contribute to improving Public Health outcomes and this transformation and re-commissioning will support this work to improve the health of Kent residents and reduce health inequalities.

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Ipsos MORI
Social Research Institute

Kent County Council
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January 2016

# Adults Health Improvement Service

## Workshops with the general public

# Contents

# *Executive Summary*

# Executive Summary

## Background

A new public health strategy for Kent is being developed to ensure that the future approach to public health will be based around the needs of the person, encourage personal responsibility, be delivered within integrated services and reduce health inequalities.

As part of this strategy, Kent County Council (KCC) is looking to change the way adult health improvement services are provided and it has developed a proposed service model which this research study has sought feedback on. The proposed service model will integrate the current separate healthy weight, smoking cessation, physical activity and health trainer services and include elements of health checks, alcohol and sexual health services. It is envisaged that the proposed service model will look beyond individual behaviours and seek to improve the overall health and wellbeing of the person, with mental and emotional wellbeing underpinning the whole service delivery. This proposed service model will be commissioned in early 2016 to start delivery in 2016/2017.

This qualitative research study is part of a wider consultation[1] including a public survey and behavioural insights study, and it has focused on securing in depth feedback through workshops with the target audiences that KCC wish to engage with the proposed service model.

## Research aims and objectives

The specific research objectives for this study were as follows:

- To understand how the target audience feels about the proposed service model for Adult Health Improvement Services.
- To identify suggested improvements to the proposed model and seek opinions on how to encourage access and engagement with it.
- To provide enhanced and more detailed feedback on the proposed service model which compliments that being collected through the public consultation.

## Healthy Living and KCC's public health role

Participants understood healthy lifestyles to mean eating a balanced diet, exercising, monitoring their weight and not undertaking any risky behaviour. They also thought a positive mentality and active social life was fundamental to keeping individuals happy and consequently healthy. However, leading a healthy lifestyle was viewed as expensive and time consuming.

[1] Kent County Council Health Improvement Services Consultation http://consultations.kent.gov.uk/consult.ti/Healthimprovement/consultationHome

There was a general lack of awareness of the role Kent County Council (KCC) currently played in public health and the services they provided. Participants assumed that most of the public health services were funded by the NHS rather than KCC, for example. Participants did not have a problem with KCC funding such services and felt they had a major role in public health, especially in terms of keeping parks and green spaces open, providing council leisure centres and swimming pools and in preventive educational work in schools and local communities (unaware that some of these are the responsibility of District councils). They also suggested using stricter planning processes (also unaware this is a District responsibility) to stop the proliferation of fast food shops in town centres, as well as more support for individuals on lower incomes and mental health problems to stay healthy.

Bad past experiences with the Council (though in some instances participants incorrectly assumed a District responsibility was KCC's), particularly relating to non-public health issues had impacted on some participants' confidence in KCC to deliver public health services, and consequently expressed cynicism regarding their ability to provide services that are meant to improve individuals' wellbeing. .

It was agreed that self-motivation is crucial in driving behavioural change, and therefore participants thought it was right and pragmatic that public health services concentrated on strengthening this in individuals seeking to change their behaviour. Weight management and stop smoking services had been used, but participants struggled to change their habits due to lack of continuous support and programme adaptability and flexibility.

## Current Service Model

There was an element of surprise when the current service model was introduced. Many participants did not realise the range of services on offer or they had very low awareness of them, so they were generally pleased to learn that such services were currently in place. Although they thought the current service model should be publicised more, they were concerned that a renewed push on promotion would consequently increase demand and put a strain on resources. Having said this, few said they would actually use the services currently on offer for a variety of reasons. These included: the service is not for them because they don't need a service to change their behaviour or they aren't unhealthy enough to warrant using the service, the service appeared to be disjointed (with users having to attend separate services to address multiple health behaviours). They could see this latter factor contributing to an increased drop-out rate.

There was a strong view that services had to be accessible outside of conventional working hours and should operate out of community settings that are private and confidential, of which there were plenty of suggestions below. Importantly, there should be no stigma attached to using the services, or the setting in which they were based and it would be crucial to find a way of presenting the services so that it did not emphasise mental health – even though they thought it was right to have this as an underlying element of the service. Participants were supportive the idea of a health trainer and continual face-to-face contact. Although they could identify risks with having health trainers who gave advice on the whole gamut of public health issues; they were particularly concerned about such health trainers having too generalised skills.

Participants spontaneously mentioned elements of the proposed service model when thinking about improvements to the current service model. In particular, they mentioned how they would like to have a mentor as part of their support package, how much better it is to take a more holistic approach to wellbeing, and how they would like the flexibility of getting support and advice through different channels. This would lend itself to a more tailored and personalised approach which is more person-centred. They also thought the services needed to be better linked up and spoke about establishing bespoke health centres instead of running separate services in order to prevent people getting 'lost in the

system'. Better sharing of patient information and increased communication between individual services were considered to improve the current service model and possibly the uptake of services, if people thought it could be joined up better.

## Proposed Service Model

There was strong support for the changes suggested by the proposed service model; many participants spontaneously suggested elements of the proposed model having examined the current model.

A number of elements were particularly favoured such as the more holistic model considering the 'root causes' of behaviour and wellbeing alongside physical health. The new model was thought to be more convenient and less disjointed by having support primarily through one point of contact, which in turn is thought to increase the chances of building trust and rapport between the health trainer and patient. Participants also liked that the service could be tailored to individuals needs so they could opt for some support through different channels, had a mentoring system built in, and allowed the possibility for group sessions. All of these aspects were well received and positively remarked upon.

Despite this, there was some underlying cynicism (particularly in workshops among lower social grades) that the proposed service model was 'too good to be true' and would ever become a reality. Participants were able to identify potential risks with the proposed service model, which included a generalisation of health trainers' skills, an over-demand on the services if they were adequately advertised, and that this over-demand could potentially result in long waiting lists and a more costly service.

## Proposed Service Model: Service Requirements

Participants were keen for the proposed service model to be flexible with the ability for it to be tailored to each individual's needs, so that it can be accessed through various channels to suit the individual's preferences. It should also be tailored in a way that it reflects each individual's abilities to make behaviour changes, with those needing more help to get support for as long as they needed.

Despite wanting a variety of delivery modes, participants thought face to face advice and support was the most important channel, and was likely to be the most effective way to encourage and sustain behaviour change, as well as establishing a relationship with the health trainer. Initial face to face meetings were viewed as particularly important, in order to set the foundations for the future. Ideally, the same health trainer/advisor would be seen through an individual's journey, although participants recognised there were logistical issues regarding the feasibility of this.

They felt the proposed service model needs to be accessible to those with a variety of working and family commitments. There was a desire for flexible opening hours to suit various working arrangements and cater for various needs. Some recognition was given that alternative modes of contact could be used when face-to-face advice was not possible.

Participants were fairly flexible about where face to face services should be delivered. Possible locations included civic centres, GP surgeries, leisure centres and supermarkets. The primary requirements were for them to be accessible and offer privacy.

The concept of group sessions and mentors were well received; participants considered these to be appropriate support mechanisms and able to stimulate behaviour change. There was some discussion of the practicalities of a workable mentoring system including debate around quality control (the availability of good mentors) and whether the role should

be paid or voluntary. Participants were positive about the opportunities group work offered for increasing motivation and reducing feelings of isolation.

The consensus was that the service needed to be positive in tone, welcoming, informal, fun, supportive, honest, and non-judgemental. Whilst most participants felt they would not personally make use of the proposed service model as they knew how to live a healthy life and were capable of changing their behaviour by themselves if they wanted to, they thought the proposed service model should be available to 'everyone'. However, some were concerned that this would about result in an increased demand on services by 'timewasters' (such as the 'worried well'), and wondered how this might affect access for people with genuine need, for example, people too impoverished to eat well.

## Service Promotion

In order to raise awareness of the proposed service model especially among those most in need of it, participants thought it should be widely promoted. The suggested channels and locations for promotion were extensive and included TV, local radio, posters, leaflets, newspapers, council/local newsletters, in-street promotion by staff, and social media. More creative forms of promotion were also suggested, such as outdoor cooking events to raise the profile of the service and something akin to the Sexual Health Blue Bus.

In addition to raising awareness, promotion was seen as incredibly important to dispel the underlying scepticism that the Council does not want people to access the proposed service model (in order to limit demand and therefore save on costs), a view expressed by those who felt that current services might be deliberately under-promoted for these reasons.

Future promotion of the service needs to be mindful of the context in which it is being introduced, recognising that many of the potential service users are living challenging lives which can prevent them from modifying their behaviour, and information needs to be provided in languages other than English to prevent language barriers to awareness among target groups.

Furthermore, participants exhibited a range of different mind sets which communications will need to acknowledge. For example, there is a mind-set that the services look useful but are only for very unhealthy people ('it's not for me' mentality). Another mind-set expressed was that the proposed services cannot possibly deliver what it promises, because such joined up services rarely exist. There was also a fatalistic mind-set which was that that behaviour change is down to individual choice and motivation, and there was a limit to KCC's role in directly changing individuals' behaviours through the Health Improvement Service.

## Service Positioning

Some participants were unfazed by who delivered the proposed service model adding the caveat that it would be more convincing if the successful contractor has some track record or association with public health issues. Others were impassioned about who should deliver the service as this affected how cost-effective and successful they thought the proposed service model could be. As a whole, individuals were opposed to purely profit-making organisations being involved in its delivery.

The NHS was considered to have the right skillsets required but participants did not think it should be burdened further with delivery of the proposed service model. Charities were well liked by some as potential delivery partners, although the suitability of their skillset was questioned.

There was also a strongly expressed view that the proposed service model should be delivered by KCC to maintain accountability for the service delivery quality, despite being advised that this was not a feasible scheme. Participants were generally positive or neutral about KCC branding on the proposed service model; they thought it would place KCC in a favourable light showing that it cared for, and was looking after, local communities and their wellbeing and could also help to stimulate greater trust in the council.

Participants favoured a simple and memorable name for the proposed service model but were not in agreement about whether the name should make reference to 'health' or not, and whether explicit reference should be made to mental health/wellbeing or not.

**Conclusions: 10 observations from the workshops**

**The 12 workshops showed that:**

**1. Participants considered wellbeing to be about both their physical and mental health. On this basis there would appear to be little risk of major negative reactions to wide communications that the transformed Health Improvement Service will focus on wellbeing in the round with mental and emotional wellbeing underpinning the whole service delivery.**

**2. Participants also understood the wider determinants of poor health and are acutely aware that health inequalities exist. They unfailingly could name Thanet as being most the likely area to have lower life expectancy, for example, given its social and economic profile. In this respect, it is unlikely there will be adverse negative reactions to the Public Health Team having to explain its focus on reducing the differences in outcomes within and between communities. Indeed, participants could see the link between good public health and (what they saw as) the Council's provision of municipal parks, green spaces, leisure centres and so on. Some felt these things might be more effective in tackling poor health than direct interventions where self motivation of the indivdual is key to successful outcomes.**

**3. By this token, many participants supported the concept of KCC funding public health services. It may be worth communicating what other activities KCC is involved in to reduce health inequalities alongside the Health Improvement Service. For example, what preventive educational work in schools and local communities is taking place, and how it is working with the District councils to address things like planning and the public realm.**

**4. However, there may be too high expectations of what the Council can and should do given that adult people have their own free will and ultimately are in control of whether they engage in unhealthy behaviours. This suggests that the message about self-motivation being key to success must be consistently conveyed, as the Health Improvement Service cannot 'make' people healthy.**

**5. There is strong support for the major changes suggested by proposed service model – indeed many participants spontaneously suggested elements of the proposed model when critiquing the current model. However, there are some tricky mindsets to manage. Firstly, among sceptics who feel that the proposed Health Improvement Service is being introduced primarily to cut costs, not because it could be more effective or efficient. And secondly, among cynics who have previously had negative experiences of (what they assumed were) council services or the NHS and do not believe a public health**

**service would be able to help them. There is also a fatalistic mindset, which is that its up to individuals' to make the change in their unhealthy behaviours, could this be a waste of time in many cases?**

**6. Participants viewed acquiring or maintaining a healthy lifestyle as expensive and time consuming. Therefore, there is mileage in emphasising the free nature of the Health Improvement Service and any other things that might allay fears about expense (free phone or low-cost telephone numbers) or pressure on their time or unreasonable time commitments (choice of channel is important, as is flexibility and access outside of conventional working hours).**

**7. There was a genuine concern that if the new Health Improvement Service is promoted effectively (currently it is not viewed as such) that there would be 'over-demand' – especially if GPs started to refer people more proactively. There may be mileage in explaining that the services are far from full capacity and in fact, it has been under-utilised in the past.**

**8. Also, it is worth trying to tackle what people feel are risks of the proposed model without it seeming defensive: Things like the skills of health trainer not being too generic to be effective, the skills of mentors, and so on.**

**9. There was no consensus about the best community settings in which to base the Health Improvement Service. On one hand it is desirable to make use of existing community assets but on the other hand, there is a strong appeal in having a bespoke service in a dedicated setting. This might help remove a potential stigma attached to using the new services and might help to give it a 'professional' feel. Whether there can be a mix of both is worth discussion.**

**10. It was felt the service should to be tailored to individuals' needs. There was a strong sense that anyone who was accepted onto the service, who was motivated and committed to changing behaviour should be given support for as long as they needed it in a way they prefer, until some tangible results can be realistically achieved.**

# 1 Background

# 1 Background

This chapter provides an overview of the research programme, looking at the background to the project, its aims and objectives and the methodology undertaken.

## Background to the study

A new public health strategy for Kent is being developed to ensure that the future approach to public health will be based around the needs of the person, encourage personal responsibility, be delivered within integrated services and reduce health inequalities.

As part of this strategy, Kent County Council (KCC) is looking to change the way adult health improvement services are provided and it has developed a proposed service model which this research study has sought feedback on. The proposed service model will integrate the current separate healthy weight, smoking cessation, physical activity and health trainer services and include elements of health checks, alcohol and sexual health services. It is envisaged that the proposed service model will look beyond individual behaviours and seek to improve the overall health and wellbeing of the person, with mental and emotional wellbeing underpinning the whole service delivery. This proposed service model will be commissioned in early 2016 to start delivery in 2016/2017.

This qualitative research study is part of a wider consultation[2] including a public survey and behavioural insights study, and it has focused on securing in depth feedback through workshops with the target audiences that KCC wish to engage with the proposed service model.

## Research aims and objectives

The specific research objectives for this study were as follows:

- To understand how the target audience feels about the proposed service model for Adult Health Improvement Services.
- To identify suggested improvements to the proposed model and seek opinions on how to encourage access and engagement with it.
- To provide enhanced and more detailed feedback on the proposed service model which compliments that being collected through the public consultation.

## Research approach and methodology

To meet the objectives of this study a qualitative approach was adopted in order to provide detailed insights into the views of those taking part. The discussions covered participants' reactions to current service provision, examining what was working well and where improvements could be made before moving on to explore the proposed service model. Since

[2] Kent County Council Health Improvement Services Consultation http://consultations.kent.gov.uk/consult.ti/Healthimprovement/consultationHome

the subject area of service redesign can be complex, a deliberative technique was used. This involved providing participants with detailed information at various stages of the research process, so that they were then able to clearly understand the issue and the options available, with the aim of equipping them to decide the best way forward.

Twelve workshops took place throughout the Consultation Period (2nd November – 14th December), one in each district in Kent. Each lasted three hours – this extended length of time allowed for a lot of information to be imparted to participants and for their feedback to move beyond their top-of-mind views. The workshops followed a discussion guide, designed in conjunction with KCC. Pilot workshops were conducted in Tonbridge and Malling and Sevenoaks to test the right questions and techniques were being employed and subsequent changes to the discussion guide were made in agreement with KCC.

Within the deliberative workshop approach facilitators 'set the scene' with initial high-level discussion of what healthy lifestyles are and what public health services exist, before going into more detail on specific aspects of service transformation, and conducting a series of activities to aid discussion and the development of emerging ideas and points of view.

Kent County Council and Ipsos MORI collaborated to develop activities and the use of case studies to use as stimuli, and to inform research participants about pathways into public health services. Each case was selected to inspire discussion of a range of different variables which might affect attitudes towards the proposed service transformation, such as using different types of communication channels to access health trainer support and maintain motivation.

## Recruitment

KCC was interested in hearing the views of potential service users and to ensure the research participants reflected various equality groups. As such, quotas were set at the recruitment stage. All participants exhibited a health behaviour which could be addressed by the proposed service model (smoker, higher risk drinker, undertake low levels of physical activity and/or self-identified as being overweight) and broadly half expressed a desire to change one or more of these behaviours.

Participants were recruited using a 'free-find' technique, meaning they were approached and invited to take part in the workshops on the street, as opposed to being selected from a list of people who have registered their interest in taking part in research projects. This method enables access to the views of people who are 'fresh' to the research process rather than those who frequently participate in research. All recruitment was handled by Ipsos MORI's in-house recruitment team. Participation was encouraged by offering participants a cash incentive to thank them for their time and contribution. The profile of the workshops is shown below.

Profile of the workshops

| | Social Grade | Age | Other characteristics |
|---|---|---|---|
| **Tonbridge and Malling** | ABC1 | 55+ | |
| **Sevenoaks** | ABC1 | 18-30 | |
| **Swale** | C2DE | 65+ | Long term illness |
| **Canterbury** | C1C2 | 18-34 | Eastern European |
| **Maidstone** | C2D | 35-64 | Men only, all manual/routine workers |
| **Tunbridge Wells** | ABC1 | 31-54 | |
| **Thanet** | C2DE | 18-31 | Mix of NEET and long term benefit reliant |
| **Dover** | C2DE | 31-54 | Long term benefit reliant |
| **Ashford** | C2DE | 16-40 | Women only, pregnant/on maternity leave/single parent of child under 16 |
| **Shepway** | C2DE | 55+ | |
| **Gravesend** | C1C2D | 35-64 | Women only, Indian/Pakistani/Bangladeshi, mix of religions |
| **Dartford** | C1C2D | 36-64 | Black African/Caribbean/British |

## Presentation and interpretation of the data

It is important to note that qualitative research is used to shed light on why people hold particular views, rather than to estimate or quantify how many people hold those views. Such research is intended to be illustrative and detailed rather than statistically representative of a wider population and, as such, does not permit conclusions to be drawn about the extent to which something is happening. It also enables researchers to test the strength of people's opinions. With this in mind, when interpreting the findings from this research, it should be remembered that the results are not based on quantitative statistical evidence but, like all qualitative research, on a small number of people who have discussed the relevant issues in depth.

Verbatim comments from the interviews have been included within this report to provide evidence of participants' views. Quotations should not be interpreted as defining the views of all participants, but have been selected to provide insight into a particular issue or topic expressed at a particular point in time. Where quotations have been provided, they have been identified as belonging to one of the groups involved in the research.

The following chapters of this report will now discuss detailed findings from the twelve workshops.

# 2 Healthy Living and KCC's Public Health Role

# 2 Healthy Living and KCC's Public Health Role

This chapter explores the context into which the proposed service model is being introduced. Understanding how the target audience feel about healthy living and what they perceive to be KCC's role in that is instrumental to understanding their response to the proposed service model.

**Summary of key points**

- Participants understood healthy lifestyles to mean eating a balanced diet, exercising, monitoring their weight and not undertaking in risky behaviours. They also thought a positive mentality and active social life were fundamental to keeping individuals happy and consequently healthy.
- Despite recognising what a healthy lifestyle entails, it was viewed as expensive and time consuming to lead and maintain.
- There was a general lack of awareness of KCC's role in public health and the services currently provided to assist residents in living a healthier life. Participants did not have an aversion to KCC's role in public health but rather they could grasp the Council's potential impact on the wider determinants of health, especially in terms of what they assumed was KCC;s role in keeping parks and green spaces open, providing council leisure centres and swimming pools and in preventative educational work in schools and local communities.
- It was felt that KCC could do more to support individuals who were raising families on low incomes and for individuals living with mental health problems to stay healthy.
- Some individuals talked of previous encounters with non-public health services they assume were provided by KCC that had reduced their level of trust and confidence in the Council. This generated a degree of scepticism about the quality and delivery of current public health services provided by KCC.
- Participants thought personal responsibility and self-motivation were crucial in making and sustaining behavioural changes, and therefore the focus of public health services on motivation is seen as sensible.
- Participants were most likely to have made use of services for weight management and smoking cessation, but often they struggled to change their habits due (in part) to lack of continuous support and/or programme flexibility.

## Healthy lifestyles

Participants were initially asked to name the words and phrases they associated with 'healthy lifestyles' to understand what this meant to them. In doing so the importance of exercise, a balanced diet, monitoring their weight and alcohol consumption, and not engaging in risky behaviours such as smoking were all mentioned. Access to open, green spaces with low pollution levels and clean air was additionally considered an important aspect of keeping healthy.

Mental health was also mentioned as a key factor, particularly so in workshops with younger people and mothers who were concerned about a lack of mental health support and services for children and students. These participants showed

an appreciation of mental wellbeing being related to physical wellbeing, that stress can cause ill health and vice versa. Participants believed that a good work-life balance with relatively low stress levels was necessary to maintain a healthy lifestyle, and were concerned that increased workforce insecurities and pressures meant this was difficult to obtain. Challenging and stimulating their minds with activities, in addition to a positive outlook on life and active social connections were fundamental to keeping them happy and consequently healthy.

***"I think you're happy if you're healthy aren't you?"***
*16-40, C2DE, Ashford*

***"Friendship is so important, because if you haven't got friends around you especially when you move in at an older age... friends literally make you happy."***
*55+, ABC1, Tonbridge and Malling*

Participants spoke of seeing a doctor as soon as they felt unwell, to maintain their health and to prevent any future illnesses. For this reason, having access to health professionals was felt to be important in order to have a healthy lifestyle, as well as educating and encouraging people to take up the preventative health opportunities they are offered without feeling embarrassed, such as cancer screenings.

***"It's a case of embarrassment really; we need to educate people to take up opportunities for health screenings."***
*55+, ABC1, Tonbridge and Malling*

Schools were seen to be as a suitable avenue through which healthy behaviours could be publicised, promoted and engrained in children from a young age, through various means such as walking buses, cycling schemes, healthy lunch guidelines, and cooking classes. Participants spoke of learned behaviours and education at a young age being pivotal in promoting healthy lifestyles, and a lack of education within families as well as schools causing people to lead unhealthy lives.

***"Your educational background helps you to make choices, if nobody has educated me about what impact fruit and vegetables has on me then I will only go and buy McDonalds."***
*35-64, C1C2D, Dartford*

***"Education is really important because with little ones if you have education by the time they are our age they will know what to eat."***
*35-64, C1C2D, Dartford*

However, education was not only seen as a role for the school; this was seen as something KCC could play a larger role in.

## Barriers to healthy lifestyles

Although healthy lifestyles were viewed positively as something which participants wanted to achieve, there was discussion about the financial and logistical issues of how they could attain this for both themselves and their families. They acknowledged that they could be healthier, but their busy lifestyles often got in the way. There was consensus about how time consuming it was to prepare healthy meals and exercise whilst working - sometimes odd or unsocial hours - and looking after a family.

***"The ideas [we've come up with] are great but there are a lot of things you can't always fit in."***
*16-40, C2DE, Ashford*

Additionally, it was felt that healthy lifestyles were more attainable for the wealthy, and the price of healthy food and gyms were putting additional pressures on those on lower incomes. They appreciated that although money could not grant happiness, it could provide opportunities and choices in life that would otherwise not be offered. This view was held by individuals from across the spectrum of social grades.

***"A lot of people on benefits can't afford to go out and buy fresh produce."***
*31-54, C2DE, Dover*

***"You can go on diets and go to the gym, but it does cost a lot of money. The healthy options are always expensive – salads, pots of fruit. It's expensive to be healthy."***
*18-30, ABC1, Sevenoaks*

***"If you have a reasonable amount of money you can achieve a healthier lifestyle than if you are on a tight budget."***
*31-54, ABC1, Tunbridge Wells*

Despite this, there was recognition that one could eat healthily on a budget and exercise without using a gym if they were sufficiently self-motivated. Self-motivation was considered an important factor when leading a healthy lifestyle; one could have all the resources, but a lack of self-motivation would hinder any chance of success.

***"You don't need a gym to lead a healthy lifestyles… everyone can do it, it's whether they choose to."***
*31-54, C2DE, Dover*

***"We're all habitual people. Once you start a habit, like exercise, you're more likely to continue. You can have all the money in the world but if you don't have the motivation you're not going to do it."***
*55+, C2DE, Shepway*

## KCC's public health role

Participants knew little about KCC's role in public health and the services it funds. They were not adverse to KCC having a role in public health, indeed they were quick to grasp that KCC had a role in the wider determinants of health talking about (what they assumed was) the Council's responsibility for keeping parks and green spaces open, providing council leisure centres and swimming pools, and in preventative educational work.

### Education

Participants thought education was a key area in which KCC could have a role, such as running fitness and healthy eating programmes, especially at secondary school when participants felt bad habits were picked-up. Young mothers especially felt that KCC needed to have a greater input in schools to reduce peer pressure and make children aware of the future impacts of their unhealthy behaviours.

***"My impression is primary schools teach kids about good eating but it's lost when they go to secondary school where you end up with vending machines and bad food served to them. It seems to fall to the wayside at secondary school."***
31-54, ABC1, Tunbridge Wells

***"I used to drink a lot of diet coke, and when I looked into it, I was shocked. People don't realise. They are not evil. They need to be educated."***
35-64, C2D, Maidstone

Related to this, participants thought that KCC should do more to prevent fast food and other unhealthy settings opening near schools (not realising this is a District responsibility), and that the Council could take on more of an educative role in delivering health prevention and healthy living courses to the general public, which they assumed the NHS has provided thus far.

***"Bookmakers and pubs affect people's health too. In Maidstone, it's become all about bookmakers, pubs and takeaways."***
35-64, C2D, Maidstone

Although planning is a District council responsibility, these kinds of views nevertheless show that the public feel that local councils could use their considerable powers more effectively to preserve the wellbeing of the public.

### Family support

Many participants talked about the stresses of daily life and ways in which they thought KCC could help. This was a particularly pertinent topic in workshops with mothers of young children, who thought that feeding their children was one of the most stressful aspects of parenthood. As a result, mothers would welcome support from the Council very early on, or even during pregnancy about how their own eating habits might influence their children's, or actions to take if children were not eating properly.

***"As a parent, getting your child to eat is the most stressful thing, to eat the right things and eat enough. I get so stressed."***
*16-40, Ashford, C2DE*

***"I think it should start with pregnancy, there's nothing free or offered to you. In ante-natal classes, you'd think they'd teach you certain things."***
*16-40, Ashford, C2DE*

Despite this, mothers did not wish to be told what to do by KCC; whilst they would be reassured that advice and support from KCC were available if needed, they might still rely on their own instincts when posed with challenges.

In some of the workshops, participants described the struggles they face to make sure their children have enough to eat. Some individuals suggested that KCC should look at healthy diet in a different way and provide services for malnourished people, particularly children, rather than solely focusing on services for those who are overweight.

### Subsidising exercise facilities

Given cost was one of the key barriers continually raised as to why healthy lifestyles were hard to achieve, participants were quick to suggest KCC could make exercise cheaper, for example, through reduced pricing of Council funded leisure centre services. Although participants were aware of outdoor gyms and (what they saw as) KCC's role in their provision and upkeep, they were not seen to be particularly safe spaces or practical during bad weather. Instead they were eager for KCC to subsidise indoor gyms and leisure facilities such as swimming to increase the likelihood of using them (not realising this is a District responsibility).

### Mental health

Particularly in workshops with younger people, participants felt there were a lack of available mental health services, and there was a stigma surrounding mental health which the Council could do more to address.

***"We don't talk about it [mental health]. This is one of the only places I've ever talked about it. People talk about being overweight, but mental health needs to be socially acceptable to actually talk about it. Start as young as you can get, and normalise it for people. So they're not talking about something alien, it's something that happens to real people."***
*18-30, ABC1, Sevenoaks*

***"People will say to you – you need to lose weight, stop drinking. With mental health, you can't necessarily see that someone is suffering. And people aren't necessarily open because of the stigma. A lot of that is culture – how we normalise things, make things talkable about. It's education again. The council should do things in primary schools, right from the bottom up."***
*18-30, ABC1, Sevenoaks*

There was concern that the demand for children's counselling services outstripped supply, and that today's children were more subject to mental issues than in previous generations. One mother worried that her child's counselling services were being cut and was concerned that she was being directed to an alternative service that wouldn't be as effective.

***"There are so many children suffering from abuse, they've cut down all counselling services for children. This 'live it well' website is adult based. My daughter has to use the adult services as they've cut the children services. These issues have to be addressed as and when they happen, not just depending on age."***
*16-40, C2DE, Ashford*

## Awareness of current public health services

Participants were presented with a list of public health service presently funded by KCC. In general, awareness levels of the current services was low. There were some awareness of the weight management, health checks and mental wellbeing services, though participants thought most of the services were funded by the NHS rather than KCC. They wondered if GPs were fully aware of the services because, if so, they thought more people would have heard of them or have been referred to them.

***"I would associate KCC with education and the NHS with this [services on handout]."***
*31-54, ABC1, Tunbridge Wells*

***"It sounds like GPs don't know about KCC services otherwise would refer people to them."***
*31-54, ABC1, Tunbridge Wells*

In some workshops there was a general disbelief that KCC funded all the services listed given awareness of them was so low. Some cynicism was expressed (particularly by those from lower social grades) about the range of services, with individuals feeling that the services were poorly promoted to avoid high levels of demand and thus to save resources.

***"If they do all of this, how come we don't know about it?"***
*55+, C2DE, Shepway*

***"I can't help feeling that they are not advertising them so they can save money."***
*35-54, C2D, Maidstone*

Some scepticism was also expressed about the viability of the listed services given the funding cuts being faced by KCC.

***"I think this is great. My first concern seeing the breadth of this is the government has cut its grant to councils by fifty per cent to what it was before the crash. This is great, it will support people, particularly mental health services, but are they starting something they'll be able to continue?"***
*55+, C2DE, Shepway*

Where participants expressed scepticism over the current services, this tended to be fuelled or heightened by negative encounters with the Council previously. Some participants told stories of turning to the Council (when in reality they may have been turning to a District council) for help with housing and employment only to be 'passed from pillar to post' and being told they could not be helped despite being given contradictory advice to suggest they were entitled to help. Such experiences affected these individuals' confidence in KCC and the services provided by the Council, and reduced the likeliness that they would go to KCC for help in the future. For these people, there was some doubt that public health services would be any different.

***"These bad experiences put you off going to KCC for help with anything."***
*16-40, C2DE, Ashford*

## Moderation activity and current service use

Individuals talked of knowing what they needed to do to be healthier, but it was difficult doing it sometimes, with the reality of taking action limited by available time and energy. They referred to self-motivation and the need for the individual to drive their own behaviour change rather than being reliant on KCC to provide services for them, emphasising the importance of a state of mind and willpower.

***"When I decided to give up smoking, I didn't have time to go to a GP. I did it myself. I used a vaporiser. I've attempted to give up smoking a couple of times and failed. I hope I've cracked it this time, but it's hard. The only reason I gave up smoking is because I wanted to do it. Ideally you've got to want to do it. It's down to you."***
*18-30, ABC1, Sevenoaks*

Across all social grades it was acknowledged that individuals have personal responsibility for their health, regardless of KCC's role in public health.

***"It's hard for the Council because at the end of the day, it's your own free choice as to what you will eat and whether you buy from takeaways."***
*35-54, C2D, Maidstone*

***"I don't think we should expect as much as the list. It's taking the initiative away from me as I should look after myself. You don't need someone to tell you 'stop today' you've got to do it yourself."***
*55+, C2DE, Shepway*

### Current service use

There was limited experience across the workshops of individuals having used a public health service funded by KCC. Whilst some participants mentioned using Alcoholic Anonymous (AA) services and mental health services, the most common services used were weight management programmes such as Weight Watchers or Slimming World. Those who had used them liked the idea of a social group environment motivating them to change their behaviour, but some found it hard to maintain the discipline.

Others spoke about needing a GP referral to shock them into changing their behaviour, as in the case of an individual who had chest pains and was referred by his GP to the weight loss service.

***"The GP referral encouraged me. When you sit down and see what you put inside of yourself at the weight management place, it scares the s*** out of you. The Council should do it for longer than 10 weeks. I think 80 per cent of people would go if their GP referred them. You take better notice of the GP. It helps admit to yourself that you have a problem."***
*35-54, C2D, Maidstone*

Smoking cessation services were the other most commonly used service, although participants had a lack of success with these. Participants thought these courses, which they were referred to by their GP, increased their stress levels and made them start smoking more, rather than stopping them. The rigid structure of the courses had a large impact on the success rates; if the support was not appropriate or flexible for their lifestyle, then people found it hard to make (or maintain) any changes.

***"I struggled with giving up smoking. The support is b*******. They don't ring when you need them to ring you. And they ring you when you're fine. I phoned up the national quit line, they're meant to give you calls and texts to encourage and motivate you but it's always at the wrong time, dinner time, school run… can you not just ring at a sensible time that's not 6pm in an evening? It's too late then. It stressed me out more to be honest."***
*16-40, C2DE, Ashford*

Others did not have continuous support, which made them wonder why they were referred on to the scheme in the first instance if follow up care was not in place from the beginning.

***"Why start something with me when they couldn't support me any more due to funding?"***
*55+, C2DE, Shepway*

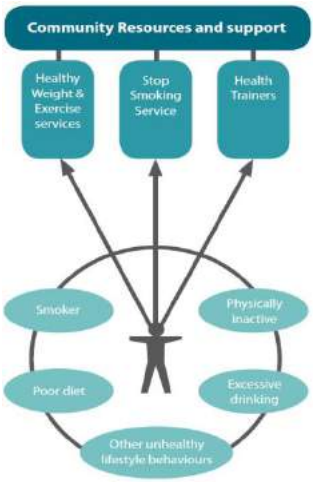
***"If you do a 10 week course, you still haven't stopped smoking, so you need that continual support. You need it for at least a year."***

*35-64, C2D, Maidstone*

Those who had managed to quit smoking had done so either by using medication, or through sheer determination and willpower, stating it was often easier if they had another person they could cut down with, such as a friend or partner.

# 3 The Current Service Model

# 3 The Current Service Model




Before being shown the proposed service model, participants were explained how services are currently structured. This chapter explores responses to the current service model, giving consideration to participants' suggested improvements.

**Summary of key points**

- There was an element of surprise when the current service model was introduced to participants. Many had no knowledge of the current service model and were pleased to learn of its existence. For some, the scepticism continued with suggestions of the current service model being 'just a front' so that KCC was seen to provide these services.
- Participants were fairly quick to critique the current service model for being 'disjointed' with users having to attend separate services to address multiple health issues which may well be associated. It was hypothesised that splitting up the user journey in this way increased the likelihood of people dropping out.
- It was suggested that the service could become more effective if individuals sought advice about multiple lifestyle issues from the same health trainer. However, some participants felt health trainers would become a 'jack of all trades' which could reduce their effectiveness. This generalisation of skills was raised again later in the workshops as a risk of the proposed service model (as discussed in Chapter 4). Other participants therefore thought the solution was to have a health centre or 'hub' where multiple advisors could be seen for the different behavioural issues but that this could be done in one place where service users' notes could be shared centrally.
- Participants spontaneously mentioned other elements of the proposed service model when thinking about improvements to the current service model. In particular, they mentioned the concept of a mentor, needing a more holistic approach, and the flexibility of different support settings and delivery channels to suit personal preferences.

## Response to the current service model

There was an element of surprise when the current service model was introduced to participants. Prior to seeing this and the list of current public health services funded by KCC, many did not realise what was on offer so they were pleased to hear this model was currently in place. Several participants wondered why they themselves had never been directed to any of the services by their doctors when they had needed support.

***"If this exists then it is great I want to know where it is and how to access it."***
*35-64, C1C2D, Gravesend*

***"I think it sounds quite good actually. I think it's amazing if people can get 7 weeks from an adviser to stop smoking. That wasn't available when I stopped smoking."***
*31-54, ABC1, Tunbridge Wells*

Participants also acknowledged that the current service model was a good starting point, but they believed self-motivation was still needed if services were to be utilised to their full potential.

***"It's a good thing really to start people off, but if you stop smoking, you do it because you really want to do it."***
*31-54, C2DE, Dover*

Whilst some participants were appreciative that the current service model exists, the cynicism expressed earlier by some continued with claims that the services were 'just a front'.

***"It's just a front – they [KCC] have to have something in place so that they look decent. But it's not really proper. I don't think a lot of these services really help. It's up to the individual."***
*35-54, C2D, Maidstone*

Aside from this cynicism, the main criticism levelled against the current service model was that its structure was 'messy' and 'disjointed' with individuals having to seek help from separate services to address multiple – probably related - issues. As a result, participants hypothesised that service users were unlikely to commit to accessing multiple services and that the drop-out rate was likely to be high.

***"It's messy because you go from here to here to here."***
*55+, ABC1, Tonbridge and Malling*

***"If you are one of these people who have to access all of those [services] and there are six different things to go to, you are not going to go to them."***
*31-54, ABC1, Tunbridge Wells*

***"It's not a holistic approach, you are not looking at causes, and it's disjointed."***
*31-54, ABC1, Tunbridge Wells*

They thought they would get frustrated if they had to see different people in different places, which would only add to the stress of changing their target behaviour in the first place.

***"I would have got frustrated, it's too much like hard work, all the different people in different places, adding to the stress."***
*18-30, C2DE, Thanet*

When analysing the 'Adam' case study (see Appendices), participants were concerned that there was no central point of contact, and care for the service user would suffer as a result. Whilst some thought that GPs should be the main point of contact as they would be able to help with all the behavioural issues, participants recognised the burdens currently facing the GP profession. Participants suggested it was important for service users to have a 'case worker', or a health trainer who would be responsible for monitoring their progress, and to increase motivation, rather than the individual being passed between different advisors without fostering a relationship with any of them.

***"He's [Adam] being passed along a little production line. You need to feel like someone cares and is concerned about your health."***
*35-54, C2D, Maidstone*

They had concerns about the independent services not working well together and cited possible examples where conflicting advice was given by different advisors, each of whom is focused solely on addressing one behaviour.

***"If they're all independently run, what's to say they don't overlap the wrong way? What if your advice to eat something isn't good if you're giving up smoking? They need to work together."***
*16-40, C2DE, Ashford*

Additionally, participants did not feel that the current service model was efficient and thought vast improvements could be made to ensure that knowledge was not wasted due to the services being separate from one another. In particular, in analysing the 'Adam' case study, they felt that the separate professionals helping him had relevant knowledge that they could provide, but did not offer as he was being directed to another service which could offer him this guidance instead.

***"The very fact that it says Tracy refers him to healthy eating and refers him on infers she has some knowledge about healthy eating so it's wasting knowledge. They could advise them on other things. Adam then has a one stop shop and everyone's helping him. It might be too much for him to change all things at once but the same person will build up a relationship so Adam might be more likely to change his behaviour if he knows that person, they know what works for him, his brain, how he likes to work, how they can motivate him."***
*55+, ABC1, Tonbridge and Malling*

## Suggested improvements to the current service model

To overcome what they described as the inefficiencies of the current service model, participants broadly suggested two options. One was for service users to seek advice for multiple behavioural issues from one individual. Many participants could envisage an improved service working in the same terms as the proposed model; they thought it would be better if they had one central point to speak to about a range of behaviours, who could work with them to manage these.

***"Doesn't that seem a little bit diluted to you? In order to get access to all 3 services, you have to book 3 different appointments and get 3 different referrals. This model is almost designed to make you give up on 2 of these services, if not all 3. If you're working 9 to 5, you're not going to have time for all 3 of these, especially if you have to go through the process 3 times. It would be much better if you could go to one person and say – I'm fat, I'm unhealthy and I smoke."***
*18-30, ABC1, Sevenoaks*

Not everyone agreed with this approach however as there was some concern that individual health trainers would become a 'jack of all trades' with limited expertise in specific areas. They questioned the qualifications of health trainers, and whether they would be sufficiently qualified in helping with multiple behaviours – this was raised again by some as a risk of the proposed service model (discussed further in Chapter 4).

***"I wouldn't be happy with one person for doing three things together … I wouldn't be happy with one person doing a three person job."***
*31-54, C2DE, Dover*

***"The problem with that is you get jack of all trades and cannot focus on one particular area. You need more interplay between the individual services."***

*31-54, ABC1, Tunbridge Wells*

This led some participants to suggest an alternative approach which was for the separate services to be provided in a central 'hub' where people could go to see multiple advisors who specialised in particular lifestyle issues but that it could be done in one place. Underpinning the concept of this 'hub' was that information about service users would be shared centrally and readily available for each health trainer meaning they were apprised of service users' history and progress. This is discussed further in Chapter 5.

***"It would be better if there was a health centre instead of going to two or three different places."***
*18-34, C1C2, Canterbury*

***"If someone has all these problems, you should have it all in one block and that's that."***
*55+, ABC1, Tonbridge and Malling*

***"I think there should be a centre so you don't get lost in the system. If there's one place, you don't have to sorry about dealing with different things. If it's all scattered then it costs a lot of money too."***
*35-64, C2D, Maidstone*

When discussing further how the current service model should be improved, participants suggested that the model should take a more holistic approach, and account for the underlying attitudes and outlooks of individuals which potentially contribute to their unhealthy behaviours. This reflects one of the main aims of the proposed model.

***"It is about the holistic approach, looking at this case study that is what they need; it could be dealt all at one."***
*35-64, C1C2D, Gravesend*

***"It's the attitudes. Changing your roots is where it comes from."***
*18-34, C1C2, Canterbury*

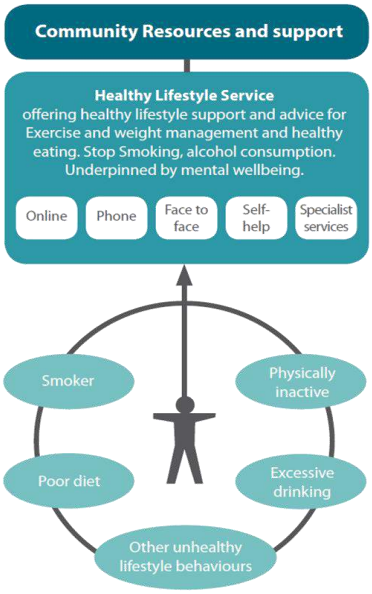
Participants also spontaneously mentioned the idea of a mentor. They thought it would be useful to see what other people who have used services had achieved, the problems they faced, and how they had overcome them. They thought this would increase their motivation, and likened this process to the buddy system used in Alcoholics Anonymous groups.

***"You need psychological bonuses to keep you going. Maybe you could get people who have done it successfully to mentor other people so you get a chain reaction and it helps everyone."***
*55+, ABC1, Tonbridge and Malling*

High importance was placed on the choice and suitability of support settings and delivery channels; the consensus being that it would not be feasible to have a 'one size fits all' approach and people should be able to choose how they wish to access and utilise the service.

# 4 The Proposed Service Model: An Overview

# 4 The Proposed Service Model: An Overview




This chapter of the report explores responses to the proposed service model; looking initially at the perceived positives and risks associated with the model, before looking in more detail about some of the specific service requirements such as delivery channels, locations and opening times.

**Summary of key points**

- Participants were very positive about the proposed service model with many believing it to be 'wholly better' than the current model.
- A number of positives about the proposed service model were readily mentioned with individuals in favour of a model that considered service users holistically to better understand what underpinned their behaviour.
- The proposed service model was thought to be less disjointed and more convenient for the user and the ability for the service to be tailored to individuals was positively remarked upon.
- There was however some cynicism (particularly among workshops from lower social grades) that the proposed service model would ever become a reality. In many cases, this reflected a sense of feeling unsupported by KCC (who they assumed was responsible for housing and benefits) and some participants thought the proposed model was simply 'too good to be true'.
- Individuals could identify possible risks with the proposed service model. These included a generalisation of health trainers' skills, an over-demand on the services if they were adequately advertised, and that this over-demand translated into insufficient numbers of mentors and a more costly service or NHS style waits due to the need for increased numbers of health trainers.

## An overview of responses

As described in Chapter 3, many elements of the proposed service model were spontaneously mentioned as improvements to the current service model. This meant that, when the proposed service model was introduced to participants, it was generally very well received. Participants were readily able to name a number of positive aspects of the proposed service model and, in the main, it was considered substantially better than the current model.

***"It seems like a no brainer then – this model seems infinitely better."***
*18-30, ABC1, Sevenoaks*

***"Absolutely brilliant, much better. I like the idea of it."***
*31-54, ABC1, Tunbridge Wells*

Whilst the proposed service model was well received, some workshops expressed a cynicism about the proposals. This cynicism was stronger in the lower social grades where there was a sense that the proposed model was 'too good to be true'. Individuals expressing this view felt that the proposed service model, despite seeming to be a great proposition, was unlikely to become a reality.

***"Call it what you like, it ain't going to happen."***
*31-54, C2DE, Dover*

Often for individuals expressing this view, previous experiences with the Council (though in reality this may have been with District councils, in relation to issues such as housing and benefits) had led them to feel unsupported, leaving them with low expectations of ever being able to access a service such as that being proposed. This sentiment was compounded for some by an awareness of the funding cuts facing councils which reiterated their belief that the proposed service model would not become a reality or that it would not be as described.

***"They [KCC] don't even help with mental illness. My friend has depression and he's passed from pillar to post, why don't they help him? Why are they just leaving him like that? He went to the council and begged for help and they said there's nothing we can do."***
*18-30, C2DE, Thanet*

***"They're telling lies about the health trainers. I called my surgery and the Council and they said I had to pay to go to a gym. You don't get anything free."***
*65+, C2DE, Swale*

## Perceived positives of the proposed service model

Participants were quick to name a host of positives associated with the proposed service model. The most commonly mentioned of which were:

- A holistic consideration of individuals and the underlying factors which may be driving behaviours. Participants responded positively to the service giving consideration to the 'root causes' and 'underlying stresses' of behaviours rather than considering them in isolation.

  ***"It targets deep issues rather than the surface ones."***
  *18-34, C1C2, Canterbury*

  ***"It is looking at you as the whole person. Looks at how behaviours can be linked."***
  *55+, C2DE, Shepway*

- The concept of the services being integrated was quick for participants to grasp. They soon identified the proposed service model as being less disjointed and far more convenient for the user – requiring less time to engage with multiple services.

  ***"It seems a lot easier and quicker."***
  *18-30, ABC1, Sevenoaks*

  ***"It would be brilliant for the NHS as well. It would stop wastage of appointments. People would get sent to the right places. It's just going to save time, money, effort."***

*16-40, C2DE, Ashford*

- A primary benefit for participants was the ability for the proposed service model to be tailored to suit the individual – both in terms of the channel through which users access the service but also in the advice that is given to them. A key assumption underpinning this view was the ability for users to see the same health trainer and thus to establish a rapport and deeper understanding with one another.

  ***"One point of contact – they can judge whether they need to call you every day, every few days, they're tailoring it to the individual."***
  *55+, ABC1, Tonbridge and Malling*

  ***"It's better. It's one place, one person, rather than lots of different people. You can build more of a relationship with that person, feel like someone actually cares."***
  *18-30, ABC1, Sevenoaks*

- The concept of a mentor was very well received. Participants were positive about receiving support and advice from someone who had been through a similar experience as them, and about receiving that support in what they assumed would be an informal and relaxed manner.

  ***"I like peer support, someone who has been through it themselves, I really like it."***
  *31-54, ABC1, Tunbridge Wells*

  ***"When I am being helped I want somebody who has the qualifications, after I have been told what to do I want to talk with somebody who has been through it."***
  *35-64, C1C2D, Gravesend*

- Participants were positive about the possibility of including group sessions in the proposed service model. This was considered to be a particularly effective mechanism for changing behaviour and many felt there were additional benefits for mental wellbeing of connecting people and reducing levels of isolation through group work.

Other positives were mentioned by participants, though less commonly so. These included the suggestion that the proposed service model could save money (a view not widely held); that it would be easier (and cheaper) to advertise one service as opposed to multiple services; and that having one health trainer offered less opportunity for conflicting advice to be given to service users from multiple advisors. Again, this latter point assumed that the same health trainer could be seen for the duration of service use.

## Perceived risks of the proposed service model

Whilst participants were quick to name perceived positives of the proposed service model, the potential risks of such a model required more consideration. That said, participants were able to identify a number of potential risks, with the most commonly mentioned being:

- The potential generalisation of health trainers' skills (as discussed in Chapter 3). Questions were raised as to health trainers' ability to successfully handle different behavioural issues. For some, this was placed as a caveat on their support for the proposed service model – if health trainers could be suitably trained and the quality of the

service was not diluted, then they were still supportive of the model. Others pointed out that it would be costly for KCC to provide the additional training which health trainers would require to be able to address multiple behavioural issues.

***"Is she [the health trainer] qualified in every aspect or does she send you to someone who's a specialist? When you are trained in all aspects then the qualifications are diluted."***
*35-54, C2D, Maidstone*

***"You can't have one specialist who helps you with all of these things. It is impossible."***
*35-64, C1C2D, Gravesend*

***"KCC has got to spend a lot of money getting the right qualified people to handle this. If they can afford it, that's great. You need someone qualified enough to deal with all these things."***
*55+, C2DE, Shepway*

- High case load for individual health trainers and over-demand on the service as a whole was felt to be a key risk. Individuals felt that if the proposed service model was advertising adequately, it could be inundated with demand. Some worried that this demand would result in long waiting lists that would be off-putting to potential service users or that the high volume of service users would result in inadequate amounts of time being spent with health trainers.

***"If there's a huge demand on it, it might be hard to run. People might be discouraged if they have to wait for a month for an appointment."***
*18-34, C1C2, Canterbury*

***"How many people can each trainer handle? You can't have any dilution of the service whatsoever."***
*55+, ABC1, Tonbridge and Malling*

- The potential high demand on the services led some to raise the risk that the service could end up catering for the 'worried well'. Generally, participants were opposed to who they called 'time wasters' accessing the proposed service model (this is discussed in greater depth in Chapter 5).

- Some participants worried that the proposed service model would be more costly than the current model as they believed a greater number of health trainers would be needed relative to current staff numbers and that a significant amount of money would need to be invested in their training to ensure they could handle multiple behavioural issues.

- Though the concept of health trainers was positively received, some wondered about the consequences of not getting on with that particular trainer which they believed would be detrimental to successfully achieving their desired outcomes.

- For some, the potential of having to address multiple behaviours at once was raised as a risk with this generally being seen as too much to ask of individuals. That said, this fear was generally allayed when reviewing the case studies in which it became apparent that individual health behaviours would be addressed in a staged process.

- Mentors were generally considered a key positive of the proposed service model. There were however some concerns (discussed more fully in Chapter 5) that insufficient numbers of mentors would be secured if these individuals were to be unpaid volunteers.

  ***"It's great if you have good take up [to be a mentor] in one area, but what if you don't get volunteers in another area? It seems too important a thing to leave to volunteers."***
  *18-30, ABC1, Sevenoaks*

  ***"I'm being pragmatic. Imagine if you're the only community champion in Maidstone, it would be very tricky."***
  *18-30, ABC1, Sevenoaks*

Other risks were raised by participants, though less commonly so. These included the possibility that there would be a loss of services or service quality in the transition period.

***"There will be that period between what exists now and what might be where it will be a whole lot of chaos."***
*35-64, C1C2D, Dartford*

Other individuals worried that seeing one health trainer could result in poor advice being provided that was not picked up somewhere further along the pathway as might happen under the current model.

***"What if this one person makes a mistake in your development? Previously, you'd have 3 different departments that could spot an error by another department and try to correct it. But now it's only one person – they might not see it."***
*18-30, ABC1, Sevenoaks*

Some individuals talked about the risks of using language around mental health – making reference to it being a potentially stigmatising term that, if not handled carefully, could lessen the appeal of the proposed service model.

***"If you say 'mental health', people look at you and think it's a bit screwy. Would there be a stigma associated with mental and emotional wellbeing?"***
*18-30, ABC1, Sevenoaks*

The possibility of people not being referred into the services was raised as another potential risk by some individuals. This was mainly discussed in the context of it being challenging to secure GP appointments and an understanding that individuals would need to be referred by their GP. Some also explained that the current services had never been mentioned by their GP and this led them to conclude that a risk going forward is that GPs remain unaware of the proposed service model.

***"Not everyone's GP is good. If you wanted to be on the service who would you go to, to get onto this?"***
*35-64, C1C2D, Gravesend*

On the other hand, some felt that there may be better uptake of services if GPs were more proactive in referring people on:

***"I don't think anyone would ring the service off their own back. People need to be referred. They'll want to make that change because someone has told them something is wrong."***

*35-54, C2D, Maidstone*

For some individuals, poor awareness of the current service model would mean its structural change would be inconsequential.

***"I have my doubts the council will advertise it and it'll be a waste of money and time [making these proposed changes]."***

*35-64, C2D, Maidstone*

# 5 The Proposed Service Model: Service Requirements

# 5 The Proposed Service Model: Service Requirements

This chapter focuses on the desired requirements of the proposed service model including consideration of requirements around health trainers, mentors, working in groups, opening hours, locations and receipt of support by different channels. The chapter concludes with an exploration of who should have access to the proposed service model.

**Summary of key points**

- Participants were keen for the proposed service model to be flexible with the ability for it to be personally tailored. This meant they were keen for the service to be accessed through a variety of delivery channels to suit individual preferences.
- However, participants regularly returned to face to face advice and support as being the primary or most important channel. It was thought that seeing a health trainer face to face was likely to be the most effective channel at encouraging and sustaining behaviour change. It was particularly important that the service journey begins with a face to face session so a relationship with the health trainer has the best foundations for the future.
- Seeing the same health trainer consistently was of paramount importance as this would allow service users and trainers to establish rapport and build trust.
- The concept of mentors was well received with this feeling like an appropriate support mechanism within the community. There was some discussion of the practicalities of a workable mentoring system including debate around the availability of good mentors and whether the role should be paid or voluntary.
- Group sessions as part of the proposed service model were thought to be effective mediums through which to change behaviours, plus participants were positive about the opportunities group work offered for feeling socially connected and reducing feelings of isolation.
- The proposed service model needs to be accessible to those with a variety of working and family commitments. Across the week, it was felt there needed to be some sessions during the day, evening and weekend to cater for diverse needs.
- Participants were fairly flexible about where face to face services should be delivered – the primary requirements were for them to be accessible and offer privacy.
- Participants were emphatic that the service needed to be positive in tone, meaning it needs to be welcoming, informal, fun, supportive, honest, non-judgemental and not patronising.
- Most participants felt they would not make use of the proposed service model themselves as they had an understanding of how to live a healthy life and were capable of making changes independently if they really wanted to.
- Initially there was broad support for the proposed service model being available to 'everyone'. Some workshops spontaneously discussed concerns about managing demand and how this might affect access whilst other workshops needed prompting to consider this. Consensus was not reached on whether the proposed service model should be based on first come, first served or based on need, though participants predominantly thought it should be the latter.

## Delivery channels

Participants recognised that individuals would have different preferences for the delivery channel through which they access the proposed service model. They were therefore keen that a variety of options were made available to suit individual preferences – again reaffirming the view that the proposed service model should be as flexible as possible to allow for a tailored service. It was seen to be important that individuals had choice about the delivery channel and that they were not required to use any particular channels should they not wish to.

***"You have to tailor it to an individual. If they prefer face to face, then that's what they get. If they prefer phone, then they should get that. Not a blanket solution."***
*18-30, ABC1, Sevenoaks*

***"There's a lot of choice and we're all different and we'll all prefer one medium or another."***
*55+, C2DE, Shepway*

***"If you're thrown into it [the online service] without having a say, that's problematic. But if you choose it, then that's quite flexible."***
*18-30, ABC1, Sevenoaks*

***"I think you should be contacted how you prefer, so I'd prefer online."***
*35-64, C2D, Maidstone*

Whilst participants were supportive of a range of delivery channels being available, they regularly returned to face-to-face contact as the primary or most important channel. This was considered the best medium through which to establish a connection with the health trainer, with individuals recognising this as being important to the successful achievement of desired outcomes.

***"For this kind of relationship, it needs to be based on face to face [contact]."***
*18-30, ABC1, Sevenoaks*

***"I don't always tell full story until I feel comfortable / I know I won't be judged. You can usually pick up on this face to face."***
*16-40, C2DE, Ashford*

Face to face was also thought to be the most effective way to ensure people were making progress against their target outcomes. It was suggested that individuals would find it easier to lie about their progress if communicating with their health trainer on the telephone or online.

***"I'd prefer face to face. When I sit down and see what my behaviour is like it makes me think, on the phone I might lie."***
*35-54, C2D, Maidstone*

In general, whilst there was support for people having options in terms of delivery channels, participants felt that the first contact with the proposed service model should be face to face – after which the service user and their health trainer could agree the best approach for future points of contact.

***"It always has to start with face to face, even if it then spreads out into different media."***
*18-30, ABC1, Sevenoaks*

***"Once you have got things under control and you see someone is motivated you can ease off and do online or telephone support but you can't do that too early."***
*35-54, C2D, Maidstone*

When asked specifically about accessing the service through the phone or online, participants could name a number of benefits although this did not necessarily mean they were likely to access the service in this way themselves. Individuals talked about phoning their health trainer and mentor so were clearly amenable to this mode, but very few felt they themselves would make use of the online services as described in the case study of 'Rebecca'.

Individuals could recognise that a key benefit of telephone and online would be the ability for individuals to remain anonymous. Some participants felt this would be important, not for them, but for others who might find it embarrassing to meet face to face or for those who valued a greater degree of privacy.

***"Some people like having that anonymity so it works well for those people."***
*55+, C2DE, Shepway*

***"Some people feel embarrassed to tell their problems in person, phone could help."***
*65+, C2DE, Swale*

***"Not everyone is comfortable being outspoken especially when you have needs."***
*55+, C2DE, Shepway*

As well as being anonymous, participants could also see the value that telephone and online offered in terms of convenience. As discussed later in this section of the report, there is a need for the proposed service model to fit flexibly around service users varied schedules and participants saw telephone and online as options available to help with this.

Participants were clear that accessing the service through telephone would require a Freephone or reduced tariff. There was some suggestion (though not widespread) that a call-back system could be offered as part of the service so that individuals' unanswered calls would be returned within the hour.

Participants did however see a number of drawbacks to accessing the service by telephone or online. As aforementioned, participants felt it would be easier to lie about their progress, but they also thought these modes would be less effective as they would require individuals to be substantially more self-motivated than if they were primarily seeing their health trainer face to face. Participants often equated accessing the service by telephone and online as 'doing it by yourself' and thus they thought it would be harder for individuals to maintain intended changes in their behaviour.

***"It is a good choice that she [Rebecca] has the motivation to do it herself. But it is easy to go off track if you are just doing it yourself."***
*35-64, C1C2D, Gravesend*

A handful of participants also expressed a concern about the security of sharing confidential data online and talked about the risk of data being hacked.

***"How do I know who I'm talking to online? I don't know who you are."***
*31-54, C2DE, Dover*

## Health trainers

The concept of health trainers was well received across all workshops. Individuals liked the idea of having a dedicated point of contact with whom they could interact, and they believed that having someone to answer to would help push them towards their desired goals.

***"Having someone to prove to, then that would make me do it. It's someone and something to aim for – someone who is going to ask me questions."***
*35-54, C2D, Maidstone*

Participants' positivity about health trainers was intimately bound with their belief that the same health trainer should be seen throughout an individual's journey. The main benefits of having a health trainer relied upon this assumption. Successfully changing target behaviours was thought to be partially dependent on having good rapport with, and trust in, your health trainer. Therefore it was important to participants that the same health trainer was seen continuously over time to enable that trusting and supportive relationship to develop. Similarly, only by seeing the same health trainer, was it possible for that trainer to identify how best to motivate the individual they are working with. It was thought to require multiple sessions with the same health trainer for them to learn to understand the individual service user, what drives their current behaviour and what most effectively motivates them. Individuals also thought that seeing the same health trainer would mean service users did not have to repeat their history to a new individual each time they accessed the service. Participants likened seeing the same health trainer to seeing the same GP.

***"You're more inclined to talk to someone you trust."***
*18-30, C2DE, Thanet*

***"You open up to them as you progress. You get better trust if you keep the same person."***
*35-54, C2D, Maidstone*

***"One person who knows what's going on can monitor it better."***
*18-34, C1C2, Canterbury*

Individuals did give some consideration to the feasibility of always seeing the same health trainer recognising that it might not always be possible. One suggestion was for the health trainers to advise service users of their availability so that together they could plan around any expected absences. Other participants recognised that if it was not possible to see the same health trainer, that at least individuals' notes should be collectively available to other health trainers.

In the group with women from Indian, Pakistani, and Bangladeshi backgrounds, the removal of possible language barriers was emphasised strongly as a key requirement of the proposed service model. Many of the participants in this group described instances where members of their community were limited from accessing services due to a lack of translated information. Whilst language did not present a challenge for attendees of this group, they talked about having to accompany family members (often from older generations) to medical appointments to act as a translator. This presented a number of problems for them. Firstly there were logistical difficulties of being available at the appropriate time to attend such appointments, and secondly they felt family members (particularly those of the opposite sex) were likely to withhold certain information that was potentially embarrassing in nature. The participants in this group were therefore keen to stress the importance of making users with English as Second Language (ESL) were catered for in the proposed service model. This could be through the use of professional translators, having health trainers who could speak multiple languages or through having group sessions run entirely in community languages.

***"My generation is fine, but my dad for example, if there was no language support he would need me alongside him. I would need to be there with him."***
*35-64, C1C2D, Gravesend*

***"I think that they [GP surgeries] have clocked on to the facts that Asians have a big family and therefore they think that they don't need to provide interpreters."***
*35-64, C1C2D, Gravesend*

***"There is a language barrier that is the biggest problem for us. You have to have people from your own culture. It is a cultural need."***
*35-64, C1C2D, Gravesend*

As well as considering language requirements, participants were quick to vocalise their expectations of health trainers' attributes and skills. Health trainers were expected to be experienced and knowledgeable (particularly if required to handle multiple behavioural issues whereas previously they may have been specialised in just one). They were also expected to be caring, supportive and non-judgemental – attributes which are reflected in the suggested 'tone' for the services (see later in this chapter). Some participants from lower social grades were keen to emphasise that health trainers should not be too forceful – some habits (particularly smoking) are deeply ingrained and can reflect the challenges of living demanding and stressful lives.

***"They need to be careful that they don't push it on people, because people will back off and won't want to do it."***
*18-30, C2DE, Thanet*

Getting on with your health trainer was considered important if individuals were to successfully achieve their goals. A small number of participants had suggestions to ensure compatibility between service users and their health trainers. These included prospective service users completing a personality profiling tool so they can be best matched to health trainers depending on their delivery style. Another suggestion was for service users to have a 15 minute chat with up to three health trainers to identify the one most suited to them.

Flexibility continues to be a consistent requirement of the proposed service model when considering how frequent the contact with health trainers should be. Participants could not name a particular frequency of contact as they were aware that their requirements could be very different to someone else's, and that if the proposed service model was truly tailored to individuals then so too should be the frequency of contact. They were, however, mindful that contact needed to be fairly frequent to keep service users motivated.

***"Once a week might be fine for one person but not for someone else. Everyone's different and one size fits all doesn't work this way."***
*55+, C2DE, Shepway*

***"Think it needs to be regular to keep him motivated. Yeah like once a week."***
*31-54, ABC1, Tunbridge Wells*

Frequency of contact was also dependent on the particular behaviour in question. Smoking was commonly raised as the health behaviour which would require the greatest amount of contact, at least initially. Participants were also keen to know if the proposed service model would allow for individuals to proactively contact their health trainer (and indeed mentor as described below) when they were having a 'wobble'.

***"You don't have a re-bounce, to keep him on track… is there any opportunity for him to contact them in case he is having a wobble?"***
*31-54, ABC1, Tunbridge Wells*

## Mentors

As discussed in Chapter 3, the concept of mentors was introduced spontaneously by participants as a suggested improvement to the current service model. They saw it as a natural progression from receiving specialist advice from the health trainer, to establishing a more informal relationship with someone who would support them and help keep them motivated to maintain their changed behaviours.

***"It's reinforcing their positive behaviours, someone professional will do it for a bit, then the mentor can help them as they've done it themselves and know what problems they're going to face. People have got to be self-motivated but you can help them become that by positive reinforcement."***
*55+, ABC1, Tonbridge and Malling*

***"The idea of a mentor is great. They can really become friends and be passionate about it. This is really helpful for people."***
*18-34, C1C2, Canterbury*

They placed a lot of value on mentors having gone through a similar journey to them previously. This real life experience was thought to give mentors credibility and make their advice more helpful and realistic. Participants also thought that it would be motivating to know people who had successfully managed to change their behaviours – to give them hope that change was indeed possible.

***"I think that I would listen to you if I know that it is something that you have been through. A mentor is someone who has been there and done that and is a positive role model."***
*35-64, C1C2D, Dartford*

***"Understanding. If you've become a mentor because you've had an understanding of this [experience] rather than something you've read in a textbook, I'd have more confidence in them."***
*55+, C2DE, Shepway*

***"You want someone who has been through it. So you can see that it's possible. Sometimes there's nothing to prove that it actually works."***
*18-30, C2DE, Thanet*

Participants could also see the benefits of mentoring for the mentors themselves. Having to provide support and advice to others meant mentors were more likely to maintain their changed behaviours and acting as a mentor was likely to positively reinforce these changes.

Participants talked about being able to contact their mentor at a moment of weakness when they wanted a cigarette or were tempted by a drink, for example. At first, it was assumed that the level and type of contact with mentors would be highly flexible and situational to meet service users' needs. However, as discussions developed, some participants pointed out that there needed to be boundaries and limits to how often, and when, mentors could be contacted. This led some workshops to debate whether mentors should be paid rather than comprise of voluntary roles. If mentors were in unrewarded voluntary positions, then people felt less willing to consider contacting them at moments of weakness (even at unsociable hours)thereby imposing their own limits on access. It was recognised that voluntary mentors could have full-

time jobs and demanding family lives, around which they were fulfilling their mentoring duties. If mentors were in paid posts, it was thought that there would be a greater obligation for mentors to be available to speak with their mentees whenever was needed (within reason).

***"You should be able to phone them any time you feel like having a drink."***
*65+, C2DE, Swale*

***"But if you are a mentor would you appreciate it if you are being called up at 10pm by somebody who is calling you to say I really want a cigarette?"***
*35-64, C1C2D, Dartford*

Broadly speaking, the workshops with individuals from higher social grades were more supportive of mentors being voluntary, whilst those from lower social grades would like to see mentors being paid. It was felt by some that mentors could be placed at risk if, for example, they were expected to support an individual who was angry or aggressive when in want of drink. For some participants, this further reinforced the importance of rewarding mentors for their work and also illustrated the importance of mentors being given appropriate training on how to handle difficult situations.

***"If you're going to be a mentor, you need to be supported as well. The people you're helping will have an effect on your life. You need someone to talk to, to get it off your chest, to stop it affecting you."***
*16-40, C2DE, Ashford*

***"You need to incentivise mentors – can they become paid health advisors? Can being a mentor be seen as an apprenticeship?"***
*35-64, C2D, Maidstone*

As with health trainers, participants stressed the importance of mentors being supportive and non-judgemental. Mentors should in no way come across as condescending or patronising which was likely to vex service users.

***"If you fall off the wagon you get back up again, moral support and not someone on the high-ground making them feel foolish if they fail again."***
*55+, C2DE, Shepway*

In general, the term 'community champion' was not well received. It was thought to have an over-inflated sense of importance, it felt patronising and participants joked it made them sound like they are 'superman'. The term 'mentor' (or in some workshops 'buddy') was thought to adequately describe the role and were therefore perfectly acceptable.

***"The name 'community champion' is a bit over the top. It sounds like they've run a marathon and climbed a mountain… It sounds like they're wearing a suit of armour."***
*18-30, ABC1, Sevenoaks*

***"'Community champion' makes you feel like a failure."***
*31-54, ABC1, Tunbridge Wells*

## Working in groups

In general, the opportunity to receive support in groups was positively received. Having spent time discussing the importance of feeling socially connected (see Chapter 2), participants saw group work as an antidote to isolation. Working on behavioural change in a group setting was also thought to be a more relaxed and informal approach, and some felt

that the added element of competition would help people work harder to achieve their goals. Participants talked about group work as a compliment to the individual sessions with health trainers and not in direct replacement given the importance of one-on-one time for the health trainer to work out what might be the root causes of that individual's behaviour and assess how best to motivate them to change.

***"GP they always tell you the same thing, whereas when you are in a small group, you can really talk about your weight and maybe that can encourage you."***
*35-64, C1C2D, Dartford*

***"If you see other people going through the same thing you don't feel so intimidated. Go to a group appointment together with someone, then they've got your back… we could bounce off each other."***
*18-30, C2DE, Thanet*

***"Health-wise it's probably better individually, but you won't feel like you're on your own in a group. Maybe they should mix it up and have group and individual settings because sometimes you need the one to one."***
*18-30, C2DE, Thanet*

Some concerns about group work were raised by participants from Indian, Pakistani, and Bangladeshi backgrounds – these participants were unsure whether Asian communities would be willing to discuss personal matters in a public forum. There was some debate over this with some participants concerned in particular about older generations being unlikely to talk openly in a group context. For others, it was important that men and women were not in the same groups to overcome associated taboos with this.

***"Asians have got such a stigma that they won't sit with neighbours and discuss their problems."***
*35-64, C1C2D, Gravesend*

***"I think with the older generations, it [groups] would have to be with the same community."***
*35-64, C1C2D, Gravesend*

## Opening hours

Participants felt the proposed service model needed to be available to suit varied lifestyles, working and family commitments. They felt that, at some point during the week (not necessarily everyday), the service should be accessible during the day, evening and weekend to cater for all.

***"12-8pm would encompass those who do and don't work. Rather than a 9-5 structure."***
*55+, C2DE, Shepway*

***"Weekend hours. Day time and perhaps an evening one for people who work during the day."***
*65+, C2DE, Swale*

***"To be honest, nowadays it needs to be 24-7 because we are working such long hours."***
*35-64, C2D, Maidstone*

Some participants were keen for the proposed service model to offer help to individuals and their families. Providing a service that caters for families would mean that it would be more accessible to people who would otherwise be unable to attend due to childcare issues for example.

***"I would like somewhere where I can take them [children] where they can do something and I can exercise as well."***
*35-64, C1C2D, Gravesend*

It was felt that that any face-to-face element of the proposed service model needed to be designed in conjunction with local transportation. This meant, for example, that the proposed service model tallied with local bus timetables to make sure it remained accessible to those reliant on public transport.

Participants were keen for some element of the proposed service model to be available to them in 'moments of weakness'. Being able to seek some support when reaching for a cigarette or a drink was considered to be important. Participants recognised that alternative modes of contact (such as online or telephone) could be used if the opening hours of face-to-face channels were inconvenient.

***"These aspects – eating drinking smoking – these are evening things."***
*35-64, C1C2D, Gravesend*

## Locations for face-to-face services

Participants were fairly flexible and non-prescriptive about possible locations for face-to-face interactions. Suggestions included community halls, civic centres, GP surgeries, health centres, leisure centres, supermarkets, and libraries (though for some this was seen a place for the proposed service model to be advertised rather than hosted). Individuals were not supportive of sessions being held in churches or temples either because they were uncomfortable with religious surroundings or because these were considered to be too public.

The idea of providing some services in a pharmacy setting tended to divide opinion. For some, this made sense as long as consultations were held in a private room. For others, pharmacies are too medicalised and the association with drugs was out of character with the more holistic proposed service model.

***"At my pharmacy I think they do something like that. I think it works well, as long as they are qualified and they have time, it is good because they take the pressure off other services."***
*35-64, C1C2D, Gravesend*

***"For me it becomes like medicine... pharmacy to me is drugs."***
*16-40, C2DE, Ashford*

It was commonly agreed that the service locations need to accessible and private. For individuals reliant on public transport, the choice of service location was important in determining how likely they were to access it or not. Locations need to be central or close to frequent and well-established routes of public transport.

***"The town centre, they should set up there. People would definitely sign up. Obviously you don't want the hard sell but just let people see what's available."***
*35-64, C2D, Maidstone*

The service also needs to offer some degree of privacy – consultations with the health trainers need to take place in private rooms.

***"You don't want to know what is going on there. If people know what goes on there then the gossip begins."***

*35-64, C1C2D, Dartford*

Individuals also talked about the possibility of there being a stigma attached with accessing the service. This led to two possible scenarios – one being a highly discrete service where it is not obvious to onlookers about what service is being accessed. The other being a dedicated centre where all attendees are there for the same reason and thus any embarrassment is lessened. Some participants really liked this idea of having a 'healthy lifestyle centre' or 'hub' which they described as being a one-stop shop in which to address multiple behaviours where there were comfortable spaces to meet with others aspiring to the same goals, and could be co-located with services such as gyms. This presented a solution for those participants who worried about the high work load and generalisation of skills of health trainers – multiple health trainers, each specialised in their one particular field, could be available to service users in this one space (as discussed in Chapter 3).

As well as being accessible and private, it was felt that the locations should feel comfortable, relaxed and welcoming – contributing to the right 'tone' for the services (see below).

***"As long as it's not sterile, not like hospitals. [It needs to be] comfortable surroundings with a relaxed approach."***
*18-30, C2DE, Thanet*

***"I'd like a big complex with free gym attached with a café that pays for itself."***
*35-64, C2D, Maidstone*

One participant suggested that health trainers could do home visits – as seeing service users in their home environment was likely to lead to a deeper understanding of them as an individual and the behaviours they exhibit.

***"You can see them in their surroundings. If you can see a glimpse of their life, you're gonna get a better view on how to help them."***
*18-30, C2DE, Thanet*

## Tone of the proposed service model

Participants were emphatic that the proposed service model should be positive in tone. They listed a number of attributes that would contribute to this sense of positivity and thus they felt the service should be:

- Welcoming and friendly
- Informal and relaxed
- Fun
- Supportive and caring
- Non-judgemental and without humiliation
- Honest and authentic

Participants felt service users should not feel patronised, and that the service should not feel prescriptive.

***"It has to be friendly, it has to be inviting, the experience has to be positive."***
*35-64, C1C2D, Dartford*

***"They have to feel like they care about you, that they're a real person, not that they're repeating the same thing to everyone."***
*18-30, ABC1, Sevenoaks*

***"A relaxed atmosphere – it should be quite fun, to feel comfortable."***
*35-64, C1C2D, Gravesend*

In general, participants mentioned that the proposed service model should not use scare-tactics as a means to frighten people into change. That said, some individuals thought that they personally would respond better to the 'fear' of explaining their progress to their health trainer and thus this lead into discussion of how to best match service users with health trainers' styles of working. In some cases, it was felt acceptable for health trainers to take a direct approach with no 'pussy footing' accompanied by various tactics that would help demonstrate the amount of progress/lack of progress made. Examples of things that might have an impact on the service user include keeping photo diaries, so that they could see how much weight they are losing or showing how much money was being saved by not drinking or smoking. This would show trainers were not simply ticking boxes, but focused on results or outcomes.

***"We don't want a person going through the motions getting their pay check. They need to properly show you how you are progressing."***
*35-64, C2D, Maidstone*

The desired tone for the proposed service model was sometimes described in contrast to negative experiences had elsewhere, such as at the Jobcentre, which was described as being 'cold' and 'judgemental'.

## Likely uptake and prioritisation

Many participants felt they would not use the proposed service model themselves – they felt they had a clear understanding of how to live a healthy lifestyle and believed that behaviour change was down to individual choice and motivation. Indeed, many acknowledged there was a limit to KCC's role in changing individuals' behaviours given this ultimately relied upon a personal responsibility and real desire to change.

***"I'm aware of my alcohol consumption; it's not excessive but more than I want. I do not need to access this [service] for these issues. For those who find it more challenging to identify and then change their behaviour, it's going to work for those people they're designed for."***
*55+, C2DE, Shepway*

***"I believe that it is all about discipline, I know what I should be doing. I wouldn't point a figure at a local authority and say they have responsibility for me."***
*35-64, C1C2D, Dartford*

***"It is about taking life seriously, no matter what the Council provides, it is about your discipline, it is up to us."***
*35-64, C1C2D, Dartford*

Initially there was a general consensus that the proposed service model needed to be available to everyone. The sentiment that if someone needed help they should be seen irrespective of the demand placed on the service was

underlined by comments like, 'we are all tax payers aren't we?' However, some workshops recognised (without the need for prompting) that there might need to be limits to who can access the service.

***"If the model becomes very successful, you'll have to limit it."***
*55+, ABC1, Tonbridge and Malling*

In the later workshops participants were asked to consider whether the service should be allocated on first come, first served or based on need. There was no one consensus on this issue though broadly people were more supportive of the service being allocated on need if limits on access had to be put in place. Participants felt that if funding was limited, it was best to spend it on those who most needed the help. However, there were certain limitations to this as discussed below.

***"But maybe people could be prioritised as those who need help most get more access, and healthier people get a shorter programme."***
*35-54, C2D, Maidstone*

***"Maybe start off focusing on the high risk groups. You start off by piloting it, and then if you think it's working very well and see if others can benefit from it, you take it a step further. You need to spend the money on the people who really need it."***
*55+, ABC1, Tonbridge and Malling*

***"If you offer people the chance and they say no, that's one thing, but if you don't offer them it then that's something else. I'd rather people who needed it were offered it."***
*55+, ABC1, Tonbridge and Malling*

As discussed in Chapter 4, a potential risk of the proposed service model was that the service catered for the 'worried well' or 'time wasters'. So, whilst participants were broadly supportive of the services being allocated on the basis of need, they wondered if certain parameters should be put in place to avoid over-usage and ensure fair access. This included suggestions of individuals not being allowed access to the service or having to pay for the service if they consistently missed appointments or if they made a lack of progress against their objectives.

***"Maybe if you miss appointments you should be cut off from it."***
*35-64, C1C2D, Gravesend*

***"It should be free for the first and second time but if you are going back a third time they will have to pay for it."***
*35-64, C1C2D, Gravesend*

Some participants also felt the service should only be available to those who demonstrated a commitment to change their behaviour as time and money should not be 'wasted' on those who were referred into the service and who demonstrated little appetite for change.

***"Rather than wasting money, you need a system to work out whether people are committed or not."***
*18-30, ABC1, Sevenoaks*

Not everyone agreed that limitations should be put in place in terms of service access if little progress against goals was made. Individuals may experience unforeseen events in life or have mental health problems that cause them to regress in terms of their behaviour change and thus some participants felt service users should be given multiple 'chances' to change their behaviours.

***"I think [it should be based on] need because some people's problems might be more important than others. I don't think that we should limit [access to the service] because, for instance, if I do it and lose weight but then I have bereavement and I can't help it, why should I be prevented from getting it [access to the service]?"***
*35-64, C1C2D, Dartford*

# 6 Service Promotion

# 6 Service Promotion

This chapter of the report gives consideration to how the proposed service model should be promoted to potential service users.

**Summary of key points**

- It was felt that the proposed service model needed to be widely promoted to ensure those in need of it were aware of it and to counterbalance some of the cynicism which exists where people felt the current services were under-promoted to limit the demand for them.
- The suggested channels and locations for promotion were broad and included TV, local radio, posters, leaflets, newspapers, council/local newsletters, in-street promotion by staff, and social media.
- Participants were also keen to see more creative forms of promotion such as outdoor cooking events to raise the profile of the service and something akin to the Sexual Health Blue Bus.
- The promotion of the service needs to be mindful of the context in which it is being introduced, recognising that many of the potential service users are living challenging lives which can prevent them from modifying their behaviour, and information needs to be provided in languages other than just English to ensure there are no language barriers to awareness.

## Promotion of the proposed service model

Participants were adamant about the importance of the proposed service model being widely promoted to ensure those who needed help were aware of it. This was particularly important to counterbalance some of the cynicism held that KCC was purposively not widely advertising current services to limit demand for them.

***"I'm taking this [list of current services] home and I'm going to make sure people I know, know that these exist!"***
*31-54, ABC1, Tunbridge Wells*

A wide array of possible advertising channels were listed by participants. The most commonly mentioned were TV, local radio, posters, leaflets, newspapers, council/local newsletters, and social media. Places where participants thought information could be displayed included GP surgeries, hospitals, bus stops, village halls, community boards, shopping centres, train stations, the Jobcentre, libraries, churches, mosques, temples, care homes, and through employers.

***"[KCC] should flood the market so people notice."***
*35-54, C2D, Maidstone*

Some positive reference was made to the Blue Bus that offers among other things instant chlamydia testing, believing these types promotional approaches to be effective ways to attract attention to the service. The benefits of the service are obvious and immediate. Another suggestion made by a handful of participants was for information about the service to be conveyed to parents through a letter/leaflet sent by schools – they felt that information sent in this way was guaranteed to be read. In the group of women from Indian, Pakistani, and Bangladeshi backgrounds some reference was

made to community leaders – figureheads who are well known with local circles. Making sure these individuals were aware of the proposed service model was thought to be an effective way of ensuring widespread awareness among their communities.

***"What I have noticed in Dartford is that sometimes there is a bus that pulls up that talks about blood pressure and things like that and those kinds of things are good and that might be a good example of how to talk about these things."***
*35-64, C1C2D, Dartford*

Others suggested more interactive and innovative campaigns to raise awareness using examples such as outdoor cooking experiences, festivals and big social events to which potential service users could bring their families.

***"It could be putting on events 'brought to you by…. [healthy lifestyle services]'. If you see it from lots of different angles, it will start to sink in. A single advert won't work."***
*18-30, ABC1, Sevenoaks*

It was also noted that private companies hire people to promote their goods and services with powerful effect and that the Council or whoever ends up providing the service could learn from the in-street approaches being employed here.

***"Why don't they employ people to give out leaflets about this? There are enough people in the centre handing out leaflets for TalkTalk. The council need to be there more often. They have that health check bus but that's once in a lifetime."***
*35-54, C2D, Maidstone*

However the proposed service model was promoted, there were two clear prerequisites. Firstly that the service needs to be promoted with awareness of the challenging lives some potential users face. As mentioned in Chapter 2, there are a number of reasons (often relating to lack of resources – time and money) which limit individuals from living a healthier life. Promoting the service without acknowledging these difficulties would lose credibility and relevance to potential service users. And secondly, the service promotion needs to account for language barriers, providing information in languages other than English.

***"I strongly feel that there are a lot of people in Gravesend that do not get to know about these things because of the language barrier. There aren't many people who can tell them in their own language what they can do. There are no leaflets in Punjabi explaining it."***
*35-64, C1C2D, Gravesend*

# 7 Service Positioning

# 7 Service Positioning

Participants were asked to briefly consider how the proposed service model should be positioned – thinking about issues such as who would be seen as trusted partners to deliver the service, its branding, and its name. Once the service has been commissioned, it is likely that a full branding exercise will be undertaken where propositions can be tested with potential service users. Given there are no set propositions yet to test, the exploration of these issues with participants was kept light touch with high level feedback being sought. This chapter looks at this early exploration of how the proposed service model should be positioned.

**Summary of key points**

- Some participants were unfazed by who was involved in the delivery of the proposed service model whilst others expressed strong views. Both groups however were opposed to purely profit-making organisations being involved in its delivery.
- The NHS was considered to have the right skillsets required but participants were acutely aware of the demands currently placed on the NHS and therefore felt it should not be burdened further with delivery of the proposed service model.
- Charities, in some cases, were well liked as potential delivery partners though questions were raised as to whether their skillsets would be adequate.
- There was a strongly expressed view that the proposed service model should be delivered by KCC despite being advised that this was not a feasible proposition. Delivering the service itself meant KCC could maintain accountability for the quality of service delivery.
- Participants favoured a simple and memorable name for the proposed service model but were not in agreement about whether the name should make reference to 'health' or not, and whether explicit reference should be made to mental health/wellbeing or not.
- Participants were, in the main, positive or neutral about KCC branding on the proposed service model. For some, branding the proposed service model would place KCC in a favourable light showing that it cared for, and was looking after, local communities and their wellbeing.

## Trusted providers

In general, participants were opposed to the proposed service model being fully or partially delivered by a purely commercial organisation, by which we mean a private company which exists to make a profit with little interest in societal or community benefits. Some workshops were particularly articulate about what they saw as the issues of having purely commercial organisations involved (such as the invested interests of profit-making organisations not always aligning with what is best for the service user or for KCC), others just expressed a general dislike and distrust of organisations set-up to make profit.

***"You don't want to mix someone providing a service with someone trying to make a profit."***
*31-54, ABC1, Tunbridge Wells*

***"I think that when you give it out to other companies, their priorities are to make profit and you have to manage that."***
*35-64, C1C2D, Gravesend*

Some participants were unfazed by who delivered the proposed service model adding the caveat that it would be more convincing if the successful contractor has some track record or association with public health issues. Others were quite impassioned about who should deliver the service as this affected how cost-effective and successful they thought the proposed service model could be.

***"So long as it isn't Coca Cola or something like that. It's better if they are related to healthier lifestyles."***
*35-54, C2D, Maidstone*

There was broad agreement that the NHS was over-burdened and thus participants expressed little support for the proposed service model to be delivered by NHS bodies. Whilst this was the predominant view, it was not shared universally as some individuals saw the NHS as being the only body with the necessarily skillset and therefore the only viable delivery partner.

***"I think the NHS has too much on their plate [to deliver this service]."***
*65+, C2DE, Swale*

***"I would say keep the NHS out of it – the council should be preventing problems before they become a medical issue."***
*18-30, ABC1, Sevenoaks*

***"The only thing is that we have all the different services already. To bring them all together to one platform you need something more grounded to bring it together. The NHS is the only one that can do that."***
*35-64, C1C2D, Dartford*

There was some discussion about the suitability of charities being involved in the delivery of the proposed service model. Whilst people were favourable towards charities in general, some felt they would lack the necessary skills to deliver the proposed model.

***"The problem with charity is that the people in charity may have the best motivations but they may not have the skills."***
*35-64, C1C2D, Dartford*

A number of workshops returned to their preferred option of KCC delivering the proposed service model. Participants were fairly dismissive when told that this was not a feasible proposition. They understood it would take significant investment upfront but felt that it would pay-off in the long run. As participants saw it, if KCC delivered the service it would have accountability so that the service was delivered to the standard KCC set for it.

***"When it's not in the council's hands, if it doesn't work, they can just put up their hands and say – we don't run it, it's not our fault."***
*18-30, ABC1, Sevenoaks*

***"If KCC is the one that's doing [funding] it, they should be the one that's implementing it. That way, your vision is more likely to be the end product, rather than someone's interpretation of it."***
*18-30, ABC1, Sevenoaks*

## Service name

Participants were asked to briefly give consideration to the name of the proposed service model. In general it was thought the name should be simple and memorable that was not patronising or too 'heavy-going'. Opinion was divided on whether the service name should make explicit reference to health – some thought this would put potential service users off, whilst others thought this was important to ensure there was a common understanding of what the service comprised and that it addresses health and wellbeing in the round. The selection of verbatim comments below shows the variety of views on this matter.

***"You can't be patronising at all, that'd be the worst thing, that would finish it."***
*55+, ABC1, Tonbridge and Malling*

***"You have to get the message across that it's about your lifestyle and it covers the whole lifecycle."***
*35-64, C2D, Maidstone*

***"I think healthy shouldn't be in it, it puts you off to start with it. The last generation has been nagged – don't do this, don't do that."***
*55+, ABC1, Tonbridge and Malling*

Opinion was also split on whether the service name should be explicit about the service covering mental health/wellbeing. For some this was really important to demonstrate that the service was considering individuals in the round and looking beyond physical health, others were concerned about the potentially stigmatising terminology.

***"Something to do with wellness as it covers the whole spectrum... It needs to be obvious that it covers both mental and physical health."***
*18-30, ABC1, Sevenoaks*

## Branding

Participants were asked to consider what they thought of the proposed service model being branded KCC. In the main, participants were positive or neutral about KCC branding. In some instances, where individuals had a difficult relationship with the Council, KCC branding was not favoured. However, in the main participants did not see any negative connotations with services being branded as KCC. They thought KCC's involvement could help to engender a sense of 'civic pride' and would show that the Council is investing in their local communities' health and wellbeing. Many participants thought this could also engender greater trust towards the Council.

***"It shows they're trying to help their communities as well, makes us more likely to trust them."***
*16-40, C2DE, Ashford*

***"Councils have a negative stereotype – it's important to change that."***
*18-30, ABC1, Sevenoaks*

***"It would be great for Kent people to feel proud.... Civic pride would be nice for a change."***
*18-30, ABC1, Sevenoaks*

# APPENDICES

# Discussion Guide

15-065374-01 Kent County Council: Adults Health Improvement Service Groups

This guide outlines the discussion that will take place between members of the public and facilitators at a series of groups taking place in Kent over the course of November and December 2015. The research has been commissioned by Kent County Council with the following objectives:

- To understand how the target audience feels about the proposed model for Health Improvement Services.
- To identify suggested improvements to the proposed model and seek opinions on how to encourage access and engagement with it.
- To provide enhanced and more detailed feedback on the proposed service model which compliments that being collected through the public consultation.

| | | |
|---|---|---|
| 6.15 – 6.30 | Moderators welcome observers, run through their roles and rules of engagement | Guidelines for observers/experts |
| 6.30 – 6.45 | <u>Plenary introduction and quiz</u><br><br>• Food and drinks served<br>• Welcome participants; thank them for coming, introduce Ipsos MORI (as **independent** research company)<br>• Introduce Public Health Team at KCC – they have asked us to talk to local residents to hear your views about how local healthy lifestyle services might develop in the future<br>• Explain the 'other issues' flipchart which we will use to park issues not directly relevant to the research but which participants want to comment on<br>• Outline anonymity, Market Research Society code of conduct<br>• Seek permission to audio record<br>• Reassure participants that it is okay to disagree and that everyone's opinions are valid and important, and that the moderator may need to interrupt people to move the discussion on<br>• Housekeeping – toilets, fire escapes, mobile phones on silent etc.<br>• Timetable for the session – breaks<br><br>• Moderator to ask participants to introduce themselves.<br><br>HAND OUT QUIZ SHEET<br><br>Participants to complete quiz in pairs or more. Explain this is just for fun.<br><br>We are using this as an ice-breaker and warm-up, not to test knowledge. | This section will be used to introduce everyone to the workshop and help everyone feel comfortable. We will explain what will happen, the 'ground rules' and answer any immediate questions people have.<br><br>Aim of the quiz is to get participants relaxed, familiar with the group discussion context and to start framing the discussion around |

| | | |
|---|---|---|
| | *Moderator to go through answers to the quiz.* | public health issues. |
| 6.45-6.55 | <u>Healthy lifestyles</u><br><br>'HEALTHY LIFESTYLES'<br><br>To begin today, we're going to talk a bit about what you understand by the term 'healthy lifestyles'.<br>When I talk about "healthy lifestyles" what words come to mind? What do you immediately think of?<br><br>*Encourage participants to name short (ideally one word) answers, moderator to note responses on a flipchart. Note whether words and images tend to be positive or negative.*<br><br>Tell me a bit about why you picked those words<br>*Make sure moderator captures their reasoning as well as answers to the question – why do they think certain things?*<br><br>Probe around the following:<br>• What made you think of that word/thing specifically?<br>• What does [word] mean to you?<br>• Do you see it as positive/ negative/ both? Why? | Obtain initial top-of-mind thoughts on healthy lifestyles. |
| 6.55-7.10 | <u>Public health in Kent</u><br>Probe around what participants think KCC do in relation to public health and what services they're aware of.<br><br>What is KCC's role, if any, in these issues?<br>*Note if they think it is NHS or some other body.*<br><br>• How aware are you of the services KCC funds to assist people in leading healthier lifestyles?<br>• Which ones can you name?<br>• What have you heard about them?<br><br>Some of you mentioned healthy lifestyle or wellbeing services that are funded by KCC. The Council has the responsibility for improving and protecting the health and wellbeing of the public across the county.<br><br>This means reducing the gaps in health and life expectancy by addressing things like: | This section is designed to give participants an understanding of what KCC's role is in public health. |

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| | • **Reducing levels of excess weight**<br>• **Increasing levels of physical activity**<br>• **Reducing smoking prevalence in general population**<br>• **Reducing levels of smoking during pregnancy**<br>• **Improving the wellbeing of the population**<br><br>Here is a handout that shows the current services they fund. These services are funded by KCC but delivered by different providers with expertise in specific areas.<br><br>HANDOUT 1– KCC SERVICES<br>*Participants read handout and discuss as a group.*<br><br>• Were you previously aware of these services?<br>• Did you realise KCC was involved in these services? *Probe around whether people are clear about how KCC are involved in these services.*<br>• Who did you think was responsible and why?<br>• What do you think of the range of services on offer?<br>• Are there any services you would expect KCC to be fund that they are not presently? | |
| 7.10-7.35 | <u>Moderation activity and current service use</u><br>*Note: as well as capturing use of services to moderate behaviour, this section can also cover attempts made by participants to change their behaviour independently without the use of services – looking at how self-motivated they are to do so.*<br>How healthy is your lifestyle?<br>Why do you say that?<br>How do you know what is 'healthy' and 'unhealthy'?<br>*Make a note of unhealthy behaviours people are concerned about.*<br><br>You say you are concerned about X or would like to do Y less. What have you done to try and change that habit/your behaviour?<br>• Did that work? Why do you say that?<br>• IF ATTEMPT DID NOT WORK: What would have helped?<br><br>What help or support have you sought out? *Probe for help from GPs/other healthcare professionals, websites, charities, friends/family, local community initiatives, apps*<br>• Did this help in changing your behaviour? How?<br><br>What services have you used? *NOTE if participants mention KCC, private service (e.g. weight watchers) or some other.*<br>• Were you referred into the service? By whom? How did that work?<br>• How willing were you to attend the service? | This section will take participants through their own health and lifestyle, unpicking their behaviours and prior experience of services designed to help. |

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| | • How appealing was the service? Probe for location, availability, content, people<br>• Did the services work? What success did you have in modifying the behaviour?<br>• Have you continued to modify your behaviour? How did the services help you do that?<br>• How did attending the service make you feel?<br><br>*MODERATOR NOTE: We are especially interested in the referral process to other services, how appealing it is and whether participants feel forced to go to it. Do views differ between commercial and KCC funded services?*<br><br>Have you considered using any services to help change your habit/behaviour? IF RELEVANT: Why not?<br><br>What services have you considered but declined to access? Why is that?<br><br>Which services would you consider using in the future? Why? | |
| 7.35 – 7.50 | <u>Current service model</u><br><br>So thinking a bit more about the services currently offered by KCC. Here is another handout which shows how the services are currently structured.<br><br>HANDOUT 2 – CURRENT SERVICE MODEL AND 'BEFORE' SCENARIO FOR THE CASE STUDY OF ADAM<br>*KCC rep or Ipsos MORI moderator to explain how services are currently structured – emphasising that the services are currently independent from one another.*<br>What do you think about how services are currently structured?<br>• What questions do you have about how services are currently structured?<br><br>*Ipsos MORI moderator to then read aloud the 'before' scenario*<br><br>What are your initial thoughts about this scenario? What is good/bad about it?<br><br>PROBE for thoughts on key characteristics of the case study:<br>• **GP referral: what might encourage/dissuade people to take up their GP's referral?**<br>• **Continued support: What would work best (e.g. text, call, email, video call, face-to-face at an appointment or an event)? Would you want support beyond 1 year? If so, what format should this take?**<br>• **Local pharmacy: what do you think about receiving support in this setting?**<br>• **Length of time: Should there be a maximum time someone receives support for?**<br><br>How likely would you be to change your behaviours if you went through a similar journey to Adam? Do you think you could maintain this behaviour change? | This section will take participants through how services are currently provided by KCC. |

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| | What improvements could be made to how these services are provided?<br>*Probe to understand why they think there could be low uptake of some services currently*<br><br>How do you feel about the current services being independent/separate from one another? | |
| 7.50 – 8.05 | 15 MINUTE BREAK<br>*Note: Break is likely to last 20 minutes* | |
| 8.05 – 8.20 | <u>Proposed service model</u><br><br>KCC is considering changing how these services are provided. Here is a handout which shows their proposed changes.<br>*KCC rep or Ipsos MORI moderator to explain the proposed changes and rationale behind it, including reference to the key element of self-support.*<br><br>HANDOUT 3 – PROPOSED SERVICE MODEL<br><br>**What did you think about the proposed changes?** *Check initial thoughts/any confusion*<br><br>POST IT NOTE OR FLIPCHART ACTIVITY<br>*Ask participants to write down 3 thoughts about their initial reaction to the integration of services on post-it notes. Ask them to put each answer down on a separate post-it note. Ask for someone to volunteer a thought and check if others in the group named the same, place these thoughts on the flipchart and continue working through separate thoughts in a similar manner. If short of time, do this as a simple flipchart exercise.*<br><br>DISCUSS RESPONSES<br><br>Probe around the following:<br>• **What made you think of that specifically?**<br>• **Do you see it as positive/ negative/ both? Why?**<br><br>• **What questions do you have about the proposed changes?**<br><br>**What do you like about the ideas?** Why? Who would it benefit? What would happen if it worked well?<br><br>**What do you dislike about the ideas?** Why? How could it be improved/ mitigated? *Probe on if there are any gaps.*<br><br>**Do you see any risks with the proposed model?** | This section will take participants through the proposed service model. |
| **8.20-9.00** | | In this section we will |

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| | Scenario testing<br><br>Let's consider how Adam might be helped through the proposed service model.<br><br>HANDOUT 4 – 'AFTER' SCENARIO FOR THE CASE STUDY OF ADAM<br>*Ipsos MORI moderator to read aloud the 'after' scenario*<br>*Moderator to explain that the case study scenarios are fictional examples as no specific plans have been commissioned yet.*<br><br>What do you think about the proposed services in this example?<br>• What do you like/dislike?<br>• How do you think this service model compares to the current service model? What are the good/bad things about both?<br><br>PROBE for thoughts on key characteristics of the case study:<br>• **'Triage call': what do you think of the call Adam has to discuss his goals? How helpful would this be?**<br>• **Do you think it's a good idea that Adam has an opportunity to access support on a range of health themes or do you think this may put him off seeking support? E.g. if he just wants to quit smoking**<br>• **Mentor: what do you think of this idea and what does it mean to you? How might it work/not work? Should this be an unpaid role? What do you think of the name 'Community Champion'? Are there any other potential names can you think of?**<br>• **Continued support: How frequent should any follow up support be offered and in what format? What else could be done to support Adam to maintain his changed behaviour?**<br>• **How important is it that Adam is in contact with the same person/health trainer throughout his journey? At what points in his journey should Adam see the same person/health trainer?**<br>• **How do you feel about the idea of a group session with a mentor? How do you think this would work? Do you think this would affect the individual's relationship with their mentor? What do you think are the advantages/disadvantages of this?**<br>• **Are there any elements of the service you would change or you feel should be included? Why? How?**<br><br>Do you think it is something that would work for you? Why/why not?<br>• Would you want to see somebody face-to-face if you were accessing a service?<br>• How do you feel about the use of online chat, video conferencing and online support groups?<br><br>The case study makes reference to a 'community venue' – what venues does this make you think of?<br>Where should face-to-face services like these be held?<br>• *Probe on dedicated buildings, GP surgeries, pharmacies, existing community spaces such as libraries, leisure centres*<br>• *Probe around issues such as transport, car parking*<br>• Are there certain places you wouldn't want the services to be located? For example, near schools or where neighbours might see you? | talk through the two case studies (Adam, and either Susan or Rebecca). These are based around the different channels through which people might access the re-designed service: face-to-face, telephone and online. |

What should the operating hours of a service like this be?

- *Probe on weekend/weekday/ evening and the type of support required at each of these times/days*
- What are the critical times it needs to be open?

HANDOUT 5 – 'AFTER' CASE STUDIES FOR SUSAN OR REBECCA

Let's consider another example of how the proposed service model might work.
*Ipsos MORI moderator to read aloud the case study for either Susan or Rebecca (to alternative between groups). For the case study which is not read out, probe using questions below to ascertain response to receiving support online or by telephone as appropriate.*
What do you think about the proposed services in this example?

- What do you like/dislike?
- How do you think this service model compares to the current service model? What are the good/bad things about both?

<u>Susan</u>

PROBE for thoughts on key characteristics of the case study (proposed model):

- **Telephone support: what do you think about receiving advice and support over the phone?**
- **Frequency of contact: is weekly contact with Jo enough?**
- **Motivational techniques: what do you think this means? What do you think of this as an idea?**
- **Continued support: is the re-contact after 4 weeks enough continued support? What else could be done to support Susan to maintain her changed behaviour?**
- **Are there any elements of the service you would change? Why? How?**

Do you think it is something that would work for you? Why/why not?

When thinking about offering support by telephone…

- Does the telephone line need to be free or a reduced tariff line?
- What should the opening hours be? What are the critical times it needs to be open?
- What other considerations should there be when providing support by telephone?

<u>Rebecca</u>

PROBE for thoughts on key characteristics of the case study (proposed model):

- **Online support: what do you think about receiving advice and support online?**
- **Online weekly group: what do you think of this idea? How would it work?**
- **Frequency of contact: is 2 weeks enough contact with Robert?**
- **Continued support: What else could be done to support Rebecca to maintain her changed behaviour?**

- **Are there any elements of the service you would change? Why? How?**

Do you think it is something that would work for you? Why/why not?

What do you think about services being provided online?
- What are the benefits/drawbacks of doing so?

Overall

Would you prefer to use a service that is provided face-to-face, over the phone or online? Why do you say that?
- What other ways should services be provided? *Probe for SMS/text, virtual contact such as Skype/Facetime/webchats, social media such as Facebook/Twitter*

What should the services be like? *Probe around characteristics such as fun, supportive, easy*

What would make attending the services a positive experience? And what would make it a negative experience?
*Probe to understand more about the 'tone' of the services and how it should make people feel*

What could be done to encourage people to use the services?

Should the services be available to everyone? Who should these services be made available to? PROBE ON: Should services be provided on a first come first served basis or based on need (so that those with the highest levels of need get treated first)?

What can KCC do to support people who want to change their habits/behaviour but who are unlikely to use the proposed services? *Probe for: what information they should provide and where, if KCC should be running communication campaigns targeted at the population level, what would make them take notice of a campaign such as this*
What else can KCC do to motivate people to change their habits/behaviours by themselves?

Having talked through these case studies, do you see any risks in changing the way services are provided? Perhaps to users? Or to KCC?
*Probe around:*
- *Dilution of specialist skills as health trainers would be generalists*
- *Too high a demand for the services*
- *Over-reliance on the health trainer*
- *Lack of compatibility with the health trainer*
- *Inability to consistently see the same health trainer*
- *People remaining in the system too long*
- *People who only want to tackle one behaviour are put off by the 'holistic' approach*

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| | Do these potential risks change how you feel about the proposed services? How?<br>What can be done about these risks?<br>• | |
| **9.009.15** | <u>Branding and communications</u><br><br>Before we move on to the final section of this workshop, does anyone have any unanswered questions about how the proposed service model will work?<br><br>What should the proposed services be called? One suggestion is 'Health and Wellbeing services' or 'Healthy Lifestyle services'<br>• What do you think of this? What other suggestions do you have?<br>• What should it NOT be called?<br><br>*Moderator to explain that KCC will need someone to provide the proposed services and they will soon run a tender process to choose the organisation/organisations that will do this. Note: avoid the terminology of 'out-sourcing' as the services are not presently provided in-house.*<br><br>Does it matter who provides the services? How important is this?<br><br>How do you feel about the services being provided by an NHS body, a leisure/fitness company, a health charity, a private company, a community group?<br>• Which of these groups would you trust to provide advice and support about healthy lifestyles? Why? *Probe to understand who are seen as trusted and influential providers*<br>• *Are there any groups/bodies that should NOT be involved?*<br><br>Should the services be branded KCC? How important is this?<br>• Should the services be NHS branded? *Probe to understand how important the branding is and whether the KCC branding or NHS branding helps or hinders KCC.*<br>• Should KCC partner with other brands (for example Change4Life)? Which brands?<br><br>How should KCC publicise the proposed service model?<br>• Where/through whom should the service model be publicised? *Probe: newspaper, leaflets, posters, GPs etc.?*<br>• What information should KCC provide about it? What is important to convey?<br>• How can the service model be made as appealing as possible? | This section will explore how the proposed service model should be communicated. |
| **9.15 – 9.30** | <u>Last comments</u> | To bring discussion to a close and administer |

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| | What questions do you still have at this stage?<br><br>Overall, what are the advantages of the services being integrated? And what are the disadvantages?<br><br>Overall what's the best thing about the proposed model?<br>• *Probe for nominated keyworker/health trainer? It being local? Community based not medical? Focus on motivation? Focus on self-help? Focus on prevention?*<br><br>*Offer KCC rep chance to ask questions if in attendance and appropriate.*<br><br>*Thank participants for taking part today.*<br><br>*Hand out incentives and sign form.*<br>*THANK AND CLOSE*<br><br>*Moderator to take photographs of the final flipcharts* | incentives |

# Case Studies

## Case Study 1: Adam's journey under the current model

Adam is a 53 years old man who displays a variety of unhealthy behaviours; including smoking, over eating and excessive drinking, he also does not do enough exercise.

Adam has been trying to quit smoking unsuccessfully. He visits his **GP** for help who **refers him to the Stop Smoking Service**.

Sharon from the **Stop Smoking Service calls Adam** 2 days following the referral and goes through all the options for quitting smoking. Adam decides to quit through in a group setting and she books him onto a **7 week Stop Smoking Course**.

Adam is supported by Tracey, the Stop Smoking Advisor, who provides him with specialist support over the 7 weeks. The aim is for Adam to be smokefree for 4 weeks. Adam agrees to Tracey following up and receives a **text or phone call 6 months and 12 months after** leaving the Stop Smoking Service to see how he is getting on.

Adam is also worried about his weight and discusses this with Tracey before he leaves the service. Tracey advices Adam on healthy eating and she makes a **referral to the Healthy Weight Team**.

Graham from the Healthy Weight team makes contact with Adam following the referral and books Adam to see a **Healthy Weight Adviser at his local Pharmacy**. Adam is then seen by Trevor for 12 weeks for support for losing weight. Trevor advised Adam to increase his physical activity and is **signposted to a local walking activity** in his area.

## Case Study 1: Adam's journey under the proposed changes

Hannah from the **Health and Wellbeing team calls Adam** 2 days following the GP referral. She gains an understanding of Adam's lifestyle, how he would like support, what he has previously tried and what his personal goals are.

Adam explains that he would like to be fitter and healthier and his main priority is to quit smoking but that he also would like to lose weight. Hannah makes an appointment to meet Adam the following week **at a community venue local** to him. Hannah explains that **she will see Adam for up to 12 weeks**, with the intention that by week 7 he would have quit smoking. Hannah also explains that she will advise on healthy eating and drinking during these sessions and will focus on healthy eating more directly for the following 5 weeks, with the hope to achieve Adam's goals. During the weekly sessions Hannah motivates Adam, providing advice and support.

After 12 weeks, Hannah discharges Adam and offers him a **'mentor'** to support him with continuing with his new healthier behaviours.

Adam also agrees to being followed up and receives a **text or phone call 6 months and 12 months** after leaving the service to check he is still on track with his changes in behaviour. Adam is also offered an **opportunity to become a mentor himself** so he can motivate others.

## Case Study 2: Rebecca's journey under the proposed changes

Rebecca would like some support to reduce her tobacco intake. She is aware of the **Health and Wellbeing team** and **phones them** to discuss her options.

Robert from the **Health and Wellbeing team assesses her motivation and need**. Rebecca decides that she doesn't need weekly face to face appointments and is happy with her other lifestyle choices.

Robert signposts Rebecca to the **Health and Wellbeing website** which has a lot of **advice and support** which Rebecca can access. The website also offers an **online weekly group** which goes through all the information needed to support Rebecca to reduce her tobacco intake.

Rebecca is **happy to go online** to gain the support needed. Robert informed her that **she is able to contact the service at any point** for addition help and agreed that he **will be in contact every 2 weeks** to see how she is getting on.

## Case Study 3: Susan's journey under the proposed changes

Susan feels she needs to increase her physical activity and goes online to the **Health and Wellbeing website.**

The website **informs her of all the free physical activity events** that are happening in her local community. However Susan **does not feel motivated** so she **contacts the Health and Wellbeing Team for advice**.

Jo, a member of the **Health and Wellbeing Team**, assesses Susan's **motivation** and looks at her **personal outcomes**. Susan agrees to **weekly phone appointments** with Jo.

Jo contacts Susan and uses **motivational techniques** to encourage her to **increase her activity levels**. After 5 weeks of contact Susan feels motivated to attend an **exercise session with support from a mentor**.

Jo supports Susan to find a **free exercise session at the local outdoor gym** and books her onto a class. Jo gets **back in contact with Susan after 4 weeks** to see how she is getting on and **whether she requires any more support**.

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## About Ipsos MORI's Social Research Institute

The Social Research Institute works closely with national governments, local public services and the not-for-profit sector. Its c.200 research staff focus on public service and policy issues. Each has expertise in a particular part of the public sector, ensuring we have a detailed understanding of specific sectors and policy challenges. This, combined with our methodological and communications expertise, helps ensure that our research makes a difference for decision makers and communities.

Ipsos MORI
Social Research Institute

March 2016

# Adults Health Improvement Service

## A focus group with carers

# Contents

# 1 Background

# 1 Background

This report presents the findings from a focus group, commissioned by Kent County Council (KCC), to explore the views of carers in relation to proposed changes in how public health services in Kent are structured and delivered. This study is an extension of research previously undertaken by Ipsos MORI seeking views of potential service users concerning the proposed changes.

This chapter provides an overview of the original research programme and the extension covered by this report.

## Background to the study

A new public health strategy for Kent is being developed to ensure that the future approach to public health will be based around the needs of the person, encourage personal responsibility, be delivered within integrated services and reduce health inequalities.

As part of this strategy, KCC is looking to change the way adult health improvement services are provided and it has developed a proposed service model which will integrate previously separate services. It is envisaged that the proposed service model will look beyond individual behaviours and seek to improve the overall health and wellbeing of the person, with mental and emotional wellbeing underpinning the whole service delivery. This proposed service model will be commissioned in early 2016 to start delivery in 2016/2017.

A number of workstreams have fed into the development of the proposed service model, including a public consultation[1] and behavioural insights study. Over the course of November-December 2015, Ipsos MORI, on behalf of KCC, ran 12 qualitative workshops with potential service users, seeking their views on the proposed service model. A full report has already been produced summarising the findings from these workshops with potential service users across Kent.

## Research objectives

The specific research objective for this study was to understand the service needs of carers; looking to identify the particular requirements of this audience in terms of accessing a service such as the one being proposed. A secondary objective for the research was to consider how the proposed service model might meet the needs of the individuals being cared for.

## Research approach and methodology

The focus group followed a discussion guide, designed in conjunction with KCC, which was similar to that used in the previous workshops with potential service users but which condensed the content down to two (rather than three) hours given the restricted time participants were available. The discussions covered participants' reactions to current service provision, examining what was working well and where improvements could be made before moving on to explore the proposed service model.

[1] Kent County Council Health Improvement Services Consultation http://consultations.kent.gov.uk/consult.ti/Healthimprovement/consultationHome

The group was held in a community venue in Maidstone in early March 2016. Nine participants attended in total.

## Recruitment

A blended recruitment method was employed whereby the Kent charity Involve Carers, based in Maidstone, contacted its members to ask if they were willing to take part in the research and give consent for their details to be passed to Ipsos MORI so that they could be invited to the group.

Contact details of those opting in were passed onto Ipsos MORI and our in-house specialist qualitative recruitment team then contacted potential participants and invited them to take part in the research. In addition to this, some participants were recruited using a 'free-find' technique, meaning they were approached and invited to take part on the street, again by our specialist in-house recruitment team. Participation was encouraged by offering to cover carers' expenses by way of a cash incentive to thank them for their time and contribution.

To ensure the views of a range of carers were included, quotas were set and a recruitment screener used to ensure a spread of characteristics (such as gender, age, and the age of person cared for). Participants were also recruited on the basis of their physical wellbeing with many exhibiting health behaviours which could be addressed by the proposed service model. The majority of carers attending the group provide support and care for more than 100 hours a week and thus have significant caring responsibilities. The individuals they care for have a range of both mental and physical health needs.

## Presentation and interpretation of the data

It is important to note that this report presents the findings of a single focus group with nine carers. Qualitative research is used to shed light on why people hold particular views, rather than to estimate or quantify how many people hold those views. Such research is intended to be illustrative and detailed rather than statistically representative of a wider population and, as such, does not permit conclusions to be drawn about the extent to which something is happening. It also enables researchers to test the strength of people's opinions. With this in mind, when interpreting the findings from this research, it should be remembered that the results are not based on quantitative statistical evidence but, like all qualitative research, on a small number of people who have discussed the relevant issues in depth.

Verbatim comments from the focus group have been included within this report to provide evidence of participants' views. Quotations should not be interpreted as defining the views of all participants, but have been selected to provide insight into a particular issue or topic expressed at a particular point in time.

## Acknowledgements

Ipsos MORI would like to thank Barbara Hagan at Involve Carers for her assistance in recruitment for this study. We would also like to thank all of those who participated in the research and shared their experiences with us.

# 2 Healthy Living and KCC's Public Health Role

# 2 Healthy Living and KCC's Public Health Role

This chapter explores the context of carers' lives into which the proposed service model is being introduced. Understanding how the target audience feel about healthy living, and what they perceive to be KCC's role in that, is instrumental to understanding their response to the proposed service model.

**Summary of key points**

- Participants understood healthy lifestyles to mean eating healthily, keeping fit, getting enough sleep, limiting stress and having a social life.
- The main barriers to a healthy lifestyle were lack of free time, logistics and money. For carers to spend time focusing on their own health, they would need to put in place complex and often costly arrangements to cover the care of their dependants.
- There was also a shared feeling that given all the unrelenting stresses of being a carer, the comfort provided by some 'unhealthy' behaviours was something they were unwilling or unable to give up.
- Finally, as a key element of 'healthy lifestyle' for this group was mental wellbeing, being a carer was seen as a real barrier to this. The 'job' was very stressful, exhausting and largely unsupported.
- There was limited awareness of KCC's role in public health and the services currently provided to assist residents in living a healthier life.
- For these services to be accessible to carers, it was felt that KCC would need to make them considerably more flexible in their delivery, as this group found it very difficult to make regular commitments outside their caring responsibilities.
- The carers' reactions to the list of KCC services were strongly influenced by their past experiences with government departments, councils and health services. This group felt largely unsupported by the authorities.

## Healthy lifestyles

Participants were initially asked to name the words and phrases they associated with 'healthy lifestyles' to understand what this meant to them. As well as the physical aspects of healthy living – keeping fit, eating healthily, getting enough sleep – there was a lot of focus on the mental aspects – the need for a social life, peace and quiet, reducing stress and having choices in life. Mental wellbeing was seen as very important, given the stressful nature of carers' daily lives, and the level of exhaustion people reported. The financial cost of achieving a healthy lifestyle was another issue raised by several participants at this stage.

There was a general feeling within the group that a healthy lifestyle was something that they would like to achieve, but many felt that given their current situations and heavy caring responsibilities, it was simply not attainable for them.

## Barriers to healthy lifestyles

The main barriers to healthy living were reportedly time, logistics and financial costs. For many of these carers to attend exercise classes or sports facilities, to visit the doctor's surgery for their own health, to meet friends, or even simply to go out for a walk on their own, they would need to put in place complex and often costly arrangements for the care of their dependants.

***We carers are a breed of our own. You have to understand us and our way of life. We can't turn up to a doctor and wait two hours for an appointment. So carers' health deteriorates because they haven't got the time to do anything about it. But the council don't understand this.***

***All these things are good in their essence. But they all require devoted time. And that comes at the expense of getting someone else in to do the caring, or arranging respite care.***

As well as any fee for the sporting activity, there was often the additional cost of paying for a replacement carer for a few hours. As many of these carers were retired, or in poorly paid part time jobs, or unable to work at all due to the needs of their dependants, finances were a serious barrier to engaging in any activities that took them away from home.

***I'd put on a lot of weight because I would just sit at home with my husband. But it got to a crunch and I realised that I had to do something. So I went to my GP and got referred to the gym. But it costs me £24 to go to a gym every time because I have to have a carer for two hours each time.***

It was also pointed out that healthy food tended to be more expensive, so again carers' often stretched financial situations prevented them from buying the most nutritious options. And some felt that the time required to shop for healthy ingredients and to cook healthy meals from scratch was a problem when their time was so taken up with caring for their family members.

Another barrier to taking time away from caring was the guilt at leaving their dependants.

***I can't leave him. I haven't been out for an evening for six years. I feel very guilty, but I now know that I need a break. It wasn't until I broke my wrist last year and had to put him in respite, that I realised I had to come out of denial.***

***I've done Weight Watchers, and the guilt meant that I'd only go for the weigh-in and wouldn't stay for the whole session.***

There was also a shared feeling that given all the unrelenting stresses of being a carer, the comfort provided by some 'unhealthy' behaviours was something they were unwilling or unable to give up.

***If I didn't smoke, I would kill somebody. Smoking is the only thing I do. I don't go out, I don't drink, I don't have takeaways. That's all I have. I don't even have my own home as we got repossessed. If anyone asks me to stop smoking, they'll get punched.***

***With my daughter, you spend a lot of time indoors. And emotionally, you might drink, you might smoke. With me, I eat. You spend hours and hours by yourself, but my neighbours and friends are out at work and don't want to hear what you've had to do during the day. And at the end of the day, sometimes all you want to do is fill your face because it gives you some satisfaction.***

***My caring day usually stops at about 10 o'clock – that's when I take the dog out, and have a smoke. That's my pressure release valve because I know when morning comes, it all starts again.***

Finally, as a key element of 'healthy lifestyle' for this group was mental wellbeing, being a carer was seen as a real barrier to this. The 'job' was very stressful, exhausting and largely unsupported. Several of the group participants had at some point taken prescription drugs to help with mental health issues, and all agreed that being a carer took a serious toll on their psychological wellbeing.

***Something has gone in me, and I just can't get myself back on track really. I'm exhausted.***

***I've been to a GP and said 'I need some chill pills or I'm going to murder someone'.***

***I'm on anti-depressants…If you talk to carers, 75% of us are on something at some point.***

***I scream at night.***

Although people did not use the language of social prescribing, they expressed views to suggest it is something they feel should be on offer to help address the wider determinants of mental ill-health and emotional stress.

***… I did go to a doctor because I needed an extra pair of hands. But what I was given was a prescription for Prozac. That wasn't what I wanted. I wanted support.***

## Awareness of current public health services

Several participants had received Health Checks, one had experience of a KCC-funded weight loss programme, and another had been referred to a gym by her GP to help with weight loss.

However, when participants were shown a list of current public health services funded by KCC, the overwhelming response was surprise that there appeared to be so many services available, apparently free to users, and some cynicism about the reasons for their lack of awareness.

***Why as carers are we not told about any of this? Why do we have to research it ourselves?***

***I'm very surprised that these services exist. I'm not stupid and I'm always Googling something and researching, but I've not heard of any of these.***

***We've always dealt with KCC care managers, but not once in all these years have they ever been bothered about my health.***

***I don't often go to the doctor's – appointments I'm offered rarely fit in with my life. Last year though, I did go to the doctor with pains in my chest. And not once did she mention any of these healthy lifestyle services.***

## Views about current public health services

It seemed clear that the participants' reaction to the list of KCC-funded services was strongly influenced by their past experiences with government departments, upper and lower tier councils and various statutory health and care services. The group felt largely unsupported by the authorities, and were sceptical that the KCC health improvement services would be any more flexible or suited to their particular needs or circumstances.

***We've been asking for psychotherapy for my husband for ten years. But they'll only give him medication. It's all very well having all these mental health services listed, but what about basic psychotherapy?***

***Even when I got to the point where I could quite easily have put her [disabled daughter] through a brick wall... I called KCC and explained how desperate I'd got, but they offered me nothing....***

***When my husband first had his stroke, I was a nobody. You have to fight for everything. They don't get back to your calls or letters.***

For several participants, local charities were seen as the sole source of support. In particular, Involve Carers and Crossroads had been a lifeline, providing support and advice specific to the needs of carers. Two members of the group had benefited from membership of a swimming group through Involve Carers, although it was noted that spaces in such groups were severely limited.

There was agreement within the group that the list of existing KCC-funded services looked good for 'ordinary people', but did not feel accessible or suitable for carers. One of the main reasons for this (as discussed earlier in the context of exercise and social events) was that they assumed attendance at any of these health services would require them to make complex and sometimes costly arrangements for the care of their dependants. They felt tied to their homes and the routines and needs of their dependants.

And the fact that such services were likely to have rigid timetables was felt to be inappropriate for carers' long and sometimes unpredictable days. Several of the participants had past experience of fitness or weight loss programmes, but regular commitments had proved to be particularly difficult, given the unpredictable nature of caring demands that had to take precedence, and the fact that several participants worked shifts to fit around their families' needs.

***If they really tried to tailor make them [the KCC services] for individuals, that would be fine. But there's no interest in individuals.***

***These services are all okay if you're an ordinary person. We have a particular set of problems that are totally unique. We cannot slot into these services. We have to be enabled, perhaps by a voucher [that could be used at times of the carer's choosing].***

It was also pointed out by several participants that after a day of caring, they often just felt too tired to commit to these kind of services or activities.

***I paid the membership, but in the end I couldn't go often enough. Something would always get in the way – like my husband was going to care for her [disabled daughter], but then he couldn't because of something at work. But mostly, it was because I was just too knackered. The thought of getting up at 6.30 to fit a swim in, and then get back and put my carers' hat on, was just too much.***

***I had to have time off work to go, and because of shifts, I could only make half the [weight loss] sessions.***

It was also pointed out by several participants that as time was so precious to them, they would not want to waste any of it attending services where they were given information that they already had. And they were also wary of being given 'patronising' advice.

***They want you go to a particular club. But I haven't got time for that. I'm exhausted. They'll tell me not to eat sugar. I know that already.***

While it was acknowledged that there was a need for mental health support among carers, there was some wariness about accessing such services because they felt they needed to appear strong for the sake of their dependants. They were also suspicious of just being offered medication, rather than more substantive support.

***Because I'm always worried about my husband being sectioned, I have to try and look really really sane myself, even if I'm feeling almost suicidal.***

***You don't want to say I'm not coping because you're the only one who's caring for your daughter or husband.***

***I know there is a course on offer, part of which deals with stress and talks about meditation. But this is not realistic. All you want to do is go to the bottom of the garden and scream. Maybe if you had someone to talk to, that would be good, but there's nothing like that.***

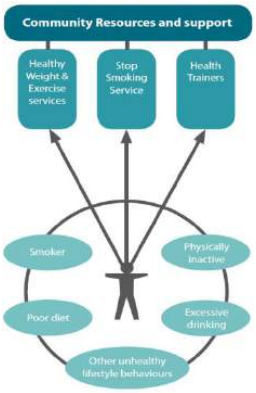
But despite all the barriers the group could see in accessing suitable services, it was acknowledged that there were benefits to be gained from weight loss and activity programmes. Almost more important to this group than the physical benefits of such programmes were the mental health benefits – the experience of much needed 'Me time' and the opportunity to meet other people.

***The weight group was good. You do get to have a chat with other people, and you do feel good because you are doing something for yourself.***

***I enjoyed the swimming, and putting the phone in the locker. I never lost weight on it, but it was something for me. I was away from my caring role. You're in your own little world.***

# 3 The Current Service Model

# 3 The Current Service Model




Before being shown the proposed service model, it was explained to participants how healthy living services are currently structured. This chapter explores responses to the current service model, giving consideration to participants' suggested improvements.

**Summary of key points**

- Participants were not very positive in their response to the current service model, viewing the type of advice described in the case study as of limited use.
- There was a shared feeling that the services should be offering practical support, not simply advice. And there was a call for KCC to divert some of the money to extend the work done by local charity Involve Carers.
- In terms of the structure of the services, it was suggested that it would be more convenient for KCC to offer a 'one stop shop' where users could seek advice on multiple lifestyle issues, rather than having to deal with a succession of different advisers.
- Another suggestion made was that KCC should offer a system of vouchers which could be used to access particular services such as swimming, yoga classes etc, and crucially at a time and place that was convenient to the user – an issue that was particularly important to carers.

The initial reaction to the 'Adam' case study (see Appendices) was not very positive. They found it hard to relate to Adam with some participants commenting that Adam's situation was quite straighforward, unlike their own more complicated lives. And several participants felt that the advice being offered to Adam (to join a local walking group) was little more than he could have found out for himself.

***You could have just googled the local ramblers group, couldn't you?***

***We don't want to be told things we already know. We haven't got time for that.***

Several participants felt that it wasn't advice that was needed. They felt that they had received plenty of advice, often unwanted. What they wanted was more practical support, and the idea of the health trainer held some appeal if he or she could be relied upon as someone to talk about their problems with but also someone who could be the gateway to more practical help or sustained support in the community – again coming back to the idea of social prescription.

***The doctor has said to me – you could do with losing some weight, your blood pressure is up a bit. But there was no direct support about what can we do to help you with this in your particular situation … for me, it's the health trainer that sounds appealing.***

***Wherever I go, I take the wheelchair. I walk everywhere. When the surgery tells me I need more physical activity, I say 'You come and do what I do. Getting her out of bed, pushing wheelchairs and so on.***

It was suggested that a better approach would be for KCC to fund more of the type of practical support currently being offered by charities such as Involve Carers out of the public health budget to address wellbeing.

***The only people that have supported us is Involve Carers. That's where the money should go – instead of going to your local pharmacy, and them telling you to go for a walk!***

Looking at the structure of the current services, some suggested that it would be better if the various advisers could all be available in a single place, rather than having to deal with several different people

***A one stop shop would be the answer – I want to walk into one building and see the different advisers for smoking, weight etc all in one place.***

They observed that the success of the service partly relies on people having enough 'devoted time' to engage on a regular basis with a health trainer, which is something they felt is rare among carers. Furthermore, it was felt that carers on the whole know what they want and need to live more healthily and it would be a waste of 12 weeks to meet someone to discuss this. There was general agreement within the group that what would be really helpful was some kind of KCC-funded voucher system, whereby vouchers could be issued to carers who could then redeem against healthy living services they want to access, but at their own convenience. For example, one carer knows swimming would make her feel happier and healthier, for another it is yoga and pilates, for another it is golf, and another it is counselling. This more flexible voucher system would get around the twin problems of rigid class times and attendance requirements, and the cost of accessing some healthy living services (either because they charge a fee or because of the cost of paying a substitute carer). This addition to the current service would be much better suited to carers' daily lives.

***In the old days they used to give you swimming vouchers – I could fit that round my caring responsibilities.***

***If there was a voucher system, to be used at any time convenient to you, then that would be really good.***

There was also a discussion about self-motivation. It was felt that none of the services on offer would be of any use or interest to people if they were not self-motivated to change in the first place. And some participants felt that they could motivate themselves to change their lifestyles without help from others – it was just that they were stymied by logitical or time barriers.

***You have to have the will to do it in the first place. If you're not in that mind set, you're not going to do it [use the public health services] anyway.***

***Physically right now, I don't need this. I think personally I can deal with this myself.***

# 4 The Proposed Service Model

# 4 The Proposed Service Model


This chapter of the report explores responses to the proposed service model; looking initially at the perceived positives and risks associated with the model, before looking in more detail at some of the specific service requirements such as delivery channels and opening times.

**Summary of key points**

- **The general response to the proposed service model and example case study was reasonably positive, with participants agreeing that the more integrated approach was much more convenient for the user.**
- **The idea of a mentor – a single person dedicated to providing support - was given a guarded welcome, although there were concerns about a system that relied so heavily on volunteers.**
- **The availability of online support was also welcomed as this would make services more available to carers who found it difficult to arrange face to face meetings, or schedule appointments during the day.**
- **For similar reasons, participants were in favour of the idea of services being available in the evening and over the weekend.**
- **One delivery channel that was thought to be missing from the proposed model was outreach (to day centres/care or nursing homes) or home visits – something that would open up the services to housebound users, and carers who found it hard to leave their dependants.**
- **But overall, the proposed service was not considered suitable for carers given it still required 'dedicated time' to engage with an advisor.**
- **Furthermore, there was evidence of some deep rooted suspicions (based on previous poor experiences of other services provided by authorities), that the health improvement services would just not be flexible enough for carers' needs.**

The general response to the proposed service model and the example case study was reasonably positive, with participants agreeing that the more integrated approach was much more convenient for the user.

***To have one point of contact who's got a general working knowledge of his condition, and his goals, that definitely helps – rather than having to tie in with two or more people.***

The idea of a mentor was given a guarded welcome, although there was some concern that the system would have to rely on volunteers. There were worries that not enough volunteers would be recruited and the service would fail. There was also some concern about the level of training that would be offered to volunteer mentors, and a feeling that if financially stretched carers were to become mentors, they should be paid.

***Having just one person to give you support – that is a good thing.***

***But are the mentors volunteers? Can they sustain that service? It might fall away again, and then there's nothing.***

***If carers went through this programme, and wanted to be a mentor, then they should be offered some monetary reward. That would give the mentor carer a little bit of income and self-worth.***

Another positive aspect of the revised service model was the proposal to offer services online. This was appealing to those who found it difficult to commit to attending sessions, but who could use an online channel to seek advice and support at a time that was convenient to them.

***I looked at this and thought – oh good, I can do this online at 3am in the morning… because we're fairly inflexible, that would give us more possibility of choosing when.***

However, others pointed out that not everyone had computer access or good enough broadband.

When asked for their views about attending group sessions, there was a mixed response. As discussed earlier in this report, the main problems identified with attending group sessions were the difficulty and cost of arranging care cover. But there was also a recognition that the mutual support offered by groups of peers could be beneficial.

Some participants felt that they would feel much more comfortable attending meetings with a group of carers than with a general public group. There was a feeling that only other carers would really understand the daily stresses that were behind individuals' unhealthy lifestyles; and there was a nervousness for some about discussing mental health issues in an open group.

***I feel comfortable in this group with all carers, but I wouldn't feel so comfortable in a group of other people. We speak a secret language. I'd go to a fat club for carers, but not a general fat club. I wouldn't want to divulge my personal life to other people in the village.***

However, other participants felt that a weight loss group of non-carers, for example, would be fine.

***As long as it's a big enough group, you can find people you relate to.***

When asked for their views about what opening hours the KCC-funded services should operate, participants agreed that the services should be available in the evenings and seven days a week, in order to maximise the availability of the service to different groups of people. It was felt that carers in particular would benefit from evening access, given that there only tended to be a break or reduction from caring responsibilities once their dependants were in bed.

***The government wants us to be 24/7, so the advice should be available at weekends.***

***Surely you could have advisers on early and late shifts.***

A key requirement for opening hours was felt to be flexibility and tailoring access according to individual users' needs.

***If you're supposed to be building up a rapport with the adviser or trainer, then surely you could arrange on a one-to-one basis what works for you.***

It was also recognised that the need for services to be available 24/7 depended on the particular health problem in question.

***Depends what the problems are – for drinkers about to go on a binge, they might need help in the middle of the night. For weight loss, it probably wouldn't be so urgent.***

One delivery channel that was felt to be missing from the proposed model was home visit, which would be particularly suitable for the housebound, or individuals such as carers who found it difficult to make arrangements to leave the house. It was suggested that home visits or outreach would work if the health trainer could plan ahead and cluster visits. It certainly would be an efficient way of seeing clients receiving support in day centres or at support groups or in nursing homes.

Overall, the group viewed the proposed model as 'fine on paper' and agreed it looked to be an improvement on the current model. However, there was a strongly expressed opinion that the proposed health improvement services would not really cater for anyone outside the mainstream such as carers. The reasons are twofold: firstly the group felt their lives were too complicated to fit in with the way the service operates; and secondly, the way the case study presented the service, carers were not convinced it would address the root of the problems they face trying to lead healthier lifestyles – things like lack of money/being impoverished, exhaustion due to caring responsibilities, and so on.

As with some of the other workshops conducted as part of this project, there was also some underlying cynicism that the proposed changes were a way of masking 'austerity cuts.'

# 5 Individuals Cared For

# 5 Individuals Cared For

This chapter explores carers' views about how the KCC-funded services could be used by the individuals that they cared for.

**Summary of key points**

- On the whole, it was agreed that the current and proposed services would not be appropriate for the individuals they cared for. It was felt that for these services to be accessible to this group of dependants, specialist staff would be needed who were trained in understanding and dealing with learning and physical disabilities.
- There was also scepticism that KCC would fund this kind of specialist service, despite there being a need for it.
- For individuals suffering from mental health problems, it was suggested that continuity and rapport with the adviser or trainer was important.
- Other suggestions to improve access for this group included home visits, and mobile advisers who could visit residential care homes to offer healthy lifestyle advice to both the residents and the staff who cared for them

Participants were asked whether they thought the KCC public health services would be of use or of interest to the people that they were caring for. On the whole, it was agreed that the current and proposed services would not be appropriate for individuals with such specific disabilities or problems.

For instance, one carer talked of past attempts to involve his wife who has severe dementia in group activities. It was clear very quickly that her behaviour was too disruptive for a group setting.

Another carer whose daughter had severe learning disabilities and required one to one support for much of the time, felt that without specialist trained staff, the KCC healthy lifestyle services would not be able to cope with her daughter's needs.

It was also pointed out that any service that a dependant attended would also most likely require the presence of the carer, organisation of transport and so on, and would therefore add to the already complex burden of that carer.

***With her disabilities, if she wanted to, I'd have to go with her. And that would be something else for us to cope with.***

It was acknowledged however that this group of individuals could benefit from some healthy living advice and support.

***It's the lack of exercise, due to the disabilities, that leads to weight gain, even if they don't eat very much.***

***My daughter hasn't got the mental capacity to choose the right food, or the right amount of food. Yes, she has weight on her, and needs to do exercise. She couldn't go to a normal gym. She wouldn't understand the machines.***

There was some scepticism that KCC would fund specialist support for this group of individuals. But various suggestions were made by the participants about how services would need to be adapted to be accessible to the people they cared for. These included specialist trainers for people with learning disabilities; referrals to trainers or services suitable for people with physical disabilities (such as adapted gyms); home visits for individuals who were house bound or for whom it was difficult to leave the house; mobile trainers or advisers who could visit residential care homes to advise both residents and the staff caring for them about healthy lifestyles.

There had been little experience of these kinds of services within the group. However, there was one carer whose paralysed son had attended an exercise class for people with disabilities – the class was run by a trainer who himself was in a wheelchair and who had some understanding of the particular problems of his class. This carer was unsure whether within the proposed services, KCC would be able, for example, to help people in wheelchairs who wanted to lose weight, or whether some of the budget could be put aside so that people with care needs could access specialised services and not be forced to use mainstream services.

For those with mental health issues, it was suggested that it was particularly important that they should be able to develop a rapport with a single adviser or mentor who understood their needs. Continuity and face to face contact was felt to be really important for this group so that they did not have to keep repeating themselves to different staff and could build up a relationship of trust.

***When my husband was looking for support in getting back to work, he saw someone who clicked with him – they were both ex-naval. But then that adviser left, and the advisers kept changing and he just had to repeat himself, or he didn't get on with them. With his mental illness, he wants to see the same person.***

# Appendices

## Discussion guide

### 16-010075-01 Kent County Council: Adults Health Improvement Service Groups: CARERS

NOTE TO MODERATORS: THIS GUIDE IS STRUCTURED SO THAT PARTICIPANTS ARE PRIMARILY ANSWERING QUESTIONS CONSIDERING THEIR OWN HEALTH. THERE IS A SPECIFIC SECTION LATER IN THE GUIDE WHICH ASKS THEM TO CONSIDER THE SUBJECT MATTER IN LIGHT OF THE HEALTH OF THOSE THEY CARE FOR

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| | Moderators welcome observers, run through their roles and rules of engagement |
| **13.30 – 13.40 (10 mins)** | **Plenary introduction**<br><br>• Food and drinks served<br>• Welcome participants; thank them for coming, introduce Ipsos MORI (as **independent** research company)<br>• Introduce Public Health Team at KCC – they have asked us to talk to local residents to hear your views about how local healthy lifestyle services might develop in the future<br>• Explain the 'other issues' flipchart which we will use to park issues not directly relevant to the research but which participants want to comment on<br>• Outline anonymity, Market Research Society code of conduct<br>• Seek permission to audio record<br>• Reassure participants that it is okay to disagree and that everyone's opinions are valid and important, and that the moderator may need to interrupt people to move the discussion on<br>• Housekeeping – toilets, fire escapes, mobile phones on silent etc.<br>• Timetable for the session – breaks<br><br>• Moderator to ask participants to introduce themselves.<br>• Ask participants to talk a little about their caring responsibilities (how much time per week they spend caring for someone else, what kind of care they provide – physical, emotional, practical, how long they have been doing this) |

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| **13.40-13.50 (10 mins)** | **<u>Healthy lifestyles</u>**<br><br>**'HEALTHY LIFESTYLES'**<br><br>**To begin today, we're going to talk a bit about what you understand by the term 'healthy lifestyles'.**<br>**When I talk about "healthy lifestyles" what words come to mind? What do you immediately think of?**<br><br>*Encourage participants to name short (ideally one word) answers, moderator to note responses on a flipchart. Note whether words and images tend to be positive or negative.*<br><br>**Tell me a bit about why you picked those words**<br>*Make sure moderator captures their reasoning as well as answers to the question – why do they think certain things?* |
| **13.50-1400 (10 mins)** | **<u>Public health in Kent</u>**<br><br>**Kent County Council has the responsibility for improving and protecting the health and wellbeing of the public across the county.**<br><br>**This means reducing the gaps in health and life expectancy by addressing things like:**<br><br>• **Reducing levels of excess weight**<br>• **Increasing levels of physical activity**<br>• **Reducing smoking prevalence in general population**<br>• **Reducing levels of smoking during pregnancy**<br>• **Improving the wellbeing of the population**<br><br>**Here is a handout that shows the current services they fund. These services are funded by KCC but delivered by different providers with expertise in specific areas.**<br><br>**HANDOUT 1– KCC SERVICES**<br>*Participants read handout and discuss as a group.*<br><br>• Were you previously aware of these services?<br>• Did you realise KCC was involved in these services? *Probe around whether people are clear about how KCC are involved in these services.*<br>• Who did you think was responsible and why?<br>• What do you think of the range of services on offer? |

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| | • Are there any services you would expect KCC to be fund that they are not presently? |
| **1400-1425 (25 mins)** | **<u>Moderation activity and current service use</u>**<br>*Note: as well as capturing use of services to moderate behaviour, this section can also cover attempts made by participants to change their behaviour independently without the use of services – looking at how self-motivated they are to do so.*<br><br>**How healthy is your lifestyle?**<br>**Why do you say that?**<br>**How motivated are you to be 'healthy'? Why do you say that?**<br>**What things encourage you to be 'more healthy'?** (probe for issues such as support of family, joining a club, good weather etc)<br><br>**What impact do your caring responsibilities have on your health and wellbeing?**<br><br>*Make a note of unhealthy behaviours people are concerned about.*<br><br>**You say you are concerned about X or would like to do Y less. What have you done to try and change that habit/your behaviour?**<br>• Did that work? Why do you say that?<br>• IF ATTEMPT DID NOT WORK: What would have helped?<br><br>**What help or support have you sought out?** *Probe for help from GPs/other healthcare professionals, websites, charities, friends/family, local community initiatives, apps*<br>• **Have you ever made use of groups or services in the community? Is this something you can imagine doing? Why/why not?**<br>• Did this help in changing your behaviour? How?<br><br>**What services have you used?** *NOTE if participants mention KCC, private service (e.g. weight watchers) or some other.* **Tell us a bit about your experience**<br><br>**What services have you considered but declined to access? Why is that?** |
| **1425 – 1440 (15 mins)** | **<u>Current service model</u>**<br><br>**So thinking a bit more about the services currently offered by KCC. Here is another handout which shows how the services are currently structured.**<br><br>**HANDOUT 2 – CURRENT SERVICE MODEL AND 'BEFORE' SCENARIO FOR THE CASE STUDY OF ADAM**<br>*KCC rep or Ipsos MORI moderator to explain how services are currently structured – emphasising that the services are currently independent from one another.* |

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| | **What do you think about how services are currently structured?**<br>• What questions do you have about how services are currently structured?<br><br>*Ipsos MORI moderator to then read aloud the 'before' scenario*<br><br>**What are your initial thoughts about this scenario? What is good/bad about it?**<br><br>**What improvements could be made to how these services are provided?**<br>*Probe to understand why they think there could be low uptake of some services currently*<br><br>**How do you feel about the current services being independent/separate from one another?** |
| **1440-1505 (25 mins)** | **<u>Proposed service model</u>**<br><br>**KCC is considering changing how these services are provided. Here is a handout which shows their proposed changes.**<br>**HANDOUT 3 – PROPOSED SERVICE MODEL AND 'AFTER' SCENARIO FOR THE CASE STUDY OF ADAM**<br>*KCC rep or Ipsos MORI moderator to explain the proposed changes and rationale behind it, including reference to the key element of self-support. Ipsos MORI moderator to then read aloud the 'after' scenario*<br><br>**What do you think about the proposed changes?** *Check initial thoughts/any confusion*<br><br>**What do you like about the ideas?** Why?<br><br>**What do you dislike about the ideas?** Why? How could it be improved/ mitigated? *Probe on if there are any gaps.*<br><br>**PROBE for thoughts on key characteristics of the case study:**<br>• **Do you think it's a good idea that Adam has an opportunity to access support on a range of health themes or do you think this may put him off seeking support? E.g. if he just wants to quit smoking**<br>• **Mentor: what do you think of this idea and what does it mean to you? How might it work/not work? Should this be an unpaid role? What do you think of the name 'Community Champion'? Are there any other potential names can you think of?**<br>• **Continued support: How frequent should any follow up support be offered and in what format? What else could be done to support Adam to maintain his changed behaviour?**<br>• **How important is it that Adam is in contact with the same person/health trainer throughout his journey? At what points in his journey should Adam see the same person/health trainer?**<br>• **How do you feel about the idea of a group session with a mentor? How do you think this would work? Do you think this would affect the individual's relationship with their mentor? What do you think are the advantages/disadvantages of this?**<br>• **Are there any elements of the service you would change or you feel should be included? Why? How?**<br><br>**The case study makes reference to a 'community venue' – what venues does this make you think of?** |

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| | **Where should face-to-face services like these be held?**<br>• *Probe on dedicated buildings, GP surgeries, pharmacies, existing community spaces such as libraries, leisure centres*<br>• *Probe around issues such as transport, car parking*<br>• Are there certain places you wouldn't want the services to be located? For example, near schools or where neighbours might see you?<br><br>**What should the operating hours of a service like this be?**<br>• *Probe on weekend/weekday/ evening and the type of support required at each of these times/days*<br>• What are the critical times it needs to be open?<br><br>**Telephone support: what do you think about receiving advice and support over the phone?**<br>• Does the telephone line need to be free or a reduced tariff line?<br>• What should the opening hours be? What are the critical times it needs to be open?<br>• What other considerations should there be when providing support by telephone?<br><br>**Online support: what do you think about receiving advice and support online?**<br>• What are the benefits/drawbacks of doing so?<br><br>**Would *you* use these services? Why/why not?**<br>**What could be done to encourage people to use the services?**<br><br>**What can KCC do to support people who want to change their habits/behaviour but who are unlikely to use the proposed services?** *Probe for: what information they should provide and where, if KCC should be running communication campaigns targeted at the population level, what would make them take notice of a campaign such as this*<br><br>**Having talked through the case study, do you see any risks in changing the way services are provided?**<br>*Probe around:*<br>- *Dilution of specialist skills as health trainers would be generalists*<br>- *Too high a demand for the services*<br>- *Over-reliance on the health trainer*<br>- *Lack of compatibility with the health trainer*<br>- *Inability to consistently see the same health trainer*<br>- *People remaining in the system too long*<br>- *People who only want to tackle one behaviour are put off by the 'holistic' approach* |
| **1505-1520 (15-20 mins)** | **<u>Service use by those they care for</u>**<br><br>**For the final 15-20 minutes of this group, let's think about those you care for.** |

| | |
|---|---|
| | **Would any of these services be helpful to those you care for?** *Probe sensitively to understand more about their physical and mental condition*<br><br>**Have they ever accessed similar services before? Tell us a bit about that experience – what worked, what didn't?**<br><br>**How likely is it that those you care for would make use of these services? Why/why not?**<br><br>**What practical considerations would need to be in place for these services to be accessible to those you care for?**<br>• Think about f2f, telephone, online access?<br>• Think about group work versus individual consultations?<br>• Think about accessing the services through a health trainer?<br><br>**What would be helpful to you *as a carer* helping someone else to access these services?**<br>• Think about transport, locations, opening hours etc. |
| **1525-1530 (5 mins)** | **<u>Last comments</u>**<br>**What questions do you still have at this stage?**<br><br>*Thank participants for taking part today.*<br><br>*Hand out incentives and sign form.*<br>*THANK AND CLOSE*<br><br>*Moderator to take photographs of the final flipcharts* |

## Case Study

### Case Study 1: Adam's journey under the current model

Adam is a 53 years old man who displays a variety of unhealthy behaviours; including smoking, over eating and excessive drinking, he also does not do enough exercise.

Adam has been trying to quit smoking unsuccessfully. He visits his **GP** for help who **refers him to the Stop Smoking Service**.

Sharon from the **Stop Smoking Service calls Adam** 2 days following the referral and goes through all the options for quitting smoking. Adam decides to quit through in a group setting and she books him onto a **7 week Stop Smoking Course**.

Adam is supported by Tracey, the Stop Smoking Advisor, who provides him with specialist support over the 7 weeks. The aim is for Adam to be smokefree for 4 weeks. Adam agrees to Tracey following up and receives a **text or phone call 6 months and 12 months after** leaving the Stop Smoking Service to see how he is getting on.

Adam is also worried about his weight and discusses this with Tracey before he leaves the service. Tracey advices Adam on healthy eating and she makes a **referral to the Healthy Weight Team**.

Graham from the Healthy Weight team makes contact with Adam following the referral and books Adam to see a **Healthy Weight Adviser at his local Pharmacy**. Adam is then seen by Trevor for 12 weeks for support for losing weight. Trevor advised Adam to increase his physical activity and is **signposted to a local walking activity** in his area.

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### Case Study 1: Adam's journey under the proposed changes

Hannah from the **Health and Wellbeing team calls Adam** 2 days following the GP referral. She gains an understanding of Adam's lifestyle, how he would like support, what he has previously tried and what his personal goals are.

Adam explains that he would like to be fitter and healthier and his main priority is to quit smoking but that he also would like to lose weight. Hannah makes an appointment to meet Adam the following week **at a community venue local** to him. Hannah explains that **she will see Adam for up to 12 weeks**, with the intention that by week 7 he would have quit smoking. Hannah also explains that she will advise on healthy eating and drinking during these sessions and will focus on healthy eating more directly for the following 5 weeks, with the hope to achieve Adam's goals. During the weekly sessions Hannah motivates Adam, providing advice and support.

After 12 weeks, Hannah discharges Adam and offers him a **'mentor'** to support him with continuing with his new healthier behaviours.

Adam also agrees to being followed up and receives a **text or phone call 6 months and 12 months** after leaving the service to check he is still on track with his changes in behaviour. Adam is also offered an **opportunity to become a mentor himself** so he can motivate others.

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## About Ipsos MORI's Social Research Institute

The Social Research Institute works closely with national governments, local public services and the not-for-profit sector. Its c.200 research staff focus on public service and policy issues. Each has expertise in a particular part of the public sector, ensuring we have a detailed understanding of specific sectors and policy challenges. This, combined with our methodological and communications expertise, helps ensure that our research makes a difference for decision makers and communities.

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Ipsos MORI
Social Research Institute

Kent County Council
kent.gov.uk

March 2016

# Adults Health Improvement Service

## Focus groups of adults with a learning disability

# Contents

# 1 Background

# 1 Background

This report documents the findings of two focus groups held with adults with a learning disability living in Kent. It covers an extension to the research previously undertaken by Ipsos MORI looking at views of the general public to a proposed change in how public health services in Kent are structured and delivered.

This chapter provides an overview of the original research programme and the extension covered by this report.

## Background to the study

A new public health strategy for Kent is being developed to ensure that the future approach to public health will be based around the needs of the person, encourage personal responsibility, be delivered within integrated services and reduce health inequalities.

As part of this strategy, Kent County Council (KCC) is looking to change the way adult health improvement services are provided and it has developed a proposed service model which will integrate previously separate services. It is envisaged that the proposed service model will look beyond individual behaviours and seek to improve the overall health and wellbeing of the person, with mental and emotional wellbeing underpinning the whole service delivery. This proposed service model will be commissioned in early 2016 to start delivery in 2016/2017.

A number of workstreams have fed into the development of the proposed service model, including a public consultation[1] and behavioural insights study. Over the course of November-December 2015, Ipsos MORI, on behalf of KCC, ran 12 qualitative workshops with potential service users, seeking their views on the proposed service model. A full report has already been produced summarising the findings from these workshops.

## Research objectives

The specific research objective for this study was to understand the service needs of adults with a learning disability; looking to identify any requirements this audience may have in terms of accessing a service such as the one being proposed.

## Research approach and methodology

Two focus groups were held with adults with a learning disability to allow a qualitative exploration of the subject matter. The discussions covered participants' approach to living a healthy lifestyle, the advice they have received to assist in this, and sought to test their response to components of the proposed service model. The focus groups followed a discussion guide, designed in conjunction with KCC, and included the use of a case study as stimulus for discussion; both of which are appended to this report. The discussion guide was loosely based on that used in the previous research with potential service users but modified substantially to meet the needs of this audience. The groups focused on physical activity and diet.

[1] Kent County Council Health Improvement Services Consultation http://consultations.kent.gov.uk/consult.ti/Healthimprovement/consultationHome

The groups were held in Gravesend, lasted approximately 1.5 hours and took place in late February/early March 2016. Twelve adults with learning disabilities attended the groups in total and were accompanied by three professionals well known to them who were either involved in recruitment or overseeing the supported accommodation in which the groups took place. These professionals contributed their views as part of the research and verbatim quotes are labelled accordingly.

## Recruitment

The focus groups were recruited through North Kent Independent Advocacy Scheme (NKIAS)[2] who provide advocacy and generic support to people with learning disabilities in Kent. The groups were purposefully held with participants who already knew one another to ensure they felt comfortable talking in the group setting. One group was held with residents of the supported living service. The other group had a mix of individuals who lived independently or with family members, alongside residents of the supported accommodation. All participants had a mild to moderate learning disability. The majority were not working. Many of the individuals involved had physical health problems which the proposed health service could assist with such as diabetes.

## Presentation and interpretation of the data

It is important to note that this report presents the findings of two focus groups. Qualitative research is used to shed light on why people hold particular views, rather than to estimate or quantify how many people hold those views. Such research is intended to be illustrative and detailed rather than statistically representative of a wider population and, as such, does not permit conclusions to be drawn about the extent to which something is happening. It also enables researchers to test the strength of people's opinions. With this in mind, when interpreting the findings from this research, it should be remembered that the results are not based on quantitative statistical evidence but, like all qualitative research, on a small number of people who have discussed the relevant issues in depth.

Verbatim comments from the focus group have been included within this report to provide evidence of participants' views. Quotations should not be interpreted as defining the views of all participants, but have been selected to provide insight into a particular issue or topic expressed at a particular point in time.

## Acknowledgements

Ipsos MORI would like to thank Louise Flatman and Tanya Orchin of NKIAS, and the staff at Blenheim Grove, for their assistance with this study. We would also like to thank all of those who participated in the research and shared their experiences with us.

[2] http://nkias.co.uk/

# 2 Healthy Living

# 2 Healthy Living

This chapter looks at the context into which the proposed service model would be introduced. It explores the barriers which prevent individuals from living a healthier lifestyle, and looks at the participants' experiences of services which aim to equip them with the know-how to improve health behaviours.

**Summary of key points**

- Many of the participants had a physical health condition such as diabetes which the proposed service model could assist with.
- Few examples were given of regular physical activity being undertaken and, for some, cooking from scratch presented a challenge leading to a reliance on others providing cooked meals or eating a lot of microwave ready-meals.
- Individuals expressed an interest in living healthier lifestyles, particularly in relation to doing more physical activity. Whilst for some this was driven by a desire to lose weight or help control their diabetes, for many the opportunity to be sociable and have some fun was more important.
- A whole host of barriers are present to living a healthier lifestyle and these pertain to travel, safety and confidence (all of which would be aided by having a companion or carer's assistance). In some instances having a lack of knowledge around food and cooking presented a challenge, and experiences of poorly communicated guidance did not help with this.
- The groups had numerous examples of being given advice on healthy living previously. Experiences of receiving this advice in a one-to-one setting (such as from a healthcare professional or carer) were mixed but participants were unanimously positive about the practical guidance they had received in group settings.

## Healthy lifestyles

Participants were asked to talk about their hobbies and daily life as a way to start the discussion around healthy lifestyles. There was a great diversity of experience with some individuals very active, and sociable, engaging in a wide array of hobbies, whilst for others this was not the case. Across the participants, few were regularly engaging in physical activity beyond that necessitated by daily life. The examples given of physical activities undertaken on a regular basis were table tennis, Zumba and walking. Again an array of experience was held in terms of participants' ability, and desire, to cook. Some did so independently (often making use of a standard repertoire of meals that they would cycle through), some were cooked for by family members, whilst others relied heavily on microwave ready-meals. Many of the participants had a physical health condition meaning they were a wheel-chair user, diabetic or overweight.

Both groups expressed a desire to live more healthily – for a few this was about learning to cook, but for many this was about doing more physical activity. This was driven by a sense of knowing it would benefit their health to lose weight or become fitter, but they also expressed an interest in the social aspects that physical activity could bring, seeing it as a fun opportunity. They could however name a number of barriers which prevented them from achieving these aspirations.

## Barriers to healthy lifestyles

Individuals were quick to name reasons why they did not exercise or cook as much as they would like. These have been grouped below.

### Travel

Many of the participants lacked confidence in using public transport independently. The individuals who attend table tennis and Zumba classes on a regular basis are transported to and from their home by a bus service specifically for individuals with a learning disability. Some participants talked about feeling unsafe and uncomfortable when travelling alone, others said they struggled with reading information such as bus stop names or remembering the route. This led many to say they would prefer travelling with a carer or companion who could be trusted.

***No [I don't travel by myself], I go with carers. I only went once to Dartford [by myself] and I didn't like it. I wanted to come back but I pushed myself. I just didn't feel comfortable.***

***I've got to have someone in the swimming pool with me and to take me there. I can't go on the trains myself.***

***I want to be independent without me weighing them [my parents] down [requiring transportation]. [I need to travel with] someone I can trust.***

Though this was not the case for all participants (a handful were comfortable travelling independently), many individuals would need to secure a travelling companion or travel arrangement which does not involve public transport, if the proposed service model needed to be accessed away from home or a location familiar to them. This in itself can present challenges.

### Safety

Linked to the above discussion on travel, some participants went on to explain that fears about their safety prohibit them from travelling independently, especially when it is dark. Feeling unsafe, and not having a suitable travel companion, stopped some participants from attending sessions for people with a disability at their local sports centre.

***We don't feel safe out there. We don't. Me, I'm looking around, over my shoulder all the time.***

***At the local sports centre on a Thursday evening, they do have a session that is for people with disabilities where you pay one price and the whole sports centre is open. The problem with it is because it's in the evening, a lot of people don't feel confident going out on their own, because we are saying to people about keeping safe, it's about having somebody to support them to go to it. So there are some services [available] but they are not always easily accessible. (Professional)***

### Confidence

For a few of the participants, a lack of self-confidence made accessing public services a daunting task. They expressed a self-consciousness about their body or their learning disability; assuming they were going to be looked at or commented upon in an unfavourable way. For one individual in particular, a nervousness and anxiety around strangers made the presence of a familiar companion all the more important.

***I don't know if it's silly or something but people looking at me, my body or something, or people pointing at me and laughing or something.***

***If there are people there without disabilities, they tend to look at you don't they, in a funny way.***

***We talked about you going for a swim and I said, 'oh you could get the bus, I'll give you the route' and you said, you didn't want people looking at you. (Professional)***

***I get so nervous with people. Once I'm in there [exercise class] I'd be fine but it's the first session, I get so nervous around people.***

The three themes listed above all concern the common desire for individuals with a learning disability to be accompanied outside the home.

***They don't have a support system. You were saying you wanted to Zumba but had no-one to go with. When people live independently, you are a lot more cut-off. There might be things there but not having the support or that bit of confidence to go. (Professional)***

### Guidance and information

Two participants in particular talked about needing a Person Centre Plan before they felt comfortable embarking on an exercise routine. For one individual who has severe epileptic fits, the Person Centre Plan was thought to be the best way of establishing which forms of exercise were safe for them to undertake and under what conditions. Both individuals expressed a strong dismay that their requests for a Person Centre Plan to be completed with them had not been answered.

***<Named individual> helped me email the swimming pool, to do a Person Centre Plan but they never got back to me. We emailed 20 times and that.***

A couple of participants named instances where they were given information on healthy living but the speed of delivery and large volume led to a lack of understanding and confusion. The delivery of guidance and information is returned to in chapter 3 as a crucial aspect for consideration in the proposed service model.

***The dietician, she was doing it too fast and I didn't understand what she was saying. I asked her to slow down and she looked at me 'why should I slow down? I want to do it quickly so I can get out and go somewhere else'.***

***They [doctor] gave me two bits of paper saying I've got to be really careful what I eat. And I get a bit confused when they are telling me about the food stuff. It was a list of foods. I'm okay if I don't have to think about too much stuff at one time.***

### Knowledge

Some participants talked of lacking the knowledge about how to cook from scratch and listed this as a reason for their reliance on microwave meals. As discussed in chapter 3, for some participants, cooking presents health and safety challenges meaning learning how to cook goes beyond understanding what is/is not healthy to eat.

***I don't [plan my meals] cos I don't know how to cook. I buy meals for the microwaves and I've been told that's not healthy. Because I haven't been trained how to cook, I haven't been shown nothing, right from day one and I still don't know nothing.***

***I always keep burning myself [when cooking].***

## Prior service use

Many of the participants had prior experience of being advised on how to live a healthy lifestyle – talking through these experiences was a helpful way for individuals to express inadvertent views on the proposed service model. Mixed experiences were had of the information and advice provided in one-to-one settings (with doctors, other healthcare professionals or carers) but participants were unanimously positive about the healthy living advice they had secured in group settings.

### Doctors

A couple of individuals talked of negative experiences they had had of doctors providing advice on healthy living. They expressed a sense of not been listened to or being spoken to unsympathetically in a way that negatively impacted on their self-esteem. Others may well have had more positive exchanges with doctors but did not bring this up as part of the group discussion. From the wider discussions as part of the groups, it is possible to infer that individuals were likely to feel negative if they were rushed through their appointment, spoken at too quickly or that they saw someone unfamiliar to them.

***The doctors don't listen to me.***

***They ask me the same questions all the time. They are stupid questions about being fat or something and I get angry and get upset when they say about fat questions, it's not like I'm obese. I don't need someone saying that, it takes your self-esteem away. You have issues with your weight when you are diabetic anyway, it makes you feel like you have even more issues. Doctors could say it in a more nicer way. They say things and they are not sympathetic to how you are feeling.***

### Other healthcare professionals

Lots of individuals had been visited by a nurse, dietician or occupational therapist to discuss healthy living, often following a diagnosis such as those who had recently learnt they were diabetic. Experiences of seeing these healthcare professionals were broadly positive and regret was expressed in many cases that the participants no longer saw them. One participant had been shown how to make healthy 'shakes' in place of the fizzy drinks they consumed, another had help to complete a Personal Care Plan for physical activity, whilst another was given a series of photographs detailing the order in which to cook their meals and providing guidance on portion size – photographs which they had kept and claimed to still make use of.

### Carers

Some discussion was given to carers' roles in assisting with a healthy lifestyle. Whilst there are likely to be countless examples of where carers have helped in this regard, the groups mentioned only the instances where the relationship with their carer had disrupted the learning process. In the most extreme example, it was described how a carer had dissuaded someone from attending their Weight Watchers sessions. Others talked of exchanges with their carers that had eroded their trust in them. One individual who has severe tunnel vision, was led across the road when a red man was showing and after this he felt distrustful of his carer and any advice they might provide. Another spoke of his carer being 'too bossy' and directive in their style of advice which made him less receptive to it.

***I had a lady who was going Weight Watchers for quite a while and then got a carer who didn't want to go and persuaded her she didn't want to go no more. (Professional)***

***She used to do the shopping with me and she took me across the road on a red light instead of a green one. No [I didn't like that].***

### Group settings

The groups gave a number of examples of where they had been given advice and practical experience concerning healthy living. These were talked about very positively as fun and engaging events which they would like to have continued. Many of the events or courses were devised and organised by NKIAS and the supported accommodation in which the groups were held; the continuation of which was affected by a lack of funding.

- Come Dine with Friends held at the supported living centre – once a week, participants would learn about calories and the content of food before selecting ingredients and putting together a menu which they then cooked (and ate) collectively.

  ***That worked really, really well because it was pictorial, but it was also practical. It was a laugh. We started that to get people making friends and maybe entertain in their own home. (Professional)***

- Healthy Living Club held at the supported living centre – each week about 12-14 people would get together and learn about healthy living. This involved being weighed, doing group exercise, having external speakers, and holding food tasting sessions.

  ***I miss that [the Healthy Living Club].***

- Cyclopark in Gravesend – the park has adapted bikes for people with disabilities and a successful one-off trip was organised. Participants expressed a desire to return but the park has limited sessions specifically for people with disabilities and these tend to be booked quickly by day centres meaning there is no space and very little flexibility to organise something more regular.

- Cookery lessons at the local college – some participants attended these practical cookery lessons but they have been discontinued.

  ***Oh yeah I loved it [the cookery lessons].***

- 'Gladiator' sessions at the local sports centre – this was a semi-regular race day specifically for people with disabilities but which is no longer run.

- Drop-in group sessions with nurses held at the supported accommodation. Different nurses would come in to speak with the group about a wide array of subjects from diet and exercise to personal hygiene, friendships and relationships. Again, some dismay was expressed at these sessions no longer being run.

In discussing the group activities in which they had taken part, it was apparent that the sociable and fun aspects were highly valued by participants (potentially more so than the advice dispensed or learnings gained). As discussed in chapter 3, there is a need for repetition of key messages and hands-on practical experience in order to assist individuals to make (and sustain) changes in their lifestyle.

# 3 The Proposed Service Model

# 3 The Proposed Service Model

This chapter explores responses to the proposed service model – both as a result of talking through the case study but also as a consequence of general discussion around settings in which individuals feel comfortable and preferences for communication.

**Summary of key points**

- Individuals spoke positively about receiving practical help and advice regarding healthy lifestyles. The integration of services as part of the proposed service model appears to be a sensible proposition as long as there is clarity on the subject areas being discussed.
- Individuals are looking for practical support, and not just advice, on healthy living. For example, this would involve hands-on experience of broad issues (such as shopping, food storage and safety in the kitchen) alongside any discussion of eating a healthy diet.
- Face-to-face contact was strongly preferred, as it was seen to be the best way to build trust, whilst communication by telephone and online present challenges. A preference was also exhibited for group work as an opportunity to socialise and have fun, though there were not inherent issues with seeing an advisor one-on-one (provided it was face-to-face).
- It was suggested that KCC could make use of pre-existing community groups or supported accommodation – either by having a health trainer attend groups in these settings, or by supporting initiatives already being run by these groups to aid healthy living.
- Continuity was considered to be important – this could be in terms of group attendees and location, or in terms of the health trainer if seen one-on-one. Some concerns were raised about an unfamiliar mentor being introduced as part of the process, though the continuity of care was welcomed and recognised to be an important part of sustaining behaviour change.
- Participants were keen for pictorial communication and stressed the importance of being spoken to 'on a level'.
- Some concerns were raised by the professionals as to how individuals living independently or with family members were to hear of the proposed service model. Being unconnected to a learning disability community could leave these individuals disadvantaged.
- It is clear that the proposed service model would need to be highly tailored to meet the needs of individuals with a learning disability. The research lends itself to the suggestion of the service being accessed through health trainers providing practical guidance face-to-face in pre-existing group sessions, allowing for some form of continuity of care to reinforce messaging.

## An overview

As referenced in chapter 2, both groups expressed a desire for help in living a healthier lifestyle (or at least an interest in some of the sociable activities which might be part of that experience). 'Help' did not always equate to 'advice' as some individuals felt they could achieve their physical activity goals through having a companion or network of individuals with whom they could exercise with.

One of the basic principles of the proposed service model is the integration of services which are currently separate. It was difficult for participants to comment on this explicitly but wider discussions suggested this was a sensible proposition logistically but that it was important subject areas such as diet and exercise were not discussed interchangeably as that could be confusing for individuals.

## Content

When discussing diet, participants felt the proposed service model needed to be broad in its instruction. Having a healthy diet meant having knowledge and confidence with respect to food shopping, preparation, cooking, storage, cleaning and general health and safety. For example, one participant bought a lot of food (including vegetables) in advance of Christmas without understanding that the use by date would come before they were planning to cook the meal. As referenced in chapter 2, another individual talked of regularly burning themselves by mistake when cooking. These examples emphasise the need to talk about diet within a much wider context. Participants focused heavily on cooking and associated tasks and little consideration was given to the choice of foods outside the home other than some individuals expressing confusion over what they should and should not be eating.

***How to cook? Is it burnt? How are you going to burn yourself? It's all that, it's not just one thing. You are talking about quite a lot of things, anything could happen in a kitchen. If you have a fit or a panic attack, whose going to help you then?***

***We want to learn health and safety, how to look after ourselves. It's all them sort of things before we even go in the kitchen.***

There was a strong emphasis on the need for practical support from both participants and the accompanying professionals. Whilst the provision of advice was helpful to some degree, having hands-on experience (such as practicing cooking together) or practical support (such as the provision of transportation to the local sports centre) was considered really valuable. Participants talked about it as a way to build their (highly valued and sought) independence. Examples of more practical support which have worked well in the past include the planning of weekly food menus and the crafting of a pictorial recipe book.

***I know you've got dieticians and you got nutrition and other things, but could you have like another advisor to give you support if you needed to go out and you can't go out by yourself and you needed support to get out and about.***

***I would like to do that [learn how to cook], not people keep doing things, I don't want that. I've never had independence, never.***

***I think all the talks are good but it needs to be more practical for people. People need to have that information so that they can do it for themselves. I did a pictorial cookery book for a lady I was advocating for so we made her a pictorial cookery book which is something lots of people have asked for. (Professional)***

## Delivery channels

A strong preference was expressed by both groups for face-to-face contact as part of the proposed service model. A number of reasons underpinned this, most notably the issue of trust which participants felt was better built face-to-face compared to other channels. Individuals also expressed a hesitancy to use the telephone unless they were speaking to someone they knew well and were comfortable with (and part of this stemmed from lessons they had received about

personal security). Some of the participants were online and talked about using Google and Facebook but never in the context of seeking health information – few could see themselves doing so.

***I'd rather see the same person cos you built up that trust. If someone breaks that trust, you ain't going to trust them no more.***

***I don't really like speaking to people on the phone. I like the group idea.***

***They come and see you. I don't like chatting on the phone. It's better you seeing them.***

***I think also, because of safety reasons, what do I say to you about the phone? [group answer: ask who it is, put the phone down if they start asking personal things]. It's easier to give people one clear instruction rather than saying 'if it's this or if it's that'. (Professional)***

## Working in groups

There was a lot of positivity from the participants about working in groups rather than in one-to-one sessions. As aforementioned, group sessions are favoured for the opportunities they present to socialise and have fun. For some, they also offer a means through which to build self-confidence by engaging successfully with others. This was not to say that individuals were uncomfortable or disliked the idea of meeting trainers on an individual basis but that the possibility of group work was much more appealing.

***Then you'll mix with other people and you're learning from them how to communicate and speak how you want to speak in your way, then you get new friends then it goes up from that to that, then it builds your confidence, then you get respect to yourself. Can you see what I mean?***

***[Would prefer to meet in a] group... you meet other people, have a chat after. Talk to a mixture of people, that way more ideas.***

More divergent opinions were held about the composition of groups as part of the proposed service model. Some participants would only want to attend a group of individuals all of whom had a learning disability; feeling more comfortable in this setting. Others actively sought to engage in groups that included individuals both with, and without, a learning disability. The professionals included in the research held the view that peer learning was important and providing advice and guidance to mixed groups would present a challenge in the differing speeds of comprehension.

***I'd stay with learning disabilities.***

***This is why I like going to Phab Club, because it's not all disabilities, it physically abled bodied as well, so they go there and we all join in.***

For one individual, the idea of attending a group with strangers was really unappealing and their preference, by far, was for a health trainer to come and advise a group of individuals who met regularly and of which they were a part.

***I had to go to a diabetic Desmond group with complete strangers and that was awful for me. I didn't want to talk to these complete strangers.***

## Locations for face-to-face services

Given the preference for face-to-face interaction as part of the proposed service model, time was spent discussing where such interactions should take place. Some discussion was given to the need for any locations to be accessible (particularly to wheel-chair users) but primarily the groups suggestions were of places familiar to them such as the supported accommodation in which many of them live or regularly visit, or other clubs that they take part in (such as the Phab Club). Some suggested the local college where they had previously completed cookery classes.

Any locations of face-to-face services as part of the proposed model need to consider the challenges faced in unassisted travel. Co-locating in familiar locations can assist with this. Alternatively running group sessions as part of pre-existing community groups or clubs would be actively welcomed – this would present fewer challenges concerning travel and familiarity of place and people.

***If you had a group session here [the supported living centre]… that would help quite a lot.***

***If someone comes to see you to talk about your food and that, I think that'd be easy.***

KCC may wish to consider assisting community groups and clubs to run healthy living services as described in chapter 2 as an alternative to establishing new networks in this community.

## Health trainers and mentors

Building familiarity and trust was an important theme to re-emerge throughout the groups. If a health trainer were to be seen one-on-one then seeing the same individual was hugely important. Participants talked of disruptive experiences where their carers had changed frequently and they found it hard to build trust. The professionals talked of the importance of a health trainer getting to know the service user well to understand how best to communicate and interpret their body language, tone and so on.

***You've had four or five case managers since being here… The professionals come and go so quickly, so there is not a confidence and a trust builder. People get a nice carer that they like and then they leave and that's difficult. (Professional)***

***It's hard to say goodbye to them [carers].***

***Working with <named individual> for 12 weeks, you would get to know when he gets frustrated, when he needs to leave. (Professional)***

It was not considered important to see the same health trainer each week if advice was delivered in a group setting – provided there was familiarity in the group attendees and location.

Responses to the idea of a mentor were mixed. In some respects, the ongoing contact would be welcomed (see below section on ongoing learning) but participants were hesitant about the mentor being someone different to the health trainer. Having built up a relationship with the trainer (assuming the same individual was seen on a one-to-one basis), their preference would be to continue this relationship rather than starting afresh with a mentor. The switch in individuals would be a particular problem if the mentor was to communicate by telephone. One of the professionals suggested that if a mentor was required (given the health trainer was committed to a limited number of weeks), that the mentor should attend the final few sessions with the health trainer to ease the process of transition.

## Ongoing learning

The main criticism levied against the case study was the finite amount of time allocated to the health trainer. Individuals would have liked to see a continuation of contact – suggesting that the health trainer could keep in touch to see how they were getting on.

***It just ends at 12 weeks don't it?***

***Good thing is you are meeting other people, and you are getting used to them, they are becoming your friends. The bad bit is that they don't get anything at the end. Once they get in, they close the door, and then they don't have anything else to do [after 12 weeks].***

The professionals involved in the research also expressed a need for repetition of message and continuous support, believing it to be unlikely individuals could sustain behaviour change on their own.

***That would a perfect answer to a lot of scenarios for people who aren't vulnerable and for people who don't need clear, concise instruction, but for the client group here, it'd need to be something that continued. (Professional)***

***Unless there is that continuous support and encouragement, it [advice and activities to help live a healthy lifestyle] doesn't happen. People with learning disabilities, they lack the ability to have the initiative to do it. If we organised something, everyone would come along and they'd really enjoy it, but they wouldn't consider keeping it going off their own backs. (Professional)***

## Communication

How individuals are communicated with significantly affects comprehension. Participants talked about pictorial information being helpful and gave examples of other information systems (such as the traffic light system) which they were familiar with and could comprehend easily.

***Looking at lists and stuff, that don't help.***

***I can't read. Do it pictures.***

***If it's red, I know it's got loads of sugar in it.***

A handful of participants also talked about the tone of communication being important. They wanted to be spoken to 'on a level', not made to feel as if they are being 'looked down upon'.

***People talking quick, I don't understand what they are trying to say to me. When they talk really fast you say 'can you talk slowly' and when you ask that they look down at you because they think something is wrong with you.***

## Accessing the service

A key challenge facing the proposed service model as identified by the professionals was raising awareness of the service and making it accessible. They talked of people with learning disabilities who live independently or with family members being disadvantaged as they can often be unaware of services or groups designed to assist them. They felt that individuals

who live in supported accommodation or who are attendees of day centres tend to be well-informed about the services available to them. They felt KCC would need to work through pre-existing community hubs to ensure widespread awareness of the proposed service model, but even this they thought would leave many individuals unaware and thus unsupported.

***The information is sent out to care managers or residential homes so people who are independent don't get that information. They are the ones that need the most support. (Professional)***

***For residents here, they have me to liaise with social services, I can then make a referral to the nurses in the learning disability team. People who live out in the community, they don't necessarily know how to access services like that. (Professional)***

## Designing the service to meet the needs of individuals with a learning disability

In response to the case study, the professionals involved in the research were uncertain that the proposed service model could work for individuals with a learning disability. However, based on the feedback provided throughout the groups, it is possible that the service could be suitably tailored to meet the specific needs of this audience. The research lends itself to the suggestion of health trainers providing practical guidance face-to-face through pre-existing group sessions, allowing for some continuity in care to reinforce messages and encourage sustained behaviour change. Working through pre-existing groups ensures there is a familiarity of attendees and location, minimising some of the barriers discussed earlier in this report in terms of travel and confidence. Underpinning this delivery approach is the assumption that there is a broad need among individuals with a learning disability for guidance on healthy living as it would not function through medical- or self-referral. It is unknown at this stage whether the proposed service model would have the flexibility to accommodate this approach, though it is suggested that meeting the needs of individuals with learning disabilities would be best achieved through a process of co-design.

# Appendices

## Discussion Guide

### 16-010075-01 Kent County Council: Adults Health Improvement Service Groups: GROUP DISCUSSION WITH INDIVIDUALS WITH LEARNING DISABILITIES

This guide outlines the discussion that will take place with individuals with mild/moderate learning disabilities and their support workers in a group setting. It compliments work previously undertaken to understand the views of Kent residents to proposed changes to the way KCC's public health services are structured.

This document provides a guide for how the groups might run – due to the unpredictability of group dynamics, it may not be possible to adhere fully to the suggested content and a degree of flexibility on the behalf of the moderator will be required. It is expected that participants will be accompanied by their support workers who are likely to contribute to the group discussion.

| | |
|---|---|
| **11.00 – 11.10 (10 mins)** | **<u>Introduction</u>**<br><br>**Introduce self and explain:**<br>• **You are here to do research for the Council about health services in Kent**<br>• **You are interested in their views – there are no right or wrong answers**<br>• **That what they say will be confidential**<br>• **That the session will last 1-1.5 hours**<br>• **That someone will take notes**<br><br>**Ask everyone to introduce themselves to the group** |
| **11.10-11.25 (15 mins)** | **<u>Warm up/ healthy lifestyles</u>**<br><br>**Tell me a bit about a day in your life – what kinds of things do you normally do?**<br>*Probe for work, social life, hobbies*<br><br>**What do you like doing in your spare time?**<br>**What *don't* you like doing in your spare time?**<br><br>**Do you play sport/exercise?**<br><br>**Do you cook?**<br><br>**What do you typically eat for breakfast/lunch/dinner?** |

| | |
|---|---|
| | **What kind of things do some people do that are healthy?**<br>**What kind of things do some people do that are not healthy?**<br>*Probe around exercise, diet, smoking, drinking – note to moderator to be clear these are the main behaviours we are talking about*<br><br>**Overall, do you think you live healthily or unhealthily? Why do you say that?** |
| **11.25-11.40 (15 mins)** | **<u>Use of health and wellbeing services</u>**<br><br>**Has anyone ever talked to you about how to live a healthy lifestyle?**<br><br>**Who said that? Was it your…..?**<br>*Probe for family, friends, GP, doctor, nurse, support worker*<br><br>**What did they say?**<br><br>**Was it helpful? Why? Why not?**<br><br>**FOR THOSE WHO HAVE NOT BEEN GIVEN ADVICE:**<br><br>**Have you wanted someone to talk to you about how to live a healthy lifestyle? Do you feel it is hard to change your health and lifestyle?** |
| **11.40-11.55 (15 mins)** | **<u>Service needs</u>**<br><br>**Do you want to know how to live more healthily?**<br><br>**IF NOT: Why not?**<br><br>**IF YES:**<br>**What would you like to hear about?**<br>**How would you like to be told this?**<br>• **Reading (eg leaflet, online) or speaking to someone (eg in person, on the telephone)?**<br>• **Why do you say this?**<br>• **Would you like to be in a group, with a friend, or alone?**<br>**Who would be the best person to tell you about living a 'healthy' lifestyle? Why do you say this?**<br>*Probe for doctor, nurse, support worker, family, friends* |

| | |
|---|---|
| | **Where would you like to go to speak about living more healthily? Why? Is it somewhere you already know or like to visit? Where would that be? Home, a friend's house?**<br>*Probe for whether they mention community assets or not, or if they just prefer home territory* |
| **11.55 – 12.20 (25 mins)** | **<u>The proposed service model</u>**<br><br>**Let's talk through an example of a service designed to help people live a 'healthy' lifestyle. This is Susan…**<br>**HANDOUT 1 – MODERATOR TO READ ALOUD**<br><br>• **Susan wants to lose a little weight and exercise more**<br>• **She meets Hannah (a 'Health Trainer') once a week for 12 weeks**<br>• **Each time they meet, Hannah gives advice to Susan**<br>• **For the first 7 weeks, Hannah talks to Susan about how to eat more healthily**<br>• **For the last 5 weeks, Hannah talks to Susan about how to exercise more**<br>• **Hannah puts Susan in touch with a 'mentor' called Billy who is like a friend**<br>• **Billy gives her support so she continues with her new healthy behaviours**<br><br>**What is good about this service? Why?**<br>**What is bad about it? Why?**<br>**What do you think of Hannah the 'health trainer'? Would you like one? Why/why not?**<br>**What do you think about the fact Susan can talk to Hannah about both problems and not need to see two different advisors (about weight loss and exercise)?**<br><br>**What do you think of Billy the 'mentor'? Would you like one? Why/why not?**<br><br>**Where would you like to meet the 'health trainer' or 'mentor'?**<br>*Probe for community centre, leisure centre, pharmacy, doctors, home etc.*<br><br>**Would it be better or worse to get advice the 'health trainer' over the telephone? Why?**<br>**Would it be better or worse to get advice the 'health trainer' online? Why?**<br><br>**Would you like to get help like this? Why/why not?** |
| **12.20-12.30 (mop-up time)** | **What questions do you have?**<br>**Is there anything else you'd like to add?**<br><br>**THANK AND CLOSE** |

## Case Study

### Example of a service which helps people live a healthy lifestyle

This is Susan. Susan wants lose a little weight, eat healthier and exercise more.

She meets Hannah (a 'Health Trainer') once a week for 12 weeks.

Each time they meet, Hannah gives advice to Susan.

For the first 7 weeks, Hannah talks to Susan about how to eat more healthily.

For the last 5 weeks, Hannah talks to Susan about how to exercise more.

Hannah puts Susan in touch with a 'mentor' called Billy who is like a friend.

Billy gives Susan support so she continues with her new healthy behaviours.

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## About Ipsos MORI's Social Research Institute

The Social Research Institute works closely with national governments, local public services and the not-for-profit sector. Its c.200 research staff focus on public service and policy issues. Each has expertise in a particular part of the public sector, ensuring we have a detailed understanding of specific sectors and policy challenges. This, combined with our methodological and communications expertise, helps ensure that our research makes a difference for decision makers and communities.

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THE BEHAVIOURAL ARCHITECTS

# Informing development of Kent County Council's new Health Improvement Service Offer and public health social marcomms

## *Adults with multiple unhealthy behaviours research report*

4th January 2016

Authors
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THE BEHAVIOURAL ARCHITECTS

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## 2. Executive Summary

Kent County Council (KCC) commissioned The Behavioural Architects to conduct research into understanding drivers and barriers to health improvement among people who engage in multiple unhealthy lifestyle behaviours, specifically; smoking, risky drinking levels, a poor diet and a lack of activity. Behavioural insight was required to inform the specification and design of a new integrated Health Improvement Service offer, and development of social marketing and health promotion campaigns in the county, aimed at this key target audience group.

Thematic findings about the audience help to contextualise the drivers of multiple unhealthy behaviours, and set up some of the specific challenges to health improvement for this audience:

- Identity is strongly tied to local friends and family and the area around where people live, making breaking 'status quo' behaviours a challenge. Relatively narrow spheres of influence also mean that people can perceive a lack of alternatives to their current lifestyle.
- The local context primes and triggers unhealthy behaviours, suggesting a need to disrupt the routines that hold people's unhealthy habits in place and help to create an environment more supportive of healthier behaviours.
- Making ends meet limits self-control and 'mental bandwidth' to plan ahead, highlighting the importance of making change easy, rather than placing too much emphasis on individual willpower or planning.
- There are limited opportunities to escape the monotony of everyday life and enjoy down-time. Unhealthy behaviours are often people's principal source of enjoyment, bonding and empowerment. The audience are therefore likely to need support in finding healthier alternatives that can facilitate transitioning from a more negative to a more positive mental state.
- Unhealthy behaviours are often default coping strategies for dealing with more acute challenges that need to be addressed for people to have the stability and self-regulatory capacities to sustain healthier lifestyle changes. The service specification and interventions will need to build in room for inevitable 'life shocks' that the audience all tend to experience from time to time – depression, family illness, financial stress etc.

The audience's multiple unhealthy behaviours were found to cluster in two key ways:
1. UNHEALTHY HABITS SUBSTITUTE FOR ONE ANOTHER: different unhealthy behaviours share consistent triggers – of boredom and loneliness, and rewards – of bonding and empowerment, which means they may be used interchangeably. As such, removal of one unhealthy behaviour risks it just being replaced by another.
2. UNHEALTHY HABITS REINFORCE ONE ANOTHER: one unhealthy behavioural habit triggers another. This reinforces the argument for an integrated and holistic lifestyle approach, rather than a narrow focus on single behaviour, to break the web of inter-connected habits.

The research identified three audience segments, based on their current mental state surrounding unhealthy behaviours, which affected both their motivation and ability to

change. Those most open to change (and with sufficient ability) were found to have one or more of the following four underlying motivations: *want to get out of a life rut; want to change for my family; noticing the effects;* and *ashamed of my behaviours*. These motivations represent rich emotional territory that KCC can tap into.

Mapping the target audience's past experiences of addressing different unhealthy lifestyle behaviours showed how there are broadly consistent stages along a behaviour change 'journey', supported by established behavioural change theories.

Across these stages, four "opportunity spaces" for KCC to steer the target audience along the behaviour change journey and prevent lapsing were identified:

- Opportunity 1: inspire health improvement and build salience (visibility and relevance) of the service, starting from the early Prime and Trigger stages of the journey. For example, through marcomms that normalise health improvement for 'people like me and in my local places'; priming underlying motivations and positive rewards of making changes; and leveraging touch-points around trigger moments such as bounty packs, health checks or gym inductions.
- Opportunity 2: connect, disrupt, and equip people in the process of Getting ready or already starting to Make changes. This is best achieved via outreach work that disrupts people in their local environments, as they go about their everyday lives; relatable individuals who can offer tailored face-to-face guidance; interventions that build commitment, chunk up the journey (baby steps) and instigate change on the spot where possible. Once engaged, helping people to change up their broader lifestyle routines is likely to be important given how unhealthy behaviours are deeply embedded. Positive replacements need to be signposted (and available) to fill the void left by the removal of old habits. People often fail to prepare for this void, and it is a key reason people lapse back into unhealthy behaviours.
- Opportunity 3: empower: give feedback and provide positive alternatives once people are Living with the change(s) and most at risk of lapsing as they adjust and start to build new habits. There is a role for providing on-going feedback and guidance, in combination with practical tools, e.g. self-tracking apps, that keep changes interesting. It will be important to keep *pushing out* appealing and easy alternatives to unhealthy behaviours, rather than waiting for people to seek them out.
- Opportunity 4: fuel Word Of Mouth and advocacy among people who have sustained changes, to help normalise healthier lifestyle behaviours within social groups. For example, marcomms that help give people a way to talk about and share their behaviour change journey and healthier lifestyle habits.

In addition to designing a service and interventions to steer healthier habits and personal responsibility, there is a need to consider the potential for environmental nudges to make unhealthy lifestyle behaviours less salient and accessible, and positive alternatives more so – e.g. safe and pleasant walking routes / making it more difficult to drive short distances. The specific interventions could be continually informed by on-going learning from the audience with multiple unhealthy behaviours that use the new service.

# 3. Background

## Introduction, aims and objectives

Kent County Council (KCC) is developing a new Health Improvement Service model, commissioned to start delivery in 2016. This new service will take a holistic approach and integrate the current separate healthy weight, smoking cessation, physical activity and health trainer services and will also include elements of health checks, alcohol and sexual health services with mental and emotional wellbeing underpinning the whole service delivery. Individuals with multiple unhealthy behaviours – principally smoking, unhealthy eating, inactivity and drinking to unhealthy levels – will be able to receive the support they need from this one integrated service.

Overall aims

KCC wants to maximise the number of people with multiple unhealthy behaviours accessing support, to help them adopt healthier behaviours and lifestyle choices.

To do this KCC requires a deeper understanding of their attitudes to health improvement services and what may motivate them to access those services or interventions. This understanding of drivers and barriers will be used to inform the development of:

a) The specification and design of the new Health Improvement Service offer
b) Future social marketing and health promotion campaigns in the county

Research objectives:

- Understand drivers and barriers to using health improvement services and interventions among the audience (people engaging in multiple unhealthy behaviours)
- Explore and identify how socio-economic, mental health and wellbeing, environmental and psychological factors impact on the customers' ability to achieve and maintain behaviour change

Specific research questions:

- Why do people have multiple unhealthy behaviours and what "benefits" do they perceive that such behaviours give them?
- Do people in this target market (as described by the Mosaic categories set out in the brief) want to change their health-related behaviours? If not, why not?
- What will help them to realise that they need to adopt healthier behaviours?
- What aspects of a health improvement service would appeal to, help motivate and reduce barriers for the target group?
- In which sequence would they want to tackle each behaviour and why, or would be best to tackle all at the same time?
- In which sequence do they think they would have most short term (change) and long-term (maintain) success and why?
- What role, if any, would a digital service have in improving access to and uptake of health improvement services?

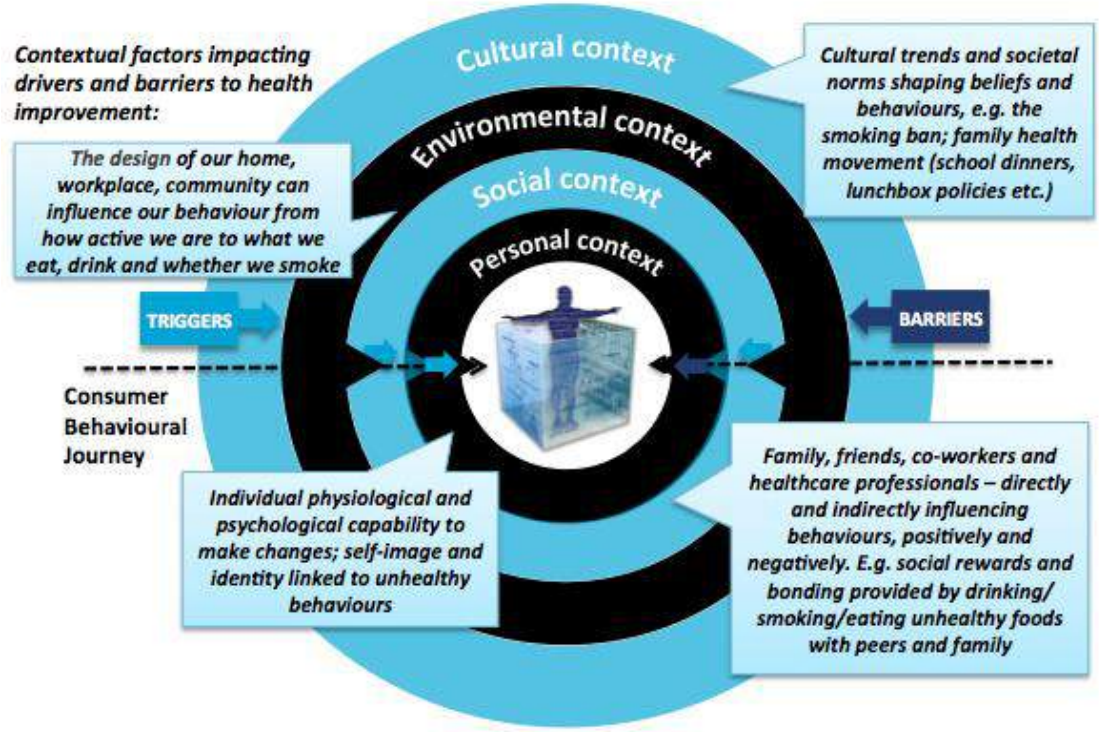
- What steps have people taken in the past to address these behaviours, and how successful have they been? What were the problems? Why did they give up? What were the triggers that made them (a) want to change in the first place, and (b) subsequently give up?
- What pathways (or "customer journeys") do people tend to take when they want to address these behaviours? Where did they go/look for information last time? How useful was the information that they received? Was it lacking in any way? Would they do anything differently next time? What would have made a difference for them?

## Key behavioural science concepts and models underpinning the research approach

The research design was underpinned by a number of behavioural science models and tools. These included:

- A contextual framework
- The neural habit loop model
- Behavioural Science concepts

1. A contextual framework was used to deconstruct behaviour and identify triggers and barriers to health improvement for the audience across different layers of context: personal, social, environmental and cultural



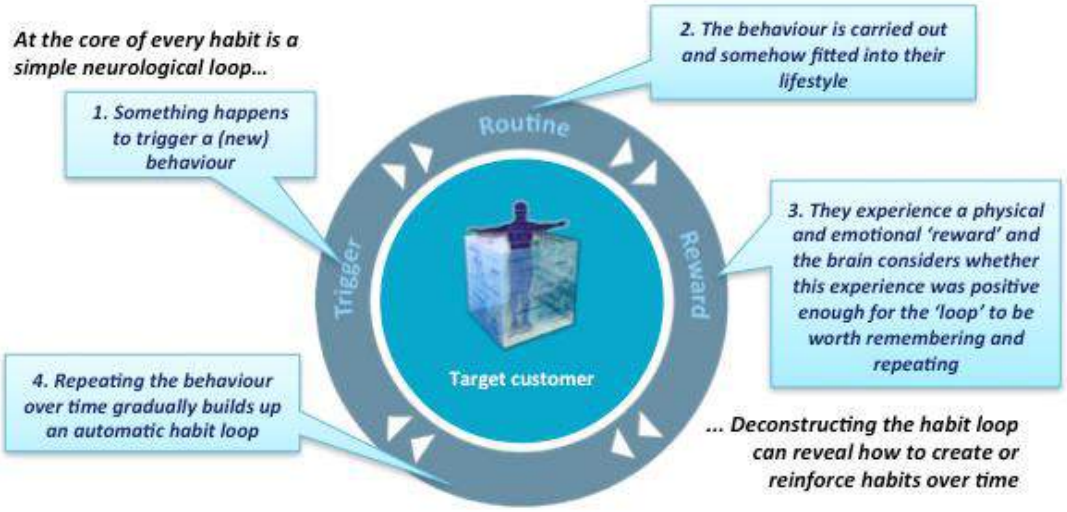
2. The neural habit loop model was applied to decode the habit loops surrounding unhealthy multiple behaviours, including how they are interlinked.

Habits are believed to be formed through the interaction of three elements. Charles Duhigg, author of the book 'The Power of Habit' defines these three as:

1. Trigger or Cue, frequently contextual (location, time of day, linked to another person or group)
2. Routine – specific actions and also ways of thinking
3. Reward – often both physiological and psychological

Each element plays a particular role in embedding the habit.[1]

A habit also becomes embedded simply through the act of repetition – doing an action over and over again, often in the same environment – so it becomes routine and engrained in our muscle memory, e.g. having a cigarette when drinking a glass of wine. Habitual behaviours become fixed in our neurological patterning. Habits can be so embedded in the subconscious that they are carried out on autopilot.[2]




3. A number of Behavioural Science concepts were used during the research to identify and understand behaviour. These included:

- Chunking: a large task or goal can be daunting it can put people off. Breaking something down into parts makes it seem much more achievable and manageable.
- Willpower: whereby a person exerts their will over their mind and feels in control of their actions. Having self-control in one area of a person's life tends to spread across other areas; conversely lethargy spreads more lethargy. Willpower is also a finite resource that gets depleted over time.

[1] Duhigg, C. (2012) The Power of Habit. Random House
[2] Hollingworth, C. and Barker, L. (2014) Habits The Holy Grail of Marketing: how to make, break and measure them. The Marketing Society

- Licensing effects: a non-conscious tendency to engage in more immoral or indulgent behaviours, like eating junk food, after doing something more virtuous, like helping a friend or going to the gym. This swinging between a good or beneficial behaviour and a bad or indulgent behaviour has been described as being like a behavioural pendulum.
- Coaction or 'snowball effects': the extent to which taking action on one behaviour increases the chances of taking action on a second behaviour

A complete glossary of Behavioural Science concepts referred to in this report can be found in Appendix 3.

## Methodology

The Behavioural Architects (TBA) recommended a staged methodology, designed to unlock deep behavioural insight.

Phase 1: Foundation Setting

TBA ran an extended briefing meeting with the KCC team to collaboratively discuss and align on the priority research questions, detailed methodological approach, stimulus requirements and respondent sample frame.

In addition, to ensure that the research built on existing evidence, TBA conducted a brief review of the relevant academic and applied literature investigating what makes an effective health improvement service. This included:

- Exploring evidence around the most effective drivers and pathways to using such services to ensure the primary research built on existing evidence.
- Drawing on literature from the behavioural sciences relevant to building healthier lifestyles, while also analysing health intervention-related literature through a Behavioural Economics lens. Knowledge and awareness of these insights create a deeper and stronger understanding of customer behaviour and the drivers and barriers to making lifestyle changes.

The literature review can be found in Appendix 2.

Phase 2: Customer Behavioural Deep Dive (primary research)

Phase 2A: Lifestyle Detective Missions: 14 lead respondents with multiple unhealthy behaviours were recruited to complete a series of 'detective missions' over a two-week period.

This included completing a paper scrapbook sent out to respondents involving:

- Keeping a food / alcohol / smoking / activity lifestyle diary for 3 days
- Chronologically mapping previous behaviour change journey(s) towards health improvement
- Planning and completing a 'habit disrupting' healthy lifestyle day.
- Recording two conversations they had with people in their social circle – one more open to changing behaviour, and one less open – about their lifestyle behaviours and past attempts at health improvement, to get an initial read on the influence of their social group, as well as extend the sample reach beyond the lead respondents.

The paper diary was supplemented with 4 email missions, which helped build rapport and keep respondents engaged, as well as helping build a picture of the audience before meeting some of them.
As part of the email missions, respondents were asked to choose from a list of web links (e.g. http://www.nhs.uk/smokefree and https://www.kenthealthandwellbeing.nhs.uk) to inspire thinking around ways they could be supported in health improvement in the future, including via a digital service. This exercise was not to evaluate websites or particular interventions but rather prime participants to the research subject, thus enabling deeper follow up discussions.

Phase 2B: Follow-up tele-depths: Towards the end of the two-week period, a telephone interview was conducted with each respondent to explore key learning with the detective missions and peer-group conversations. These interviews focused on:

- Their lifestyle diary to get a better understanding of their current behaviours including key influencers (people) and places (touch-points) in their lives
- Their health improvement journey maps, discussing previous attempts to improve a particular behaviour, including highs, lows and different contextual influences of their experiences.

Phase 2C: In-context immersions: Based on the email mission feedback and tele-depths, six respondents were selected from across East and West Kent, who exhibited a range of different unhealthy behaviours in a range on different contexts, to take part in a face-to-face research stage.

Each lead respondent was asked to bring a friend or relative along to support checking and iteratively building on emerging learnings from phases 2A-B.

In order to witness as well as discuss behaviour, the ethnographies took place in relevant contexts for unhealthy behaviours (end of working day, pub, home etc.), often going to a combination of environments to understand how the key spaces, places and unhealthy behaviours interrelated. Discussions included exploring details of how their healthy lifestyle day affected their unhealthy habits and their previous health improvement journeys, probing specific aspects of any services they came into

contact with and understanding the physical, emotional and social experience at different points in time.
Additional visual stimulus was introduced to explore the different places, people and channels that could support them around changing unhealthy lifestyle behaviours. Including the peer / relative (all of whom had multiple unhealthy behaviours themselves) increased the sample reach, enabled in-the-moment capture of social dialogue and created a dynamic which minimised the researcher effect: respondents were only too happy to call the other out where they felt each others' answers were less than the full truth!

Phase 3: Expert Eyes
The primary customer research was supplemented with three 1-hour in-depth interviews with experienced health workers who frequently come into contact with the audience around the target unhealthy behaviours.
The interviews were used to check and challenge emerging findings from customer behavioural deep-dive from an expert perspective, including exploring their ideas for better connecting with the target and success stories for long term behaviour change across multiple unhealthy behaviours, something our target audience were not recruited to have achieved themselves.

Phase 4: Synthesis
Learning from all phases was thematically analysed and relevant Behavioural Science models and concepts applied to inject added rigour and inspire ideas for future opportunities.

## Customer sample

The sample included:

2. An even mix of male and female lead respondents
3. A spread within C2DE social grade
4. 25-55 year age band, ensuring a good mix of younger (aged 25-40) and older (aged 41-55) respondents
5. Mix of pre-family, family, and empty nester / no family life stages
6. A mix of East and West Kent locations

In order to have the relevant experiences we could learn from, recruitment focused on finding people who:

7. Engaged in at least 3 unhealthy behaviours: smoking and/or higher alcohol consumption + poor diet and/or lack of exercise – ensuring good mix
    a. At least half to describe themselves as very / quite overweight or underweight
8. Had attempted to improve one or more of their unhealthy lifestyle behaviours within the last two years, and were open to improving their unhealthy lifestyle behaviours in the future.

A mix of people who were currently accessing or had recently accessed health improvement services, as well as those who had not accessed services were included.

People with known chronic conditions that were being treated (e.g. diabetes, cancer, COPD), had moderate to severe mental health problems, learning difficulties or drug or alcohol dependency were excluded from the research.

Our final sample is shown below:

| Gender | Age | SEG / Occupation | Location | Unhealthy behaviours |
|---|---|---|---|---|
| PRE-FAMILY | | | | |
| Female | 25-40 | D<br>Elderly home healthcare assistant | Tonbridge & Malling | Moderate smoker<br>Unhealthy diet, Rarely exercises |
| Male | 25-40 | C2<br>Electrician | Sevenoaks | Moderate smoker<br>Increasing risk alcohol<br>Unhealthy diet, Never exercises |
| FAMILY | | | | |
| Female | 25-40 | D<br>Housekeeper | Maidstone | Light smoker<br>Increasing risk alcohol<br>Unhealthy diet, Rarely exercises |
| Female | 25-40 | E<br>Unemployed | Canterbury | Moderate smoker<br>Unhealthy diet, Rarely exercises |
| Female | 25-40 | C2<br>Housewife | Tonbridge & Malling | Increasing risk alcohol<br>Unhealthy diet, Never exercises |
| Female | 25-40 | D<br>Support Worker | Maidstone | Moderate smoker<br>Increasing risk alcohol<br>Unhealthy diet, Never exercises |
| Female | 41-55 | C2<br>Fibre Optic Engineer | Dartford | Higher risk alcohol<br>Unhealthy diet, Never exercises |
| Female | 41-55 | D<br>Waitress | Dartford | Moderate smoker<br>Unhealthy diet, Rarely exercises |
| Male | 25-40 | C2<br>Inspection Engineer | Tunbridge Wells | Heavy smoker<br>Higher risk alcohol<br>Unhealthy diet, Never exercises |
| Male | 41-55 | C2<br>Builder | Sevenoaks | Increasing risk alcohol<br>Unhealthy diet, Rarely exercises |
| Male | 41-55 | D<br>Servicer of lifts | Dartford | Increasing risk alcohol<br>Unhealthy diet, Rarely exercises |
| Male | 41-55 | D<br>Furniture removal | Tunbridge Wells | Heavy smoker<br>Higher risk alcohol<br>Unhealthy diet, Rarely exercises |
| EMPTY NESTER / NO FAMILY | | | | |
| Female | 41-55 | C2<br>Retired | Canterbury | Moderate smoker<br>Unhealthy diet, Rarely exercises |
| Male | 41-55 | C2<br>Electrician | Canterbury | Moderate smoker<br>Increasing risk alcohol<br>Unhealthy diet, Rarely exercises |

Note: the sample naturally skewed towards Family status, as this was more reflective of the C2DE audience

## 4. Setting the context: behavioural challenges to health improvement among the target audience

Five thematic findings about people with multiple unhealthy behaviours in Kent are introduced below. These themes were consistently found to a greater or lesser extent across the target audience, accepting there will always be variation between individuals. These findings help contextualise the drivers of multiple unhealthy behaviours, and set up some of the specific challenges to health improvement for this audience.

### Identity is strongly tied to local friends and family and the area around where the target audience lives

The audience has a narrow, close-knit social circle and spends the vast majority of their time in a limited range of local locations (typically the homes of nearby friends and family, local shops, cafés, pubs, and their workplace). Both social and environmental spheres are deeply established.

Most live close to the area they grew up in; around family and friends they have known their whole lives. Free time is typically spent together at one another's homes and in local pubs. Friends and family that live locally act as key reference points for lifestyle habits and routine behaviours.

Similar attitudes and behaviours are shared between the generations. This was clearly seen in how both older and younger women approached weight management: diets/slimming clubs were the dominant reference point, rather than recent cultural trends around holistic health and wellness often seen amongst younger women.

Friends and family often share unhealthy behaviours and actively encourage them, including when someone is attempting to be healthier:

*"When I told mum that I was thinking about losing weight, she said 'don't be stupid. Why are you worrying about that at your age?' I mean, I understand it because she's older – you were always taught to eat what's given to you and not to be ungrateful."*
*(Male, Younger, Family, Tunbridge Wells)*

*"I've been smoking since I was 11 – it's just part of who I am. I tried to stop for 6 days and broke down in the pub after a hard day at work. The landlord gave me a fag and I just felt so much better immediately."*
*(Female, Pre-family, Tonbridge & Malling)*

- *Relatively narrow spheres of influence make breaking free of status quo behaviours difficult; the audience can perceive a lack of relevant and appealing alternatives to their current lifestyle.*
- *It will be important to steer behaviour change within people's local environmental settings and dial up relatable social reference points for health improvement / healthier lifestyles.*

## The local context primes and triggers unhealthy behaviours

The narrow set of environments and social settings the audience encounters often primes them towards unhealthy behaviours throughout the day, e.g. seeing neighbours smoking outside their front doors.

This is exacerbated by daily routines (e.g. people working part time and on low pay spending a lot of time in their home) and jobs (e.g. routine and manual labour) where people are reminded of, and have the opportunity to engage in, unhealthy behaviours much of the time.

*"I'll have my first cigarette when I get in to the van in the morning. I don't know what it is – habit I guess. Then I'll tend to have another one if I hit traffic and another just before I get to the job. If traffic's bad though, I could have had 5 before I even get there!"*
*(Male, Younger, Family, Tonbridge & Malling)*

Many unhealthy habits and behaviours are carried out on autopilot, cued by the immediate environment.

*"If I'm walking past this pub, I'll always pop in to see who's about. I don't even think about it. I'll come down most lunchtimes too because there's nowhere else to go really."*
*(Female, Family – partner of Male, Older, Family, Dartford)*

*"Sometimes I go into the kitchen to do something, who knows what, and I'll just end up opening a beer, just on autopilot… it's something you start and before you know it, every night you're having a beer."*
*(Male, Older, Family, Sevenoaks)*

- *There is a need to disrupt the routines that hold people's unhealthy habits in place, e.g. through interventions and environmental nudges.*

## Making ends meet limits self-control and mental bandwidth to plan ahead

The audience working long or anti-social hours leaves them feeling very fatigued and more impulsive in their behaviours, e.g. eating unhealthy food to energise or comfort. Shift working patterns are seen to deplete people's willpower and self-control, even when they are motivated to change unhealthy behaviours.

*"Working nights is difficult, who wants a salad at 3am? You want a muffin! It's about having something to lift your mood, and it's also a boredom thing... You just get short breaks so it's like, ' do I smoke or do I eat? I buy things I can just grab."*
*(Female, Empty Nester – mother of Female, Younger, Family, Canterbury)*

Even for those not working or working part-time, living on a low income uses up people's mental resources or 'bandwidth' worrying about money.[3] This can be a barrier to establishing healthy routines that require forward planning.

*"I tend to live each day as it comes and try not to worry about everyone else in the world, just looking after me and my family."*
*(Female, Younger, Family, Maidstone)*

- *Making health improvement practically and cognitively EASY is critical for this audience, rather than placing too much emphasis on individual willpower or planning ahead.*

## There are limited opportunities to escape the monotony of everyday life and enjoy down-time

Unhealthy behaviours are an accessible way to exert choice and control in a life where people often feel disempowered around their own routine.
People can lack autonomy at work and at home, e.g. when caring for other family members takes priority over their own personal health and wellbeing. Alongside this, relatively weak consumer spending power means people have limited options for de-stressing and/or enjoying themselves when not working or caring for others; they typically cannot afford to be shopping, eating out, going to the cinema, etc. in their free time.
Unhealthy behaviours facilitate transitioning from a more negative to a more positive mental state; they are a principal source of enjoyment, helping people to feel like 'masters of their own destiny' and reconnect with others.

*"We go to the meat raffle every Sunday. That's our adult time. I mean, yes, the kids are there, but it's us doing what we want to do – which is have a few drinks together, rather than doing what they want."*
*(Female, Younger, Family, Tonbridge & Malling)*

People can enjoy colluding in their unhealthy behaviours and collectively transitioning mental state. Shared experiences amplify the psychological rewards of unhealthy behaviours and facilitate bonding. This can be overt (i.e. "let's be naughty together"), or more habitual and unspoken (e.g. couples' evening drinking routines)

*"There was that day, and I hadn't had a cigarette for probably a couple of weeks, and she was stressed with Tommy, and I just said 'Shall we go and grab a packet of fags?' And we did, didn't we. And we really enjoyed it."*

[3] Research by Eldar Shafir and Sendhil Mullainathan, two prominent behavioural scientists, highlights that busy people and poor people have a diminished psychological capacity or reduced 'cognitive or mental bandwidth' because they are more focused on completing immediate tasks at hand or making ends meet. In their 2014 book 'Scarcity' they explain how this can make it more of struggle to plan ahead since decision-making and memory capacity is affected.

*(Female, Empty Nester – mother of Female, Younger, Family, Canterbury)*

- *People are likely to need support finding healthier alternatives that facilitate transitioning from a more negative to a more positive mental state – both individually and collectively.*

## Unhealthy behaviours are often default coping strategies for dealing with more acute challenges

People can use unhealthy behaviours to 'self-medicate' and dull more serious negative emotions and living experiences. Within people's social networks, domestic abuse and mental health issues are not uncommon. More immediate problems relating to financial stress – e.g. debt, unemployment, housing – often take priority over health or make it difficult to maintain positive changes. Even when there is motivation and momentum, negative life events can deprioritise healthy behaviour.

*"I just had a call from my sister – she has been recalled regarding her mammogram. I don't feel like doing anything now, especially not exercising."*
*(Female, Older, No family, Canterbury)*

*"I've had people come in and say 'I want to lose some weight', then once I started asking them about their broader day-to-day life, it quickly became clear they had much bigger issues to deal with. Sometimes they're experiencing domestic violence, sometimes they're in fear of being kicked out of their house. It's really important that we deal with those deeper issues before even thinking about weight. I signpost them to services and ensure them that I'll be here when they're ready."*
*(Health Trainer, Swale)*

- *There is a need to address chronic underlying issues in order for people to have the stability and self-regulatory capacities to sustain healthier lifestyle changes.*
- *The service specification and interventions will need to build in room for inevitable 'life shocks' that the audience all tend to experience from time to time – depression, family illness, financial stress etc.*

## 5. Decoding the habits of people with multiple unhealthy behaviours

Through a combination of deep diving into people's lifestyle habits, and structuring analysis using the habit loop model, the audience's multiple unhealthy behaviours were identified to cluster in two distinct ways.

1. UNHEALTHY HABITS REPLACE ONE ANOTHER: similar triggers and rewards for different unhealthy lifestyle behaviours enable them to be used interchangeably.

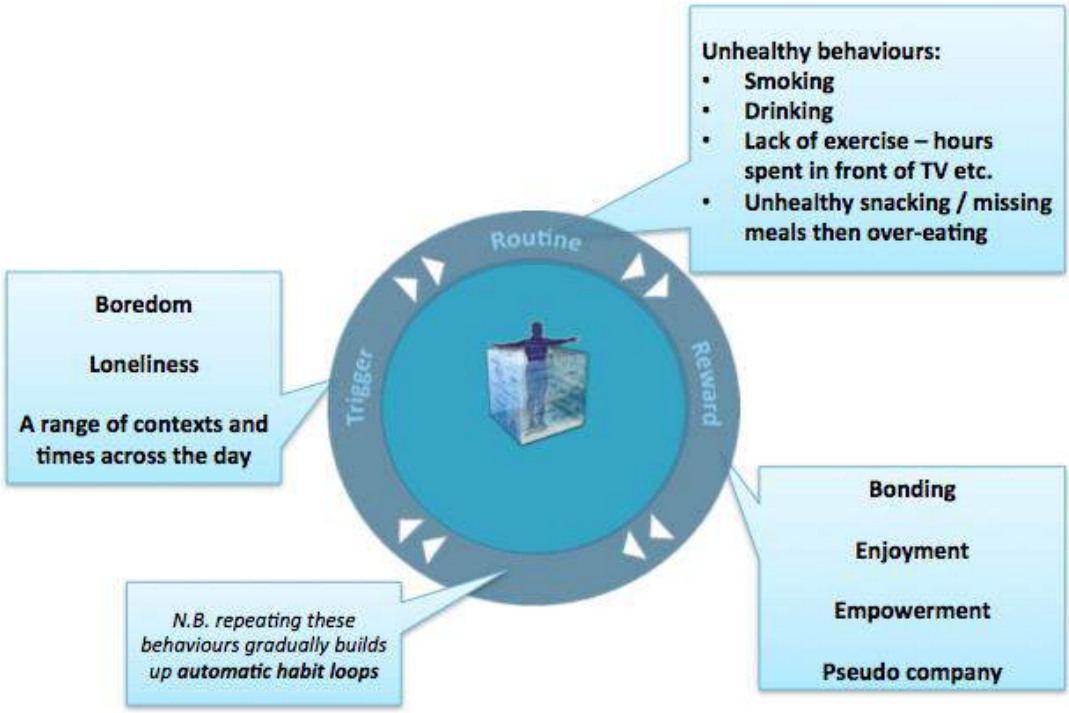
People's different unhealthy behaviours share the common psychological triggers of boredom and loneliness that appear to be a pervasive characteristic of this audience.

Different unhealthy behaviours are used interchangeably in response to these triggers, to provide powerful social and psychological rewards, to both alleviate negative emotions and enhance otherwise boring situations. As discussed in the previous section, unhealthy behaviours are often a principal source of enjoyment, empowerment and bonding in a person's life.

The specific unhealthy behaviour(s) engaged in at a given point of time is primarily driven by convenience (often time and space limitations during working hours) and social context (often depending on the degree of social acceptability).

For example, the same person who smokes in his van during the day when bored and lonely, also eats a large meal accompanied by a beer in the evening in response to the same triggers (and seeking the same rewards of a proxy for company and enjoyment).

It is noteworthy that among the audience there was a notable absence of trading unhealthy and healthy behaviours off against one another (i.e. Licensing Effects or 'taking a balanced approach to health').




- *This points to the need for a holistic approach, since the removal of one unhealthy behaviour risks it just being replaced by another, e.g. unhealthy snacking replacing times when one would be smoking.*
- *Finding positive alternatives to unhealthy habits (that can deliver sufficiently compelling emotional and social rewards) will be important to fill 'the void' which is left by the removal of unhealthy behaviours.*

***Adam's routine***

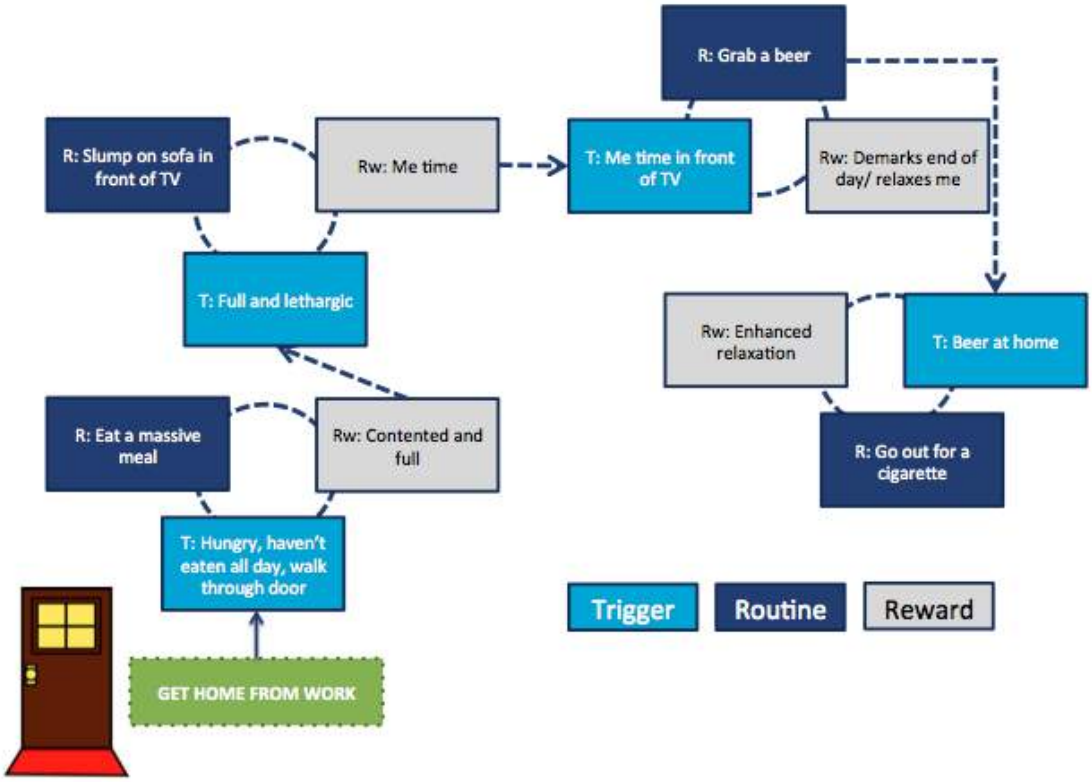
*"I barely speak to anyone all day. When I'm at home, my mum makes it clear she doesn't want me around, so I come to the pub most days to have a few pints and talk with people."*

Adam wakes up at 5am most days to leave for work in his van, never eating breakfast as he doesn't feel like eating that early. He smokes throughout the morning driving in his van for **'something to do'** when bored. Later in the morning, he will go to a roadside van to get a burger, **stopping to speak to the vendor** who knows him by name. Having spent 12 hours on the road on his own in the van, Adam stops by the pub on his way home. He doesn't even need to phone a friend; he knows there'll be a **familiar faces** to chat with there. He feels instantly more at ease the moment he walks through the door and has his first pint in hand and surrounded by company. After a good few pints, Adam heads home. His mum has normally cooked him a large, hearty meal, which he can't resist. He eats it quickly before heading to his room to get out from under his mum's feet.

2. UNHEALTHY HABITS REINFORCE ONE ANOTHER: one unhealthy behavioural habit triggers another.

One unhealthy habit loop can also trigger another (particularly not limited by contextual factors), so that there is a negative snowballing of behaviours.

An example of an evening routine involving negative snowballing:



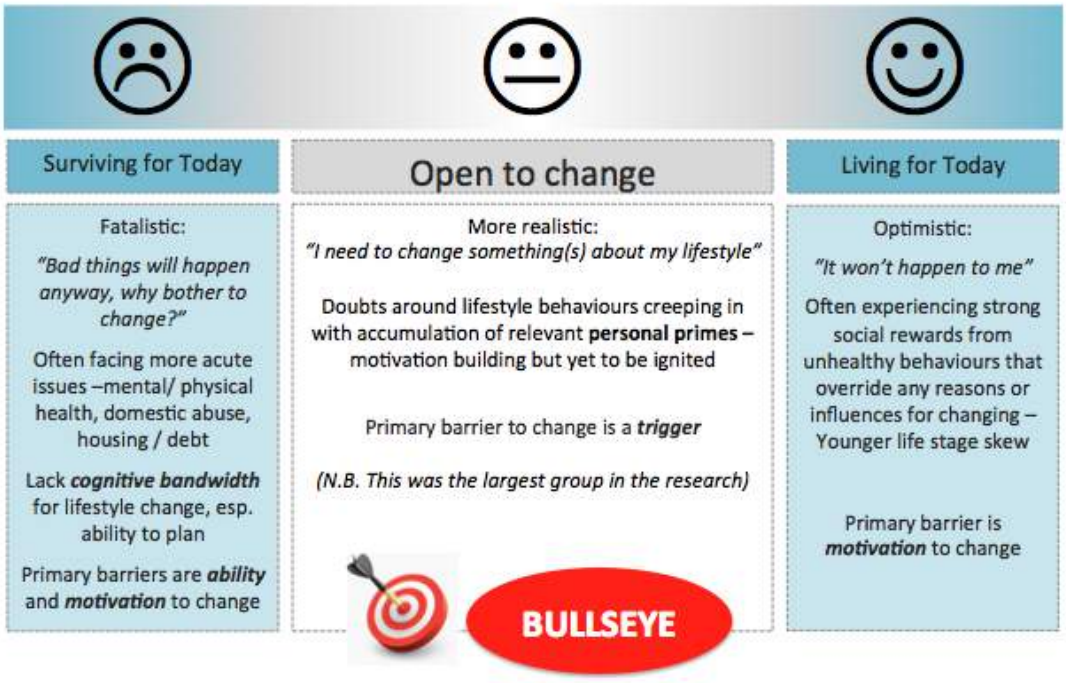

Given how the audience's habits reinforce each other, focusing on one behaviour and ignoring the context around it (including other unhealthy behaviours) is unlikely to be successful.

- *Broader routine disruption, rather than narrow focus on single behaviour, may be required to break the web of inter-connected habits; reinforcing the argument for taking an integrated holistic approach.*
- *To achieve sustained behaviour change, a combination of both a tailored, person-centred service to steer healthier lifestyle changes AND environmental 'nudges' to remove contextual triggers of unhealthy habit loops, may be required.*

## 6. Segmenting the target audience based on mental state surrounding unhealthy behaviours

Having examining people's past attempts at changing unhealthy lifestyle behaviours, and exploring current situations, it is clear that in the context of unhealthy lifestyles, behaviour change requires sufficient motivation, ability and the presence of a trigger.[4]

A person's mental and emotional state surrounding unhealthy behaviours at any given point in time was found to impact levels of motivation and ability for health improvement. The research unearthed three core groups with differing levels of propensity to actively address one or more of their unhealthy lifestyle behaviours:




☹ Surviving for Today – the Fatalists

People currently experiencing more acute challenges in their lives (untreated mental illness, unresolved domestic abuse, serious housing and debt problems etc.) typically lack the motivation, confidence and 'mental bandwidth' for making changes.

Whilst people may be aware that unhealthy behaviours are worsening their situation, unhealthy behaviours are often the default, short-term coping mechanisms, which they resort to when in crisis, in part due to their accessibility and the short-term relief they provide.

[4] Dr B.J. Fogg Director of the Persuasive Tech Lab at Stanford University, posits that these three ingredients are required to initiate changes to any and all behaviours: (1) sufficient motivation; (2) sufficient ability to complete the desired action; (3) a trigger must be present to activate the behaviour. This behavioural model is represented in the formula B = MAT, showing that behaviour change will only occur when motivation, ability and a trigger are present at the same time and in sufficient degrees. *Taken from Hooked by Nir Eyal (2014), pp. 61-62.*

*"When I'm on a low, I don't really eat. I drink more and smoke a lot. If I'm feeling better, I'll eat and not drink so much…. Every time I saw the doctor they said I shouldn't be drinking but if no one's going to take my illness seriously and give me proper treatment then of course I'm going to keep self-medicating."*
*(Male – friend of Male, Younger, Family, Tunbridge Wells)*

*"I was living with an alcoholic and was also drinking everyday, often two bottles of wine a night…I didn't realise how much at the time. He [ex-husband] made me feel worthless, and drinking helped numb that feeling. I didn't want to be stone cold sober when he was in his drunken and abusive state."*
*(Female, Younger – sister of Female, Younger, Family, Maidstone)*

This group is often also fatalistic about the risks and consequences of their behaviours, if considered, further reducing motivation to make lifestyle changes.

*An opportunity to direct to/connect from other services*

Both the audience and the professionals interviewed during the research overwhelmingly felt that removing acute stressors was critical before starting to address unhealthy lifestyle behaviours. However, coming out of an acutely stressful time in one's life was highlighted as a key transition point for making further positive changes ('Coaction' or positive snowballing).

*"Most people know if they have unhealthy behaviours but they need to change their stressful position in life, like a bad relationship or stress at work rather than their unhealthy behaviour, because that will probably follow… people have these unhealthy behaviours for a reason."*
*(Practice Nurse, Ashford)*

There may be potential to opportunistically engage hard-to-reach audiences around addressing unhealthy lifestyle behaviours at such moments.[5] People can also be receptive to continued support from services they have already engaged and placed their trust in.

[5] Other health services in the UK have shown significant success in taking an opportunistic approach with hard to reach groups. For example, the Isle of Wight Sexual Health Service (SHS) gave women using the centre for unplanned pregnancy or urgent sexual health needs e.g. contraception, STD tests or treatment to increase uptake of cervical screening. From January to June 2013, the centre reported that 38% of all cervical screening was opportunistic. Barnes, S. "Benefits of opportunistic cervical screening at a sexual health clinic" *Primary Health Care*. 25, 4, 18-22, May 2014; http://journals.rcni.com/doi/10.7748/phc.25.4.18.e904

Some people expressed having a positive experience of Cognitive Behavioural Therapy (CBT) in helping them come to terms with and make positive steps in their management of mental illness, and felt that this approach could also cross over into addressing unhealthy lifestyle behaviours.

*"What really helped me was CBT. Face-to-face was important because you just tend to forget what people have said on the phone. Honestly I'd say [my CBT therapist] saved my life because she just listened first off, then offered advice in a really constructive way…. That's the way you would want to talk about this [changing unhealthy lifestyle behaviours] too."*
*(Male – friend of Male, Younger, Family, Tunbridge Wells)*

- *There is an opportunity for the new integrated service to 'piggyback' existing services and support accessed by people coming out of an acutely stressful time in life and transitioning to a more stable way of living (i.e. experiencing a renewed sense of empowerment and upward momentum).*

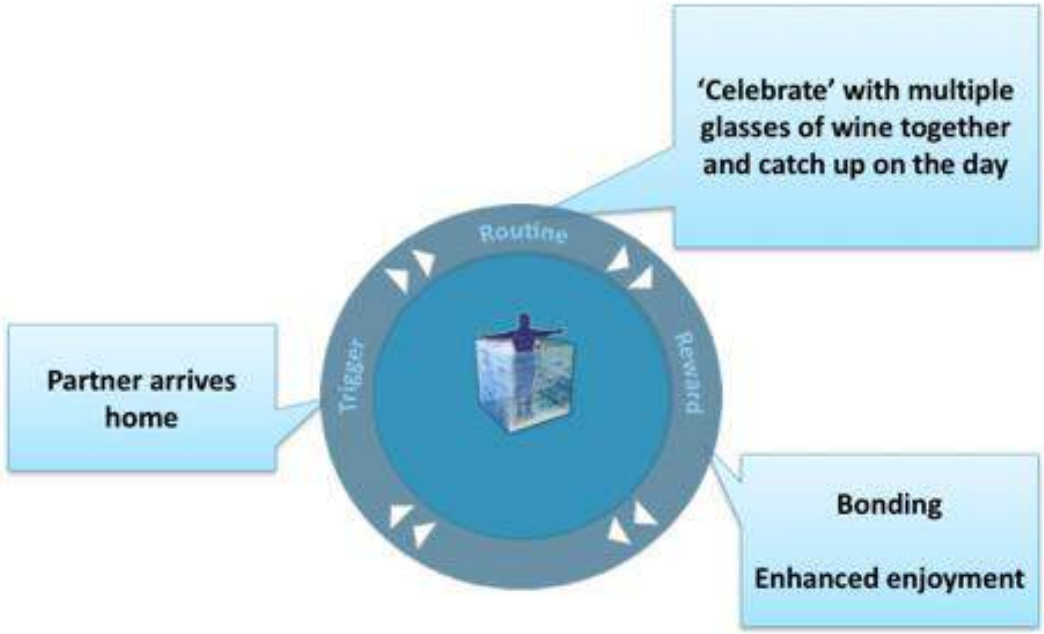
☺ Living for today – the Optimists

At the other end of the spectrum, people who are currently enjoying their lifestyle and who are not feeling the negative effects of their unhealthy behaviours typically lack sufficient motivation to make changes. This is particularly the case for people who are experiencing strong social rewards for behaviours, e.g. new couples enjoying bonding time whilst eating / drinking / smoking together in the evening.

***Introducing Sophie…***

*Sophie is 42 years old and has lived in the same house in Dartford for the past 16 years. She works in a nursery 5 minutes walk from her house though tends to drive because she has heavy bags.*
*She has a 16-year-old son who lives with her, along with her partner Andy. Though Sophie and Andy have been together for 3 years, he spent the past 18 months in Canada and has recently moved back; they are delighted to be together again.*
*Andy and Sophie tend to share a couple of bottles of wine a night, and go out to eat on the weekend. Meals are usually comforting, and Sophie routinely snacks through the day during breaks at work; biscuits and buttery toast proving irresistible.*
*Though concerned about her weight (she has used various diet programmes over the years), she is currently 'living for today', making the most of her time with Andy.*

Sophie's evening routine




People may acknowledge that their lifestyle is unhealthy but typically downplay future consequences in favour for enjoying life today (from Behavioural Economics, the concept of ***Discounting the Future***). They may also be *personally optimistic* about future health risks, often despite health scares within the family – i.e. "it won't happen to me." This group tends to skew younger when the effects of their behaviours are less apparent and the rewards of social bonding and empowerment are felt strongly.

*"I have an amazing son and husband so I'm really happy in life and will eat and drink what I want. It's a lifestyle I enjoy so there's nothing at the moment I want to change."*
*(Female, Family, Dartford)*

*An opportunity lies in Priming*

While this group tend to downplay any negative effects – and can be particularly resistant or immune to health risk messaging – their level of positivity towards their lifestyle behaviours and life in general is often a temporary state. They too experience life's stresses or start to notice the effects of behaviours (e.g. weight gain) after a time. There is an opportunity to prime people to more emotive underlying motivations for addressing unhealthy lifestyle behaviours, so that they are open to change when 'the bubble bursts'. They may be more susceptible to positive rewards than negative consequences, mirroring their current mental state, beliefs & behaviours.

😐 Open to change – the Relative Realists

The majority (of the qualitative sample) existed between the two poles, being neither excessively happy nor unhappy with their current lifestyle and situation. Doubts around lifestyle behaviours were starting to creep in with the accumulation of personal primes towards healthier lifestyles. Over time, this can lead to internalised resentment towards unhealthy habitual behaviours and build motivation for change. This group also typically has the psychological capacity to be able to make changes and therefore has most potential to change; what they quite often lack is a trigger to ignite their motivations.

Four underlying motivations for addressing unhealthy lifestyle behaviours were identified. These could be broken out in terms of whether they resulted more from a personal or social motivation (avoiding rejection, seeking acceptance), as well as whether they were positively motivated (seeking enjoyment, or hope for a better future) versus negatively motivated (seeking to avoid pain or fear). The motivations are not mutually exclusive and frequently exist in combination among the audience who are open to change.

*Ashamed of my behaviours*

This is typically driven by the social shame the audience feels from engaging in their unhealthy behaviour, and a fear of rejection. It is most prevalent in smoking among women, particularly in work contexts where they feel like an outsider for smoking and among mothers who fear judgment.

*"I'd never dream of smoking when I'm with any of the people from work; I don't want them to know I'm a smoker, it's disgusting. I even hate the smell on me now." (Female, Younger, Family, Maidstone)*

*"I don't want to smoke when I'm out with him [son] and look like a 'scummy mummy'."*
*(Female, Younger, Family, Canterbury)*

However, the same motivation is also common among people who are overweight in relation to their eating habits and levels of inactivity.

The audience are least ashamed of their increased / higher drinking levels, especially men who can feel it is socially unacceptable to *cut down* their drinking among peers:

*"I need to lose weight but beer is my one constant – even when playing hockey I'll have a few beers with mates after as a reward. It's about not changing that social dynamic and being ostracised by my friends."*
*(Male, Family – partner of Female, Older, Family, Dartford)*

*Want to make changes for my family:*

These people have often recently experienced a life change that prompts reappraisal of their lifestyle behaviours, i.e. becoming a parent, meeting a new partner. Children are often also a powerful motivator for changing a range of lifestyle behaviours, e.g. commenting on parents' smoking or drinking behaviours; children worried about own weight.

*"As a mum of 2 growing boys I want to be a good role model and feel a sense of pride that I can change my bad habits as I'm not getting any younger. My youngest son is 12 years old and overweight and lacks self-esteem. He has no motivation for exercise, I need to start thinking about activities we can do as a family and healthy food we can prepare and cook together as we don't spend much time in each other's company anymore."*
*(Female, Younger, Family, Maidstone)*

*Want to get out of life rut*

As previously noted, unhealthy behaviours are often used to alleviate feelings of boredom and loneliness. Yet the routine of engaging in these behaviours on a daily basis can itself become monotonous. The reward of the original behaviour diminishes, though the (often costly) habit is still highly engrained. In this instance, people have a level of awareness that they have become slaves to their habits and hope for a more enjoyable life. This is typical of those who drink 'on autopilot' every night.

*"I'm just really bored, I know I've put on weight but after driving round all day I just don't know where else to go but the pub."*
*(Male, Younger, Family, Tunbridge Wells)*

*"I don't even smoke all of the cigarette, it's just for a quick fix. I know I smell and I want to give up because it's disgusting and I want to save up so I can do up the house, but it's a habit I've had for years."*
*(Female, Younger, Family, Maidstone)*

*Noticing the effects*

This motivation typically stems from seeing or feeling worse for wear as a result of an unhealthy lifestyle; this could be weight gain or dull skin, or even exhaustion from waking up groggy every day. It tends to skews to older people, as the body starts to complain and medical conditions are increasingly diagnosed among their social circle, prompting people to consider their own lifestyles and future.

*"I was in Canada, away from my partner and working all day for FedEx. I was driving a lot, eating here and there and was feeling really lethargic all the time, so I decided to speak to my friend who was an instructor about my diet."*
*(Male, Family – partner of Female, Older, Family, Dartford)*

*"I'm feeling sluggish and bloated all the time and often wake up in a foul mood and don't want to anymore. I'm currently on tablets to ease digestion so know I shouldn't be smoking or drinking lots, so something's got to change."*
*(Female, Pre-family, Tonbridge & Malling)*

*"I was feeling like I couldn't play with my daughter, couldn't keep up, so wanted to lose some weight so I could be more active with her."*
*(Male, Younger, Family, Tunbridge Wells)*

- *The 'open to change' group represents the bulls-eye creative target for social marcomms. There is potential for KCC to tap into emotive underlying motivations in an integrated campaign that spans different unhealthy lifestyle behaviours.*

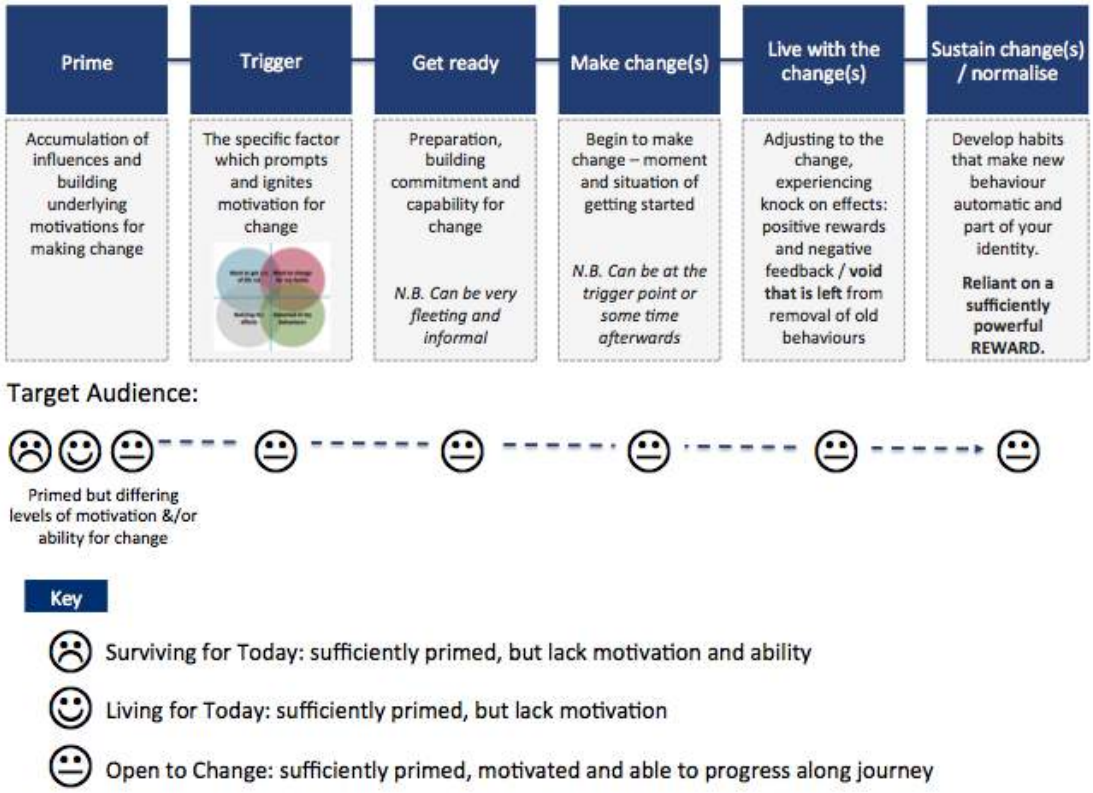
## 7. Introducing the behavioural journey model to changing unhealthy lifestyle behaviours

Mapping the target audience's past experiences of addressing different unhealthy lifestyle behaviours showed how there are broadly consistent stages along a behaviour change journey. These stages correspond with, and are supported by, established behaviour change theories, namely:

- Prochaska's Transtheoretical 'Stages of Change' model[6]
- Professor BJ Fogg's B-MAT theory of behaviour
- The Habit Loop Model

Each stage presents different triggers and barriers to moving forwards along the journey to health improvement, until it becomes the new norm.

An overview of the different stages identified is shown in the journey model below:

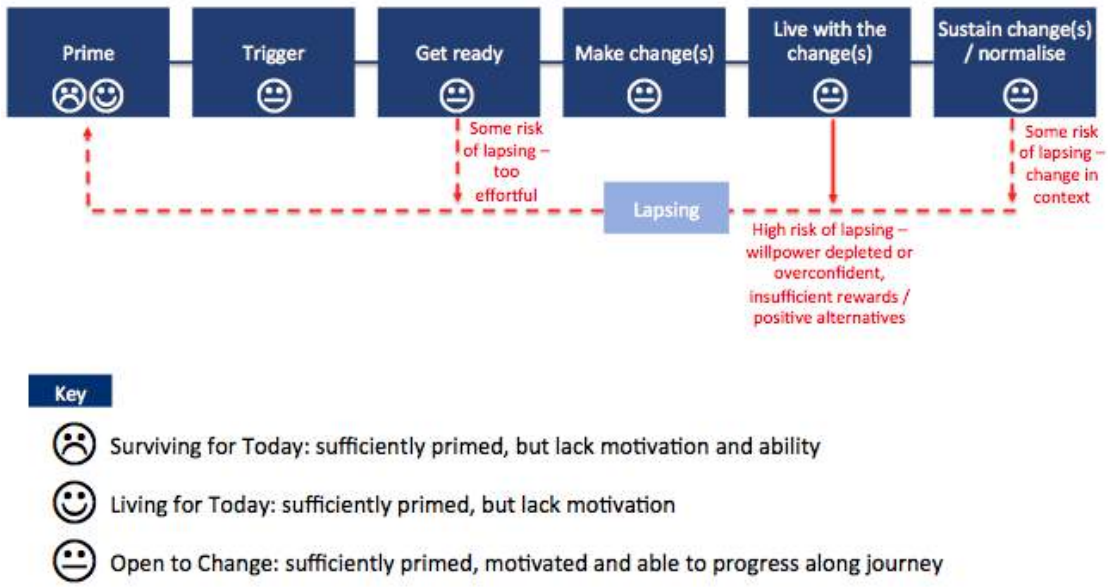



[6] http://sphweb.bumc.bu.edu/otlt/MPH-Modules/SB/SB721-Models/SB721-Models6.html

*Lapsing*

For many, the journey is not linear and most people do not move through the complete journey.

Lapsing [back] is most common at the 'Live with the change(s)' stage when the habit loop rewards (social and psychological) for change are insufficient to override old habits. There was a notable absence of positive compensating alternatives for unhealthy behaviours, and a resultant lack of positive new rewards to help establish strong, replacement habit loops. Where unhealthy behaviours are not replaced with more positive alternatives, people are particularly prone to lapsing. On the one hand, some people can become bored and tired of punitive regimes, and run out of willpower to resist deeply engrained old habits. Alternatively, some people may become overconfident and forget the underlying motivation for the change. This typically underpins the mindset of 'one cigarette won't hurt', or 'I've been good all week so I'll have a takeaway'. The rewards from the old habits are felt again, and people slip back into previous routines almost without noticing.

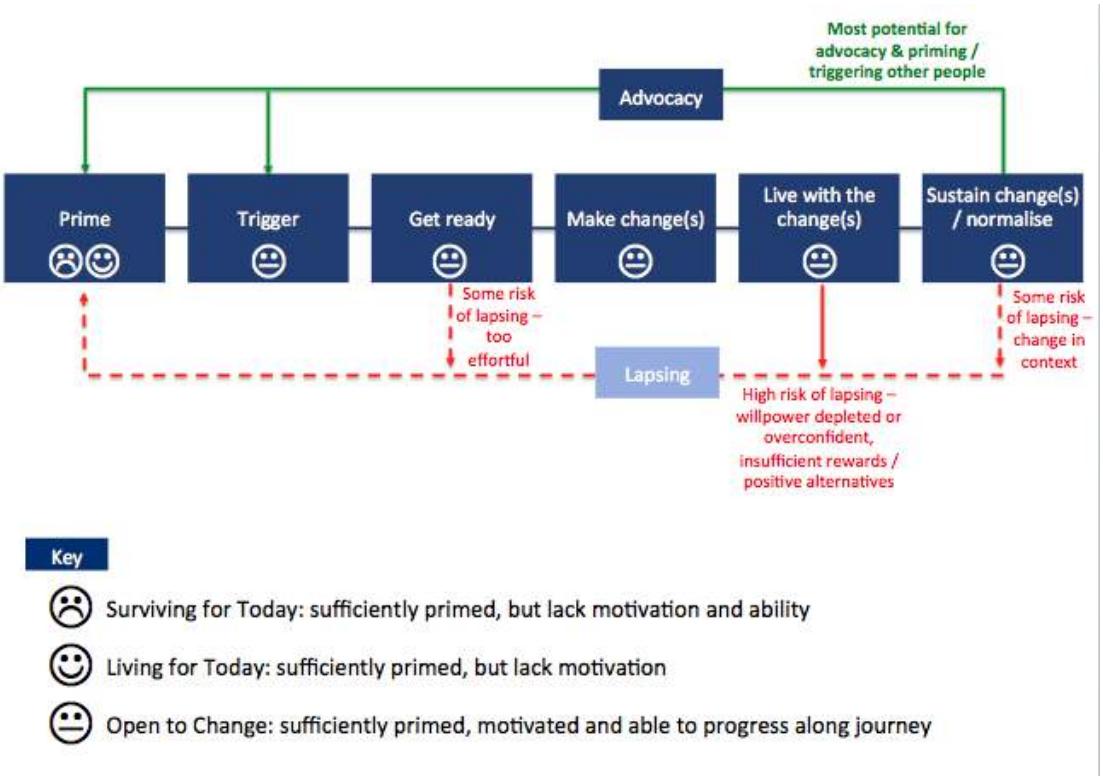



Anything involving too much mental or practical effort at the 'Get ready' stage can also stall or lead to lapsing before people have even really started.

Even having sustained a change for some time, there is always some risk of reverting to old unhealthy behaviours, e.g. when faced with a 'life shock' or a change in the environmental or social context that new healthy habits may have been built within.

*Advocacy*

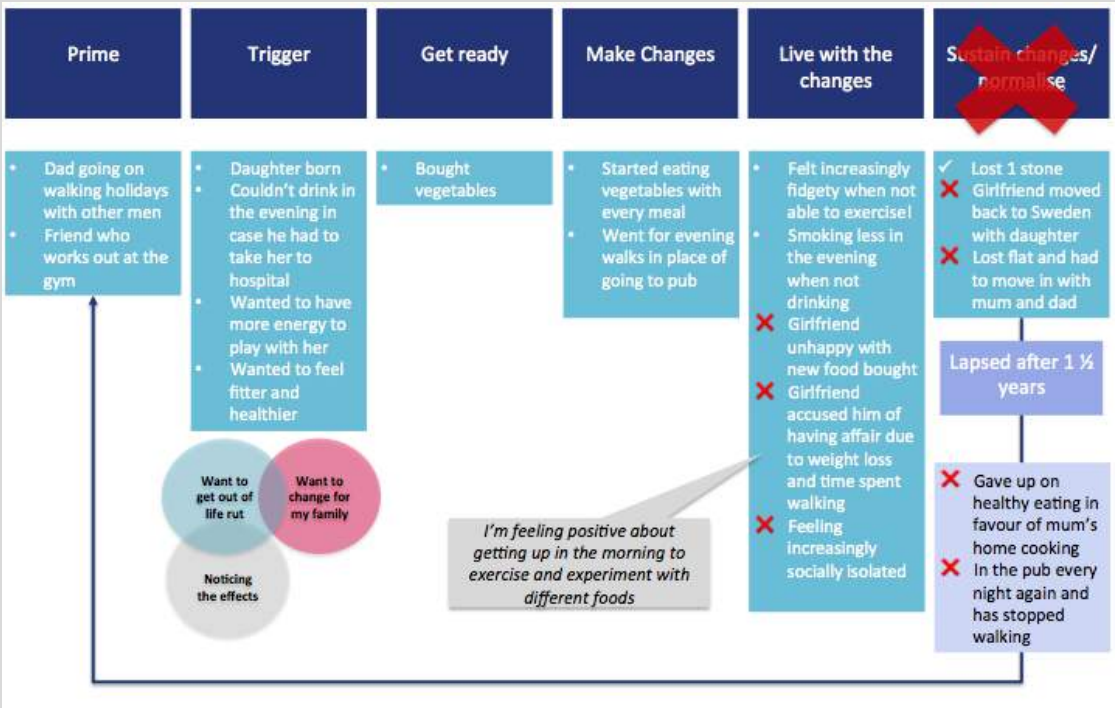
People who have sustained changes can become advocates; helping to trigger and prime friends, family and co-workers. In the research, this was most commonly seen among people who had successfully given up smoking.



***Introducing Adam…***

*Adam is 25 years old and has lived in Tunbridge Wells all his life. He currently lives with his parents following a difficult break-up from his partner. He works as an Inspection Engineer for his father's business, which involves driving to multiple building sites everyday; he rarely sees the same face twice. He has smoked since his early teens, and smokes throughout the day in his van. Every evening, he heads to the pub to see some friendly faces. He sometimes stops to get a burger or bacon sandwich to eat on the go in his van, and usually has a large hearty meal in the evening after a few beers. Driving in his van most of the day, and sitting in the pub in the evening means Adam is fairly sedentary, though recently enjoyed a walking holiday with his dad and friends. Adam finds his lifestyle monotonous and boring, but doesn't know what to do about it.*

**Adam's previous 'lose weight and get fit' journey**



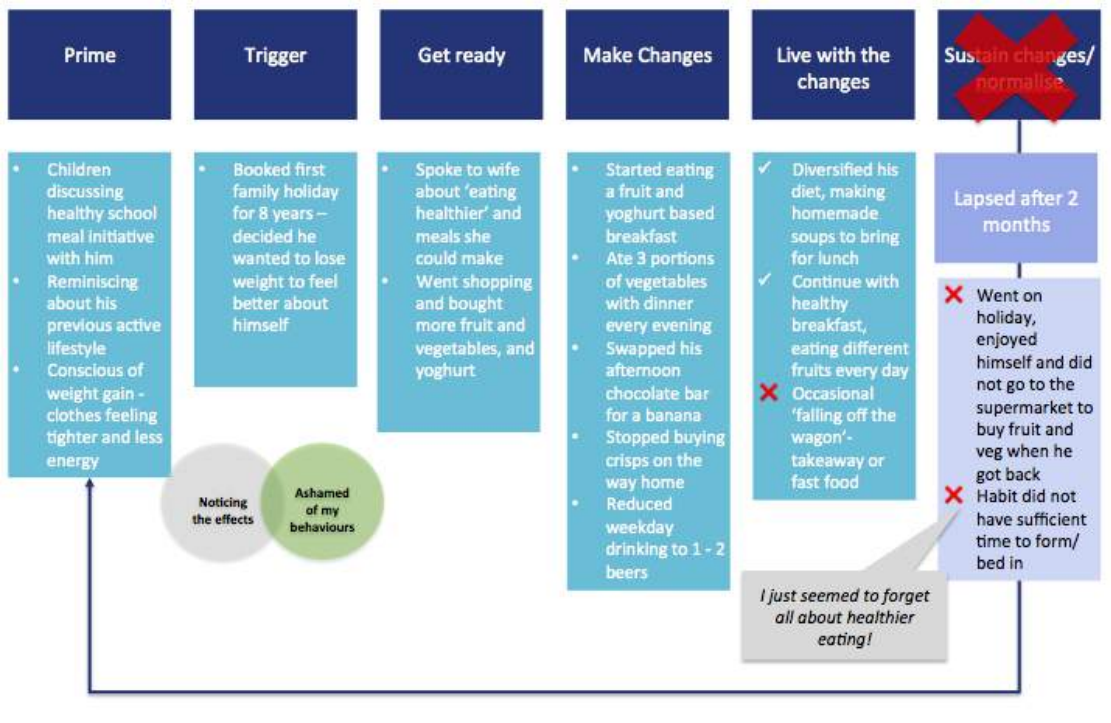
***Introducing Bill…***

*Bill is 44 years old, and is married with two young children. He services lifts for a living, but has regular hours which is important as his wife works two evenings a week at the local pub, and he needs to get home to look after the children. Bill has never learnt to drive so walks to and from the bus stop every day to get to work – he enjoys walking and wishes he had more time to do it.*

*He drinks 4-5 times a week, when his wife is at work and also when they are reunited on the weekend and on Monday, which is their adult time together. His wife Dani cooks most meals and serves up large portions for her husband as she feels he needs it. When Dani isn't there and feeling lonely, he often snacks on crisps and chocolate while waiting for her to get home.*

*"I just kill time until the wife gets home and we can catch up properly."*

**Bill's previous 'losing weight' journey**

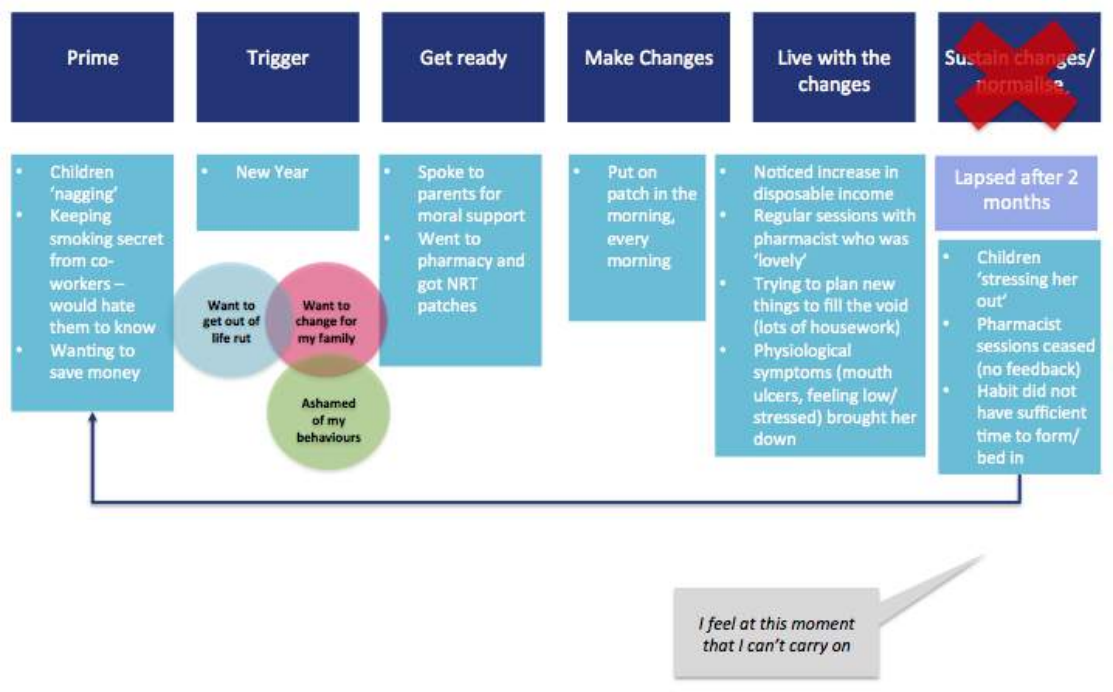


***Introducing Sally…***

*Sally is 40 years old and lives in Maidstone with her two sons aged 11 and 14. She grew up in a house of smokers so it was the norm to smoke from a young age. Sally works part time as a support worker but spends a lot of the day alone, often bored doing housework and watching TV. She will smoke or snack on crisps and chocolate rather than eat a proper meal. She isn't particularly active; usually driving to the shops around the corner and spending a lot of the day and all of the evening sat on the sofa. Even after her 2 teenage sons return from school, they rarely sit down to eat together and she finds herself back on the sofa watching TV alone, this time with a glass of rose wine, often turning into a bottle. She'll often pop outside for a cigarette hoping to strike up conversation with a neighbour also outside having a cigarette.*

*Sally is conscious that her smoking, drinking and lack of exercise is impacting on her sons' behaviour and wants to be a better role model as they grow up but she admits she finds it hard to motivate herself to make any changes.*

**Sally's previous 'quitting smoking' journey**

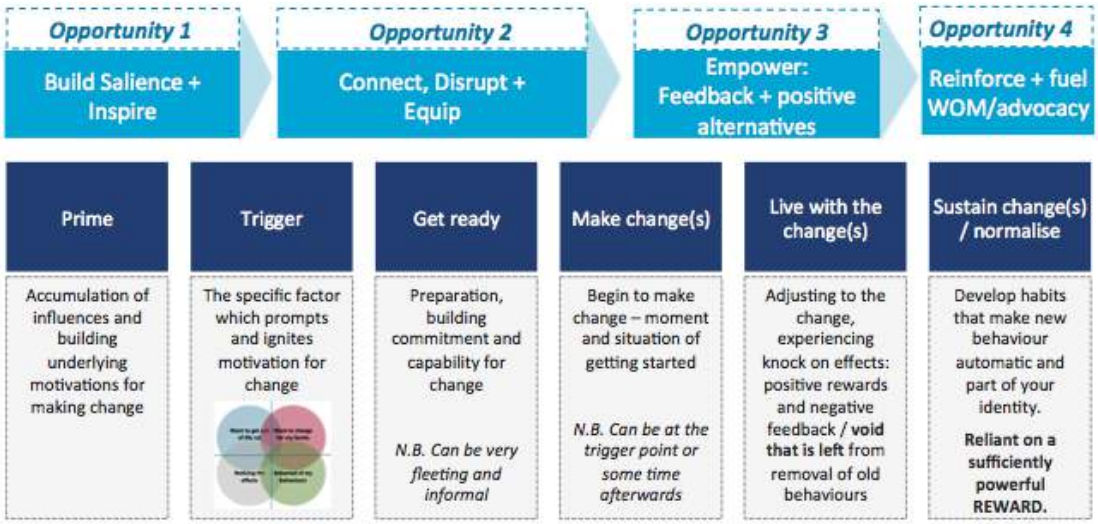


## 8. Deep-dive into the journey to changing unhealthy lifestyle behaviours

In this section, journey stages are described in detail, including discussion of the pertinent enablers and barriers.

Four "opportunity spaces" for KCC to steer the target audience along the behaviour change journey (to help prevent lapsing and support advocacy) identified through the research and subsequent analysis are also introduced. Recommendations and thought-starters for each opportunity space are highlighted in pull-out boxes following the relevant journey stages they relate most closely to.

The four opportunity spaces along the behaviour change journey:




PRIME

*Wider social and cultural influences prime people to health improvement*

While levels of motivation and ability for moving along the behaviour change journey vary, most claim they would like to feel and/or look 'more healthy'. Being overweight and smoking in particular are not aspirational behaviours for anyone.

People's immediate spheres of influence may predispose them to unhealthy behaviours, but nonetheless they are also exposed to broader cultural trends, which can prime and help to motivate change. For example:

- Increasing demonisation of smoking in recent years. People experience shame when smoking in public with their children, especially women.
- A plethora of diet programmes e.g. Slimming World, Weight Watchers, Celebrity Slim etc. are often mental anchors for weight management and healthy eating.
- The gym is the most effective, socially accepted and aspirational way to lose weight and get fit, especially for men.
- Trends towards healthier school food – e.g. children going to healthy cooking clubs after school, children brining back recipes to make at home
- Healthier food campaigns and signposting – e.g. '5 a day', traffic light food labelling, Change4Life.
- TV programmes and advertising – e.g. programmes like the 'The Biggest Loser' and 'abs cruncher' adverts.

*"Luke [son] is doing catering at school and wants to cook what he learns about at home. I've been given a list of food to buy him and I want to cook with him. It's good bonding time."*
*(Female, Younger, Family, Maidstone)*

*"I saw an advert for a spring machine to help you do sit-ups. I kept thinking about researching it but forgot!"*
*(Female, Older, Family, Dartford)*

*"Smoking in public these days is really frowned upon. If you walk down the street with a cigarette, people look at you as if you're a monster, especially if you've got your kid with you."*
*(Female, Younger, Family, Canterbury)*

People can also be primed closer to home, e.g. by co-workers who visit the gym or bring healthy snacks to work, or and older relatives who have given up smoking, typically following a health scare.

*"I have spoken to my parents as they stopped smoking and now eat regular home cooked meals since my dad was told he was diabetic and my mum had breast cancer."*

*(Female, Younger Family, Maidstone)*

The target audience is also generally aware of health risks associated with their unhealthy lifestyle behaviours but can be more fatalistic or optimistic about the consequences, depending on their current mental and emotional state. In this sense, they are all primed to the risks but interpret them differently for themselves.

*"I'm sure technically I drink too much, but ultimately I'm really happy at the moment and having been depressed in the past, happiness is the most important thing to me right now."*
*(Female, Older, Family, Dartford)*

The audience tends to have narrow and short-term frames of reference for addressing unhealthy behaviours
The main reference points when people think about how they could make healthy lifestyle changes are quitting smoking and losing weight, predominantly through dieting, especially for women; and/or going to the gym, especially for men.

These reference points – quitting smoking or losing weight/dieting – mean that people perceive health improvement as punitive; the removal of enjoyment without a positive replacement.

In general, people tend to focus on big end goals rather than a gradual journey to health improvement or the challenge of maintenance once goals have been reached, e.g. smoke free for a few months; reaching a weight loss goal. Accordingly, the audience often expresses an "all or nothing" approach to living a healthy lifestyle, versus finding a realistic balance between more and less healthy behaviours.

*"Losing weight is the easy bit, you have a weight loss goal to aim for, but once you've reached it, it's really hard to sustain that goal weight."*
*(Female, Older, Family, Dartford)*

In some cases, this has been reinforced by past experiences of engaging with services, e.g. slimming clubs or programmes advising that they address diet, activity levels and, in some cases, alcohol reduction, all at once, to lose weight. Most people's experience of this was short-term success before relapse (relapsing on one often led to a cascade of relapsing for other behaviours), priming them to quick fixes versus longer terms solutions.

*"I had a takeaway on Friday night. I've been so good recently and really felt like I'd fallen off the wagon… I thought 'oh well, might as well have a couple more beers'. Next thing I know I wake up with a hangover and the only thing to cure it is a fry-up!"*
*(Male, Older, Family, Dartford)*

TRIGGER

Trigger

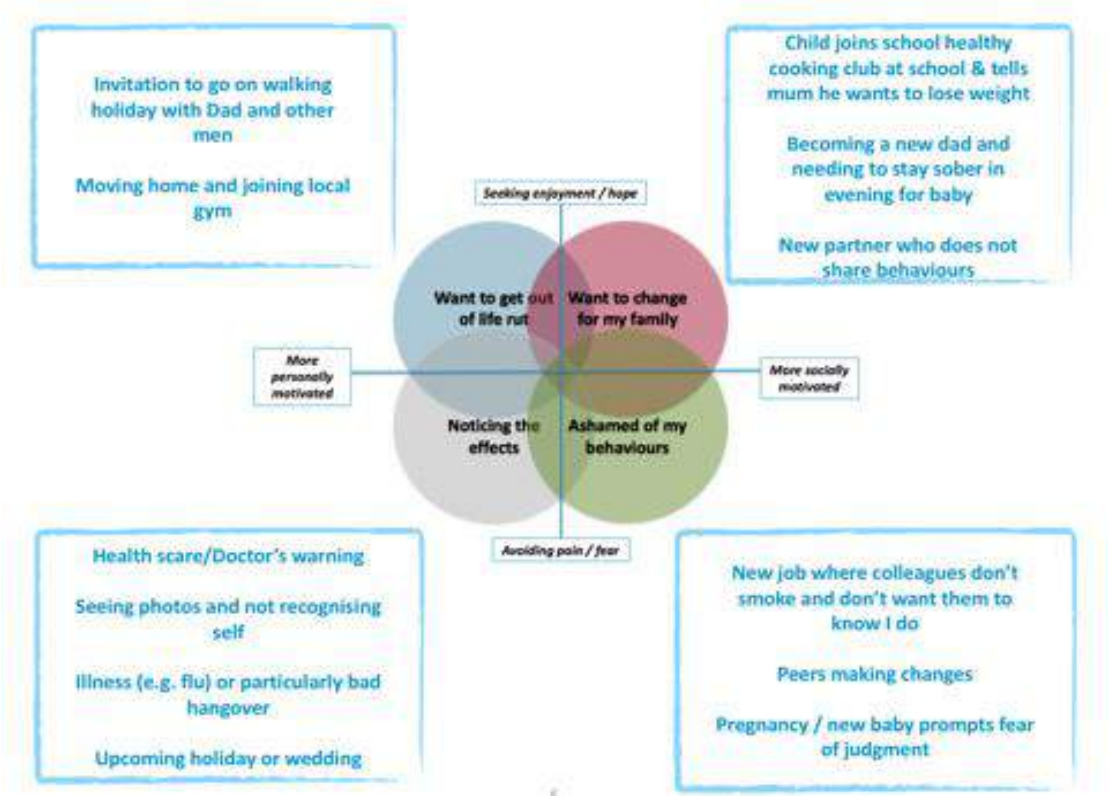
The specific factor which prompts and ignites motivation for change

*External factors typically ignite motivations for behaviour change*

Where people have made changes in the past, they often attribute them to one (or more) of the four underlying motivations.

However, detailed mapping of people's past health improvement behaviour change journeys revealed how often the actual triggers typically involve an external factor that ignites one or more of these underlying motivations. (The motivations are typically post-rationalised after the event.)

Example triggers that ignited motivations:



Once triggered, people may decide to change one or multiple unhealthy behaviours. A focus on changing just one behaviour (at least in the short term) tends to be more common when people's motivations are more socially driven.

*"I'd want to concentrate on my smoking. My mum's quit, and I just don't want to be smoking once my little boy is old enough to realise."*
*(Female, Younger, Family, Canterbury)*

By contrast, the desire to change multiple behaviours was typically associated with stronger underlying internal motivations, which involves changing their entire routine.

It is likely that people will need guidance about exactly where to start making changes to their lifestyles. People can be overly ambitious, trying to tackle one single problem behaviour without consideration of how it is triggered by other unhealthy habits. Given time to reflect, people can often see how their habits are interlinked and be more receptive to a holistic approach.

*"For my healthy lifestyle day, I had to change everything about my routine or I knew I'd reach for a cigarette. It's all about routine with me. If I'm going to stop smoking I'll need to stop drinking too, they go hand in hand for me."*
*(Female, Younger, Family, Maidstone)*

The research has found there can be mismatch between the types of behaviours experts advocate changing first versus what the target audience typically wishes to change first. Experts recommend changing the behaviours easiest for the individual in the first instance, in order to build confidence and motivation to make further changes. This perspective is supported by the broader behaviour change literature around 'chunking' behaviour change into small, manageable steps, thus 'shrinking the change'.[7]

This can feel more counter-intuitive and challenging for people who often believe they are best off tackling the unhealthy behaviour with the most severe impact, e.g. smoking, in the hope that the others will 'just slot into place'.

- *This strengthens the argument for a highly tailored approach, to support people in making realistic changes for their personal life circumstances.*

There is also a risk that removal of one unhealthy behaviour will just be replaced by another thus understanding people's broader routines may be critical for overall health improvement.

*"On the days I work, I don't smoke half as much but find I eat a lot more. When it's just me at home on my own, I'll just have a few roll ups instead of something to eat. I know it's bad."*
*(Female, Younger, Family, Maidstone)*

[7] For more on these concepts, see 'Switch' by Dan and Chip Heath (2010)

*"I'm going to try quitting in the New Year but am going to focus on losing weight before Christmas. I know I can't do both at the same time."*
*(Female, Pre-family, Tonbridge & Malling)*

- *Once triggered, the audience may benefit from help in disrupting their daily routines and finding positive alternatives to unhealthy behaviours.*

**OPPORTUNITY 1: INSPIRE AND BUILD SALIENCE**

There is limited opportunity for new service / social marcomms to trigger behaviour change beyond health checks (and potentially piggybacking the audience's use of other services). However, social marcomms can play a role in priming/inspiring healthier lifestyle changes and building salience of the new service.

**1. INSPIRE**

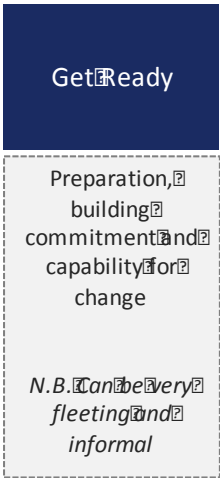
- *A role for the marcomms to inspire people that change is possible and relevant for them:*
  - *Breaking down the journey into chunks (baby steps) to make change feel easy – e.g. little ways other people switch up their routines to change what they eat; cut down how much they are drinking etc.*
  - *Providing relevant social reference points to normalise health improvement, e.g. imagery of 'people like me, and in my local places' modelling healthy lifestyle behaviours (e.g. van driver feeling/looking better for having made healthy lifestyle behavioural changes, like eating a healthy / fruity snack)*
- *Priming underlying motivations and positive rewards of changes:*
  - *Communications that prompt self-reflection, e.g. people feeling groggy from a few beers every night; someone shocked at seeing their holiday or post Christmas photos; secret smoking from co-workers, child's school or other parents as feel ashamed.*
  - *Showcasing stories of people who recently shared similar lifestyle behaviours but found positive alternatives and are feeling/looking better for it.*

**2. BUILD SALIENCE**

- *An opportunity for social marcomms to build SALIENCE of the new service through relevant content and placement, e.g.:*
  - *Interrupt and disrupt at the times when the four underlying motivations are most front of mind, e.g. on the radio during the commute to work when people are feeling groggy, seasonally (post Christmas/New Year, clock changes)*
- *Opportunity to leverage touch-points around trigger moments, e.g.:*
  - *Bounty packs and Health Visitors for new parents*
  - *Health checks*
  - *As part of introduction to new job or new home*
  - *Gym and leisure – e.g. piggybacking gym inductions (up-skilling the workforce as needed), and even when just enquiring etc.*
  - *Children's school, e.g. tied to after-school healthy cooking club*
  - *Social media where photos are shared – Facebook, Instagram*
  - *Beauty Salons/hairdressers when people are focused on themselves and their appearance*

**WATCH-OUTS:**

- *It's important to strike the right balance between tangibility and alluding to complexity / complete lifestyle overhaul, which can seem too daunting*
- *Attempting to educate around health risks is likely to prompt disengagement – people know that most of their behaviours are bad for them.*
  - *See Appendix 3: Literature Review, 'Section 1.7 – Gain framed health messages'*
  - It is important to remember that attitudinal change often follows behaviour change. In addition to priming, nudging small, positive actions to change lifestyle behaviours (opportunity 2) is likely to make the audience more receptive to marcomms.




GET READY

*Physically and mentally preparing to make healthy behaviour changes*

Once triggered, some preparation is typically involved, though there is huge variation between different people. Most will get ready informally versus engaging with services or professionals, at least initially.

Where people seek support or advice, friends and family are typically the first port of call. The exception to this is with quitting smoking, where people generally anticipate using some type of support to help them quit.

In the research, people spoke of:

- NHS Stop smoking service in pharmacy (for NRT)
- Stop smoking service in local supermarket
- Switching to an electronic cigarette [N.B. people did not class the use of an electronic cigarette as 'smoking'

The exact service people use is determined by what has been used in previous quit attempts (often recommended by a doctor) or is recommended by friends and family who have successfully quit smoking. There is a notable absence of people seeking professional/expert advice to help change other behaviours, namely poor diet, lack of activity and excess drinking. Whilst people mentioned gym instructors and dieticians, these were perceived to be expensive and not for people 'like them'.

People typically default to what they have done before, e.g. repeat previous activity or diet programme, often relying on shortcuts that require less thinking, such as cutting out particular 'problem' foods. Just the idea of having to do preparation and planning involves some cognitive strain and can be resisted, e.g. in the case of getting active, making the time to exercise or finding out what they could do can be a barrier to getting started.

The 'Getting ready' stage does not always take place. For example, a sudden life change such as moving job or becoming a parent can mean behaviour change happens organically or is forced, such as having to remain sober to drive a baby to the hospital in an emergency.

*Ways people 'Get ready'*

When preparation does happen, it can include any or a combination of the following:

- Background research and getting ideas:
  - Talking to family and friends
  - Looking up diet plans on the internet
  - Enquiring at the local gym
  - Consulting cookbooks
  - Writing a shopping list

- Personal commitment: signing yourself up:
    - Setting a date – often related to season, e.g. in the new year… when I get back from holiday
    - Registering for slimming clubs / diet programme, e.g. Celebrity Slim, Weight Watchers
    - Joining the gym
    - Visiting a smoking cessation service for NRT
    - Going to buy healthy food / alcohol alternatives (e.g. Shloer, alcohol free beer)

- Social commitment: often involving partner or co-workers:
    - Making a pact (e.g. waging a £50 bet with their boss that they would not smoke for 6 months)
    - Introducing a level of competition (e.g. a workplace 'the Biggest Loser' for weight loss); joining Weight Watchers together

N.B. The list above is aggregated feedback from across the research; it is important to remember that, for many, 'Getting ready' is a very fleeting stage of the journey.

*Factors affecting 'Getting ready'*

The level of preparation and planning varies greatly, but is broadly affected by two factors:

1. Gender – women tend to enjoy the 'Getting ready' process more than men, using it to gear themselves up for the change and start 'dreaming' about the end goal. Men are less likely to talk to other people or consult external sources, relying on their existing knowledge and willpower alone. The exception to this is men making changes as part of a couple

    "I just need to put my mind to it… I'd rather rely on willpower whereas my wife would plan everything… she'd probably have flowcharts and planners for everything!"
    (Male, Older, Family, Dartford)

    "I only went to Weight Watchers because I could go with Sophie. I was fine once there but would never have planned to go alone, the women there might have judged me."
    (Male, Family – partner of Female, Older, Family, Dartford)

2. The behaviour trying to be changed – taking up behaviours (i.e. eating more fruit and vegetables; getting active) can be perceived to necessitate more logistical planning than giving up behaviours (e.g. alcohol reduction; reducing unhealthy snacking), even if this is just about working out when to fit them in. The one exception to this tends to be smoking addiction, which is accepted to be difficult and can therefore require medical treatment.

### *Getting ready for 'Make change(s)', not 'Living with changes' over time*

In general, people tend to focus on behaviours themselves and the initial point of change at the 'Get ready' stage, versus thinking about their lifestyle or routine more holistically. For example, when people get ready to give up smoking the focus tends to be on the when and how they will make the change (e.g. get NRT), rather than preparing for the void the removal of unhealthy behaviours will leave, and positive alternatives they may need to find instead.

However, once primed to their habitual behaviours, the audience can see complete routine change as necessary for successful behaviour change.

The following two quotes are in relation to the habit disrupting healthy lifestyle day people took part in as part of the research:

*"By changing my routine, I didn't think about cigarettes all the time. I kept busy, and remained focused on different tasks like shopping, making a healthy lunch and dinner, watching TV with my boys."*
*(Female, Younger, Family, Maidstone)*

*"If I were to do this long-term, I wouldn't just plan my meals, I'd plan my whole day and everything I was going to do… I'd have to make sure I got out of the house more. Going walking or swimming, as I enjoy being outside in the fresh air."*
*(Female, Pre-family, Tonbridge & Malling)*

### *Risk of lapsing*

There is risk that if people spend too long at the 'Get ready' stage then the change can seem bigger; people can begin to question their ability and/or motivation can dwindle. While there are key benefits from preparation (notably making a public commitment), there is an argument for prompting them to make a change as soon as possible, with minimal effort or thought, and then giving support once they have already made change.

Behavioural science also shows us that if people already feel they have started to make progress, their motivation and likelihood to keep repeating behaviours is increased.[8]

[8] This is known as the Endowed Progress Effect. In an experiment involving punch cards from a car wash retailer, people who were given a punch card with ten squares to get a free car wash with two of those squares already punched were 82% more likely to complete the whole punch card than people given a blank punch card with 8 squares (i.e. both groups needed the same number to get a free car wash). *Hooked by Nir Eyal (2014), pp. 89-90.*

Make change(s)

Begin to make change – moment and situation of getting started

*N.B. Can be at the trigger point or some time afterwards*

*Actively engaging in healthier behaviours*

Some people make changes quickly following a trigger; others spend longer in the 'Get Ready' stage. This is often dependent on the nature of the trigger, for instance:

- Illness, e.g. bad cold/flu or hangover typically prompts an immediate cessation of smoking or drinking, which is then maintained when people begin to feel better:

*"I woke up hung-over as hell on a Monday, had one cigarette and it made me feel ill. So I just stopped. I went the whole week without one. But then I started getting angry and stressed and caved in the following week."*
*(Male, Pre-Family, Tunbridge Wells)*

- New year and visiting pharmacy to get NRT before quit date:

*"On 30th December 2013, I went to the chemist and bought nicotine patches and gum… On the 1st of January, I put on a patch first thing in the morning. I was feeling really motivated and prepared."*
*(Female, Younger, Family, Maidstone)*

*Changing Together*

The actual moment and situation of change is often less effortful when it involves another person[9]. For example, couples were more motivated when attending a weight loss group together, and friends felt less anxious going swimming for the first time when they were with someone 'in the same boat'. This is also seen to add in a powerful level of social commitment, i.e. having a conversation with someone else about your plans, and not wanting to be inconsistent in what you have said to them (or let them down).

Workplaces competitions and pacts can also heighten norms and commitment around the point of change, with the added benefit of priming and even triggering change in others.

*"We did the Biggest Loser at work. It was just a few of us at first, then others actually wanted to join. It was good - you kind of felt strength in numbers."*
*(Female, Empty Nester – mother of Female, Younger, Family, Canterbury)*

[9] Social support has been shown to affect perception of difficulty. In an experiment, participants who thought of a supportive friend during an imagery task saw a hill as less steep than participants who either thought of a neutral person or a disliked person. J Exp Soc Psychol. Sep 1 2008; 44(5): 1246–1255. Social Support and the Perception of Geographical Slant. Simone Schnall et al

*"My boss had cancer… when he came back after treatment he said he'd give me £50 after 6 months if I quit. I almost made it, but started smoking again after 5 months when my husband's mum was rushed to hospital. Nonetheless, I'm proud of that attempt. I needed that competition to keep me on track."*
*(Female, Younger, Family, Dartford)*

The research found an appetite for digital tools to help facilitate commitment. In particular, measurement and competition/comparison mechanics that provides a fun way to make lifestyle changes social. Those who were interested in the idea claim that such tools would only be motivating when they involved people close to them; the idea of 'competing' with strangers does not have the same level of engagement or personal relevance (i.e. in-group norms are more motivating).

*"He's so competitive, but I am too! It would be interesting if there were something where I could track how he was doing in the day. It might help me resist biscuits with my afternoon coffee!"*
*(Female, Younger, Family, Tonbridge & Malling)*

Respondents cite not having someone else to take part with, particularly to go along the first time, as a barrier to trying to something new.

*"I'm bored in the evenings and fed up of just watching TV…. I like the idea of maybe doing kickboxing or something like that involving self-defence now that I'm getting a bit older. I need someone who will do it with me though."*
*(Female, Younger, Family, Dartford)*

*A role for personalised support from a relatable guide*

The learning around how unhealthy habits cluster (replacing and reinforcing one another) points to the need to disrupt broader daily routines, versus focusing narrowly on behaviours in isolation.

This supports the argument for an integrated and holistic approach, but also one that is tailored to individual life circumstances and underlying motivations. The audience and experts included within the research consistently felt that a face-to-face service would be best for delivering this.

It was hard for people to imagine how a digital service could advise around what would be most appropriate for their personal situations. Moreover, a faceless platform would lack the same reassurance and credibility.

*"You'd want something free. Ideally face-to-face in the initial stages, like I had with CBT, then maybe you could move to apps. But I wouldn't imagine getting advice from an app."*
*(Male, Family – partner of Female, Older, Family, Dartford)*

When considering initial engagement with a service, the audience consistently stresses the importance of having a relatable figure to support them around 'Get

ready and 'Make change(s)' stages; someone who could act as a mentor/guide for changing their unhealthy lifestyle behaviours, rather than an authority figure necessarily.

People claim that someone of the same gender is preferable:

*"They would have to be a bloke. Fit but not intimidating looking – like a good version of me!"*
*(Male, Pre-family, Tunbridge Wells)*

Given that making healthy lifestyle choices can conflict with the audience's established in-group norms; it is vital that people's behaviour change journeys are understood within their social and environmental context. As such, formal qualifications of the person delivering support can be secondary to empathy and understanding of the individual and their situation.

### *The need for community outreach to connect and disrupt*

People spontaneously envisage receiving personalised guidance in more traditional health settings e.g. pharmacy, GP's surgery, leisure centre. However, the relatively high amount of motivation and planning, along with existing trust in how such a service would work, are significant barriers to use for this audience.

Accordingly, the research found a strong role for a disruptive strategy within informal environments, to pull people into the service as they go about their everyday lives, rather than relying on their individual volition to seek it out.

There is an appetite for encountering the service in locations where people feel empowered and can exert choice - e.g. supermarket, leisure centre, nail/beauty salon.

*"When I'm down the wine aisle in Morrison's, it would be great to see information near the prices on which bottles have more units or calories in them, as I often go for lower alcohol percentage if I can, as I know I put on weight with drink, and this would make it much easier to pick a healthier option."*
*(Female, Family – sister of Female, Younger, Family, Maidstone)*

*"When I'm in the nail bar I might notice something. I'm in a 'me' zone and it's not like I can just up and leave at any moment."*
*(Female, Younger, Family, Dartford)*

People also felt there was strong potential for a service to disrupt and guide them once they had already taken the first step towards making healthier lifestyle changes, including suggesting further changes they could make to support them in achieving their goals.

*"At the gym I guess. It's a bit scary going there at first so if there was someone friendly, I might stop and talk to them about eating better, or something like that."*
*(Male, Pre-Family, Sevenoaks)*

While people may not necessarily require an interaction in a formal healthcare environment, a level of privacy is important – even if just a quiet corner, out of earshot and the gaze of passers-by within more informal settings.

*"There's often some kind of activity going on outside Asda. I'm not sure I'd stop though, it doesn't seem like there's much privacy and I'd be worried someone I knew might see…. If it was in a quiet corner or you could speak to someone in a screened off bit then that would be better."*
*(Female, Younger, Family, Canterbury)*

**OPPORTUNITY 2: CONNECT, DISRUPT & EQUIP**

There is a key opportunity for KCC to guide people through the 'Get ready and 'Make change(s)' stages, including preparing them for living with and sustaining lifestyle behaviour change.

- **CONNECT**

- *Ensure first interaction is with a relatable figure with characteristics ideally including:*
  - *Matching gender to the customer*
  - *Credibility for offering advice about changing unhealthy lifestyle behaviours having 'been there themselves' or having lived within social/environmental sphere where unhealthy behaviours are the norm*
  - *Approachability, being friendly and understanding of a customer's life situation*
  - *Being empathetic and supportive rather than lecturing around the risks of unhealthy behaviours*
- *Critical to tailor to the individual's life and broader routine versus on narrow focus on one or more unhealthy behaviours*
  - *Order / number of unhealthy behaviours to be addressed dependent on how individual's behaviours work together (i.e. how their habits cluster) and what is achievable*
- *It is important to 'chunk' the journey and reframe the challenge as finding positive alternatives to unhealthy behaviours, versus just removal of enjoyment*
- *Watch out that holistic and integrated is not misperceived as extreme 'all or nothing' and therefore unsustainable*

- **DISRUPT**

- *A role for outreach that disrupts the audience as they go about their everyday lives (supermarkets, nail/beauty salons, high street, children's school) as well as more formal health settings (pharmacy, GP's surgery, leisure centre)*
- *Consider giving something of instant value away for free, e.g. free cup of tea, something for the children to play with, to entice people in and reduce practical barrier, i.e. presence of children*

- **EQUIP**

- *Offer face-to-face guidance to connect to core motivations and work through realistic changes for person's lifestyle*
  - *Build commitment, help chunk up the journey (baby steps) and instigate change on the spot where possible (e.g. download and start using SmokeFree app during session, write shopping list together)*
- *Make it social to dial up in-group norms and commitment*
  - *Help to find engaging ways to make changes social – e.g. workplace competitions; use of tracking apps / data sharing with partners and others involved in change from immediate social group*
  - *Steer the moment of change with a close friend or family member(s) – e.g. 'bring a friend for free'*
- *Help to find appealing, positive alternatives to fill the void left by removal of behaviours (and powerful emotional and social rewards they provide)*
  - *N.B. People have a tendency to only think about making the change versus what will replace unhealthy behaviours longer term*

*Since most people are prone to lapsing at the 'Living with the change(s)' stage, there is an argument for connecting, disrupting people who have made a very recent change and equipping them to sustain it. This may include steering them to start changing other unhealthy behaviours.*

**A Possible Interaction Scenario**

The following potential interaction is based on learning from discussions with the target audience and professionals. This includes the motivational interviewing approach and making SMART goals currently used by Health Trainers, with an added emphasis of starting to take actions in the moment of the interaction.

- **Step 1:** Tap into existing motivation – what behaviours and aspects of their life more broadly are most important for them to change? Where do they think a good place to start would be?

  *"It's incredibly important to build up rapport, to find out what they want to change and why. It helps them feel on a level, and empowered. If you start with that approach, they often reveal cascades of information."*
  *(Health Trainer, Swale)*

- **Step 2:** Help people to consider their life context and routine versus narrowly focusing on unhealthy behaviour(s) – critically explore and offer ways to fill the void left by the removal of unhealthy behaviours. There is a need to frame this positively and help people find healthier alternatives to unhealthy behaviours that can offer compelling emotional and social rewards.
  **This is likely to be critically important for preventing lapsing back into old lifestyle behaviours.**

- **Step 3:** There is potential to introduce the possibility of changing other lifestyle behaviours – depending on the individual's motivations and ability (as judged by the professional), and proceeding with caution:
  - It is important to never lecture, but to frame ideas based on other people 'like me' in this situation e.g. "other people in your situation have found it helps to also do xyz."
  - Potential for heightening self-awareness of lifestyle through 'gamification' – e.g. measuring drinks portions

    *"People are often shocked by how far off they are [in pouring a small glass of wine]. There's an instant realisation!"*
    *(Health Trainer, Swale)*

- **Step 4:** Make a plan, including introducing commitment devices and ways to make the change social. Wherever possible, start to take positive actions on the spot in order to resolve the intention-action gap. For example, using tools immediately, such as writing up a shopping list together; downloading apps that empower and start to build personal responsibility versus top down 'education'. [For more information, see Appendix 3: Literature Review, 'Section 1.4 – Cross category 'why wait' intervention to create drivers for change'.]
  - Watch out: too much information in one go can lead to cognitive strain and result in people falling off the journey before they have even started! It is critical to make it as easy and engaging as possible. [For more information, see Appendix 3: Literature Review, 'Section 2.4 – Too many goals'.]

Live with the change(s)

Adjusting to the change, experiencing knock on effects: positive rewards and negative feedback / **void that is left** from removal of old behaviours

## LIVE WITH THE CHANGES

***Actively engaging in healthier behaviours***

There is typically a period of adjustment following 'Make change(s)'.

### *Short-term experiences*

The first few days are often the most memorable as normal daily routines are disrupted and conscious motivation is at a peak. There is initial excitement at having turned over a new leaf and/or from the novelty of a new routine, which provides a short-term reward.

*"My mum and dad kept telling me how proud they were. They had given up smoking a few years earlier and knew how hard it is."*
*(Female, Younger, Family, Maidstone)*

Other (often unexpected) immediate benefits include feeling closer to children because of family time spent cooking a proper meal together in the evening, or feeling less tired at work having not drunk the previous evening and had a better night's sleep.

However, people often experience negative physical feedback in the short-term, e.g. aching after doing some exercise, coughs and mouth ulcers after giving up smoking.

Feedback from other people who have had a similar experience was found to be important to reassure that physical symptoms were normal, and to encourage people to keep going. For example, a pharmacist delivering the Stop Smoking service reassuring that CO levels were actually improving, or trusted peers and family explaining the positive physical changes that await.

*"I woke up feeling stiff as a board! I wasn't sure whether to do more exercise… will it make it worse? I left it a day then started again – so out of breath. I phoned my sister as I needed a bit of encouragement."*
*(Female, Empty Nester – mother of Female, Younger, Family, Canterbury)*

### *The void that is left from removal of unhealthy behaviours*

As time goes on, people increasingly tend to find that removal of unhealthy behaviours leaves a social and emotional void that they did not anticipate. This often exacerbates feelings of boredom and loneliness that are commonly seen among the audience, and which are a key trigger to unhealthy lifestyle habits! For example, after the initial novelty of a new healthy eating regime wears off, people are left with a limited repertoire of healthy foods, which can lead to boredom.

*"When I'm trying to be healthy, I buy chicken and fish then never know what to do with it. I would only boil fish and veg and feel good for having it but get bored as I find it flavourless, so then head for tastier microwaveable food."*
*(Female, Pre-Family, Tonbridge & Malling)*

People can also just switch to another unhealthy behaviour, e.g. trading smoking for unhealthy snacking or over-eating.

Some report trying to keep busy, such as through housework, even spending time looking around shopping centre, not actually with the intention of buying anything but to keep themselves from smoking. However, the substitute behaviours often do not provide compelling enough social and psychological rewards in the long term.

*"Two months in and still finding it a struggle but keep trying to plan new things. The house never looked so clean! I started to stress about everything again, the boys were a nightmare fighting and arguing all the time. Eventually I had to have a cigarette – I feel so guilty but also de-stressed."*
*(Female, Younger, Family, Maidstone)*

Time spent doing unhealthy behaviours is not normally replaced with positive, compensating behaviours. However, some found alternative healthier ways to spend their newly found free time, particularly when making the change with someone else. For example, going for day trips to the seaside at the weekend with their partner instead of going to the pub. However, these 'strategies' were typically difficult to maintain, requiring an investment of time to plan and/or money. Moreover, and crucially, people could feel segregated from their core social group.

*"I started to think about alcohol as I missed going out and socialising with my friends and family as we always meet at the pub."*
*(Female, Younger, Family, Maidstone)*

*Barriers to maintaining changes created by social and environmental influences*
The audience's immediate social group can also play a more direct role in the tendency to lapse back into unhealthy lifestyle behaviours.

Peers and family sometimes overtly disapprove of healthier behaviours, e.g. jesting for ordering a soft drink in the pub (especially for men). This was either because they miss the shared enjoyment that comes with taking part in unhealthy behaviours together, or because they do not want their own behaviour to be called into question. Friends and family also apply pressure to smoke/drink/eat unhealthily etc. because they believe healthy behaviours are too punitive or unnecessary, or that unhealthy behaviours will make the other person happy in that moment.

*"At school in mid-morning break, I had a banana instead of usual toast. My colleagues asked me what I was doing and sarcastically said 'good luck' as they didn't think I could do it. They weren't very supportive."*
*(Female, Older, Family, Dartford)*

*"People still smoking say to you 'are you sure you don't want one?', it's like they don't want you to succeed."*
*(Female, Younger, Family, Maidstone)*

In addition, some may not share the motivation for making new, healthier dietary choices with the other person, or they may resent the person spending time away from them to take exercise:

*"I decided to try and lose some weight so I can be more active and play with my daughter. My girlfriend hates vegetables though so got angry with me. I also got moaned at for being out of the house when I went out to walks…. There were constant arguments at home regarding healthy eating and exercise. My girlfriend thinks I'm cheating on her due to weight loss and being out more."*
*(Male, Older, Family, Tunbridge Wells)*

Those living the change can also miss the social connection that goes along with unhealthy behaviours:

*"It's 'us' time. If we didn't have a glass of wine or drink together it would feel like something was missing."*
*(Male – partner of Female, Older, Family, Dartford)*

People's immediate home, work and local environment also play a key role in continually prompting and reminding around old unhealthy habits, many of which can be conducted on autopilot – e.g. taking a beer from the fridge when they go into the kitchen for something else, or stopping in at the local pub whenever walking past.

These more subtle, subconscious and contextual triggers to unhealthy behaviours relating to people's everyday environments pose some of the strongest barriers to sustaining behaviour changes.

The combination of unsupportive social influences and local context together ultimately mean that the audience constantly have to apply a lot of willpower to resist the temptation that is often visible and highly accessible all around them, from seeing all the neighbours outside their homes smoking in summer, to family drinking or eating unhealthy foods around them.

*Fatalism or optimism creeping in often culminates in lapsing*

Willpower alone is very rarely enough to maintain changes, and people can lapse back into unhealthy behaviours. They often lose confidence and self-belief in their own ability to make long-term changes, which impacts future motivation. Willpower is particularly difficult to maintain when unexpected 'shocks' in life come along, such as a family illness or losing a job etc. These often push people into the 'Surviving for Today' segment discussed in section 5 of this report.

In the case of repeated cycles of weight loss and weight gain most people perceive an inevitability about slipping back into old behaviours.

*"I'm your classic yo-yo dieter – I've been on them all – Slimming World, Weight Watchers, Celebrity Slim. You name it, I've tried it!"*
*(Female, Older, Family, Dartford)*

Several previous failed attempts at quitting smoking left people questioning whether they will ever be able to stop; they often become fatalistic.

*"People trying to quit smoking don't often succeed first time and it actually takes 6-7 failed attempts…. It's about telling them not to give up giving up! If they knew this was the case, I don't think people would be so disheartened."*
*(Practice Nurse, Ashford)*

Conversely, people can become overconfident too soon. Even when they have started to create healthier habits, these are frequently overridden by the strength of old unhealthy habit loops. For example, people think they will be okay just having one or two 'social cigarettes' with a drink, or eating whatever they like for a while having successfully lost weight (often encouraged by peers who advocate 'living for today'), but these then spiral into previous unhealthy patterns because all the same *contextual* triggers for the old unhealthy habits remain.

### *The importance of on-going, positive feedback*

A lack, or the cessation, of positive feedback from other people before enough time had passed for a new habit to bed in was identified as contributing to lapsing.

*"I went to the chemist and the pharmacist was lovely so I went every week. I blew into a tube, which measured something in my lungs so they could tell if I had been smoking. They then gave you patches and gum. This really helped as I thought 'I can't smoke, they'll know'. It finished after 2 months and my boys started stressing me out so I had a cigarette. I think if that had just carried on a bit longer, maybe for six months, then I might have been alright."*
*(Female, Younger, Family, Maidstone)*

Those with experience of Smartphone apps to support health improvement are very positive about the opportunities they provide to track progress and get regular feedback.

*"It's good because it's a distraction, when you feel like smoking, by the time you've looked at the [SmokeFree] app for encouragement, the craving has probably passed."*
*(Female, Younger, Family, Maidstone)*

People who use apps featuring their personal data display a confidence and self-awareness around their ability to manage specific unhealthy lifestyle behaviours, and wished that further unhealthy behaviours could be included:

*"I've had it [My Fitness Pal] on my phone about four years now. I typed calorie counter into the app store and it came up. It's good because you enter your aims, so it's personal to you. Until my phone ran out of memory I looked at it everyday. It's good because I can look at it and realise when I might be having a hungry day; sometimes you don't realise how much you actually eat… It would be good if smoking was built in too as you don't always notice how many you've had."*
*(Female, Younger, Family, Canterbury)*

Similarly, there is some interest in two-way SMS support that involves the user actively committing to specific behaviours, one day at a time. [10] This may also be important for the audience that do not use Smartphones or are not comfortable using apps.

*"It would be really easy to just ignore a text saying 'you should do this', but this would actually get you to think a bit."*
*(Female, Younger, Family, Maidstone)*

Experiencing positive physical and emotional feedback for lifestyle changes is seen to play an important role in people internalising the benefits of their new behaviour, e.g. feeling more energetic and confident having lost weight or given up smoking.

*"I'm continuing to lose weight through diet and walking. I'm feeling positive about getting up in the morning to exercise, and experiment with different foods. On the downside, I'm finding it very difficult to keep still as I want to be more active during the day."*
*(Male, Younger, Family, Tunbridge Wells)*

These more internal rewards of changing unhealthy drinking, smoking and eating behaviours are often most apparent when people are also physically active:

*"Having changed my diet after speaking to my Martial Arts instructor friend about feeling so lethargic, I noticed real improvements in my hockey performance so I kept it up."*
*(Male – partner of Female, Older, Family, Dartford)*

[10] Two-way text support has proven to be effective to support sustained weight loss for American teens attending weight loss camps, because it leverages people's commitment bias. Researchers found that teens that were sent text messages where they were required to reply with a binding commitment to eat and live a healthier lifestyle were more successful in maintaining their new body weight, post-camp. For more information, please see Appendix 3: Literature Review, section 3.1 – Texts building commitment to a healthy lifestyle.

**OPPORTUNITY 3: Empower – give feedback and find positive alternatives**

The service and interventions it delivers have potential to steer customers on an empowering journey towards sustained behaviour change in two key ways:

1. **GIVE FEEDBACK**

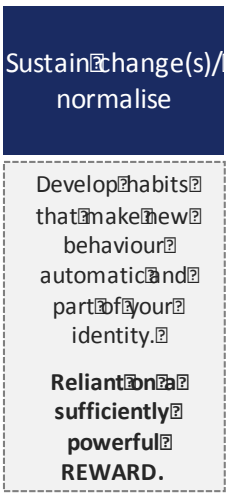
- *A role for the new service to provide on-going feedback to:*
  - *Maintain commitment to change and keep motivations front of mind*
  - *Support tracking and building on progress – including extending to other unhealthy behaviours – to mitigate one unhealthy habit replacing another*
  - *Reassure around 'failure' and guide learning from set backs – so confidence and motivation is not knocked*
  - *Celebrate success (without tipping into over-confidence) and help people to internalise the rewards of new behaviours*
- *A need for on-going face-to-face feedback support – as per Smoking Cessation now – in combination with practical tools, e.g. self-tracking via apps and other tangible collateral such as posters displayed in home for people to record and see progress*

2. **FIND POSITIVE ALTERNATIVES**

- *An opportunity for a face-to-face guide to support taking up positive, healthier alternatives to unhealthy behaviours, rather than relying on individual willpower.*
  - *Where possible, support engaging ways to be physically active (even if not the main focus), to help make the internal rewards of changing other unhealthy behaviours more personally salient.*
- *A role for interventions to positively disrupt daily routines and keep changes interesting so people don't get bored with a new regime.*
- *Given the day-to-day challenges the audience faces, it will be important to push appealing and easy alternatives to unhealthy behaviours out to people once they are 'Living with the change(s), rather than waiting for them to come to a service.*

It is important to be realistic about how challenging maintaining behaviour change will be if relying on individual motivation and willpower alone. In addition to designing a service and interventions to steer healthier habits and personal responsibility, there is a need to consider the potential for ***ENVIRONMENTAL NUDGES*** to make unhealthy lifestyle behaviours less salient and accessible, and positive alternatives more so.

- *Potential to consider how people's homes, local environment and infrastructure can nudge maintenance of changes, e.g. reconfiguring kitchen so unhealthy foods are out of sight and healthy alternatives more visible; safe and inviting walking routes/making it difficult to drive; making it more difficult for people to smoke at work; giving out free fruit to children in supermarkets or in workplaces etc.*




## SUSTAIN CHANGE(S) / NORMALISE

### *Actively engaging in healthier behaviours*

There were limited examples of people sustaining changes in the long term; most successful long-term changes involved quitting smoking which was usually triggered by a teachable moment, e.g. the beginning of a new relationship with someone who didn't smoke, or in the event of a health shock for one or both partners in a couple.

*"I started going out with my girlfriend, now wife, and she didn't smoke so I had to stop really."*
*(Male, Pre-Family, Sevenoaks)*

As the examples above show, changing with or for someone else – particularly a partner – appears to be one of the most powerful facilitators of sustained change.

People who sustain new behaviours often became advocates for lifestyle change within their families and friendship circles. In most instances, they positively primed others by making change seem more achievable and relevant for someone 'like me'.

*"My friend has been using e-cigs for a year now and not smoked cigarettes. He has blueberry flavoured ones, which sound interesting so I want to give that a go, if he can do it, I should be able to as well."*
*(Female, Pre-family, Tonbridge & Malling)*

Given that a close-knit social group are key influencers of people's behaviours, supporting positive Word Of Mouth (WOM) within the target audience's immediate social groups is likely to be extremely powerful.

### *Negative habit replacement*

However, there were examples where one unhealthy behaviour had been substituted for another that was seen to be less desirable:

*"My mum always tries to get me to stop since she quit… I know I should but she's put on three stone now and I'm trying to lose my baby weight at the moment so can't risk putting on anymore."*
*(Female, Younger, Family, Canterbury)*

Even people who successfully sustain change for a year or more are susceptible to lapsing back, particularly when the context of their life changes significantly and the original motivation for changing lacks relevance.

*"I wanted to lose weight and be more healthy so I had more energy for my baby daughter… After my girlfriend moved back to Sweden with our daughter, I lost my flat and had to move back in with my parents, and now I'm back in the pub every night."*
*(Male, Younger, Family, Tunbridge Wells)*

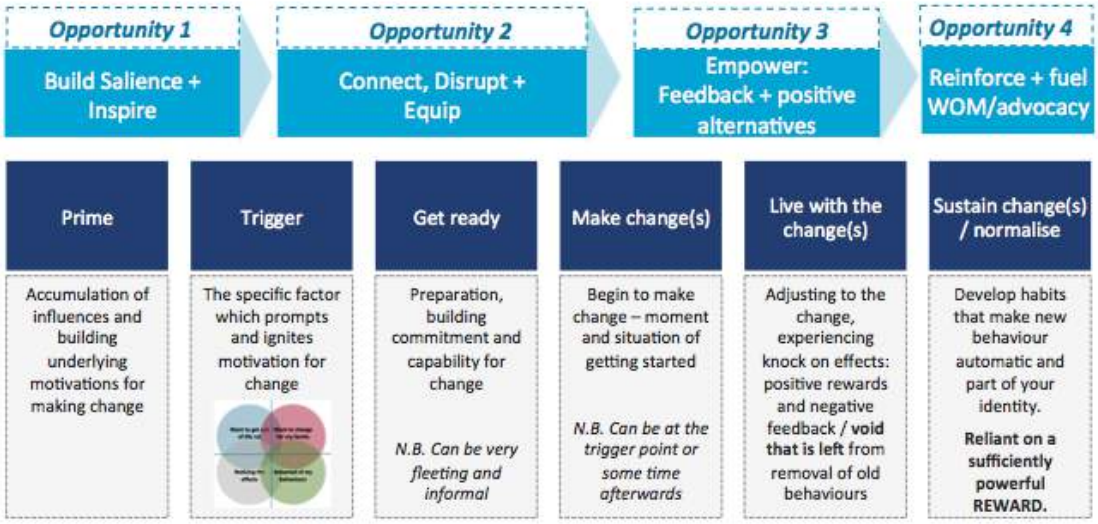
As this example shows, the habit loops of unhealthy behaviours never go away but lie dormant. People can need to have their healthy behaviour continually reinforced and socially validated long after making changes if they are to sustain them through life's ups and downs.

**OPPORTUNITY 4: REINFORCE AND FUEL WOM/ ADVOCACY**
There is potential for KCC to help facilitate sustained change through continual reinforcing of behavioural change motivations and rewards.

- *Marcomms can continue to remind and rekindle motivations*
    a. *These can be the same marcomms that prime and build salience for the new service (opportunity 1)*
- *Give people a way to talk and share their behaviour change journey and healthier lifestyle habits – dialling up in-group norms around health improvement*
    b. *Marcomms that act as conversation starters can help normalise discussing change within social networks*
    c. *Physical collateral, e.g. tracking progress on posters displayed in the home, could act as rewards and serve as visual primes for those yet to begin on a health improvement journey*
- *A role for Smart Phone apps / social sharing (with close-knit group of supportive family/friends/co-workers) to keep commitment front of mind and provide on-going positive feedback*

## 9. Summary opportunities and recommendations for KCC

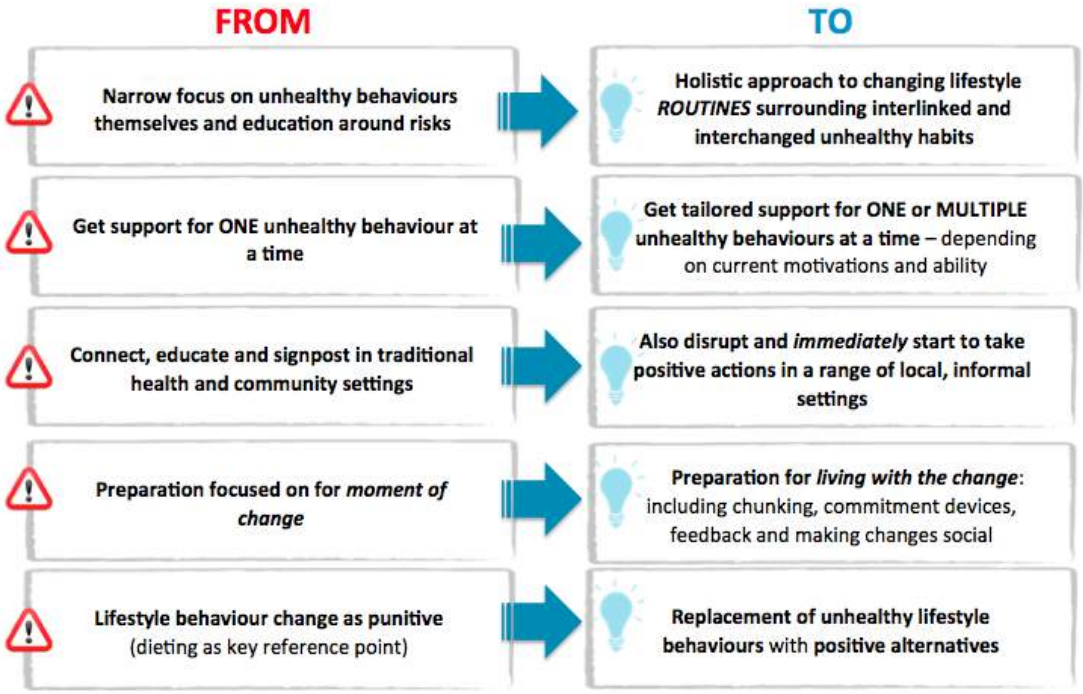
The four opportunity spaces identified present a range of ways for to KCC's new integrated service and related social marcomms to influence, disrupt and reinforce the audience's behaviour change journeys.
(See Appendix 1 for examples of potential opportunities for KCC to facilitate behaviour change for target audience respondents introduced earlier in the report.)




While each opportunity space has a centre of gravity at particular points along the journey, all build upon each other and remain relevant, particularly since people can lapse back.

Given that most people struggle to 'live with the change(s)', there is an argument for focusing most effort on people who are already triggered and on their way to changing one or more of their unhealthy behaviours.

The new service has potential to create a step-change in the audience's experiences and expectations of changing lifestyle behaviours, as follows:




Engaging and supporting the target audience with multiple unhealthy behaviours in Kent calls for a multi-pronged approach, including:

PRIMING

- Dialling up in-group norms for changing unhealthy behaviours among the target group, e.g. through inspirational stories of 'people like me, in my local places' that help to break down the journey towards living a healthier lifestyle into manageable chunks.
- Gain framed messaging primes people around the positive rewards from behaviour change, rather than the punitive loss of a habit, is likely to be more impactful.
- A key opportunity for social marcomms to tap into the audience's four key underlying motivations for changing unhealthy behaviours, to inspire health improvement and build salience of the new service.
- Potential for these types of communications to also drive WOM and advocacy, through giving people who have successfully made changes a credible way to talk about their experiences.

DISRUPTION:

- There is a need to disrupt people as they go about their everyday lives to connect them to the service, and ideally encourage them to start taking small actions on the spot to build commitment to change (as well signposting with more traditional health settings).
- There is also an opportunity for interventions to disrupt people's daily routines versus focusing narrowly on behaviours themselves, in order to break the chain of interlinked unhealthy habits and protect against one unhealthy behaviour just being replaced by another.

TAILORED GUIDANCE:

- There is no 'one size fits all' solution to the order in which behaviours should be tackled; this will depend on the individual's current motivation, broader routine and context.
- A face-to-face service is important to tailor guidance to the individual's circumstances, provide reassurance and credibility.
- Preparing people for the emotional and social void which will be left from the removal of an unhealthy behaviour, and helping them to find positive alternatives which can provide compelling rewards, will be important to mitigate them lapsing once they are 'Living with the change(s)'.
- There is potential during these interactions to steer use of digital apps, tracking devices and other tools that can offer on-going feedback, keep motivations and commitment front of mind, and promote personal responsibility.

MAKING IT SOCIAL:

- Beyond the provision of guidance, there is a need to consider the broader unsupportive social context for sustaining changes.
- Encouraging and nudging people to make changes together can make the experience easier, enhances commitment and help prevent feelings of isolation and loneliness, e.g. through competition mechanics with social groups.

ENVIRONMENTAL NUDGING:

- In addition to designing a service and interventions to steer healthier habits and personal responsibility, there is a need to consider the potential for environmental nudges to make unhealthy lifestyle behaviours less salient and accessible, and positive alternatives more so, e.g. safe and pleasant walking routes / making it more difficult to drive short distances.

- The specific interventions could be informed by on-going learning from the audience with multiple unhealthy behaviours that use the service.

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THE BEHAVIOURAL ARCHITECTS

## 10. Appendix

Appendix 1: examples of potential opportunities for KCC to facilitate behaviour change for target audience respondents introduced earlier in the report.

***Engaging Bill…***

| Prime | Trigger | Get Ready | Make change(s) | Live with the change(s) | Sustain change(s) / normalise |
|---|---|---|---|---|---|

| Opportunity 1 | Opportunity 2 | Opportunity 3 | Opportunity 4 |
|---|---|---|---|
| **Build Salience + Inspire** | **Connect, Disrupt + Equip** | **Empower: Feedback and positive alternatives** | **Reinforce + fuel WOM/advocacy** |
| Bill is at his daughter's parents evening; he is really pleased to hear about how well she has taken to healthy eating lessons, but can't help feeling a little embarrassed about his own weight.<br><br>He bumps into an old school friend that he played football with 10 years ago – he's lost lots of weight in the past year and says he couldn't have done it without his Health Trainer.<br><br>**Outcome:** Bill is primed towards health improvement and available services | Bill is at his daughter's school fete. He notices a mobile van offering healthy lifestyle advice – his daughter is keen to go in and find out more about nutrition so Bill goes in too.<br><br>There are lots of leaflets and guides, so Bill picks up a couple of quizzes about healthy eating and activity. He speaks to the service professional there who offers him tailored advice; Bill says he would like to have more energy and lose a bit of weight.<br><br>The professional maps a longer, scenic route home with Bill and mentions he should pop by to the Community Centre on a Thursday when they have a residence. | Having dropped his child at Brownie's, Bill stops at the Community Centre to kill some time.<br><br>He mentions he's enjoyed walking a bit more, and the professional encourages him to explore at least one new road per day – Bill likes making a game of it!<br><br>He also mentions that he's still feeling a bit sluggish in the mornings and the professional explains it may be to do with what he's eating and drinking. She recommends he keep a food and drink diary over the coming two weeks and come back to her.<br><br>Two weeks later, Bill returns and mentions he had no idea he ate so much chocolate, nor drank as much as he did. Together, they devise some healthy eating and drinking alternatives for 2 weeks, and next time he comes back, they would mix things up some more. | Bill's children are really enjoying spending time with their dad – he always seems up for going on an adventure and exploring somewhere new. He and his daughter have started surprising the family by cooking healthier meals together.<br>His wife is proud of him, and went along to the Community Centre with him last time to see if they could help her reduce smoking. |

***Engaging Adam...***

| Prime | Trigger | Get Ready | Make changes | Live with the changes | Sustain changes/ normalise |
|---|---|---|---|---|---|

| Opportunity 1 | Opportunity 2 | Opportunity 3 | Opportunity 4 |
|---|---|---|---|
| **Build Salience + Inspire** | **Connect, Disrupt + Equip** | **Empower: Feedback and positive alternatives** | **Reinforce + fuel WOM/advocacy** |
| Driving along in his van, Adam hears someone talking about how they lost a lot of weight and have more energy since taking up rock climbing on local radio.<br><br>Later in the pub, an old friend who had been ill talks about how gardening at the allotment has made them feel much better<br><br>**Outcome:** Adam is primed towards new environments and positive rewards from activity beyond drinking | Adam receives a leaflet through his door to try a nearby climbing wall for free<br><br>Next time at the pub he mentions it to his friend and they dare each other to go. At the climbing wall, they notice a man wearing a t-shirt with 'First time here? Come chat to me' – he goes over.<br><br>They ask him what he wants to get out of rock climbing. He then asks broader questions around lifestyle and routines.<br><br>Then and there, he signs Adam up for a two way text service, based around prompting him to get more fruit and veg to eat in his van. He's excited to try something new | On Adam's third session at the climbing wall, he chats to the service professional again.<br><br>Adam mentions that it's hard to motivate himself to climb rather than go to the pub where his friends are.<br><br>The service professional tells him about an upcoming trip rock climbing in Snowdonia and encourages Adam to sign up, which he does. Adam and the service professional discuss cutting down smoking in advance of the trip.<br><br>Adam notices rock climbing getting easier, and beats his personal best on the climbing wall. He thinks reducing smoking might make him ever faster. | Adam's friends notice his newfound confidence. Adam puts it down to being excited about the week ahead rather than dreading it.<br><br>Adam's friends ask him what his secret is, and he just says he's happy doing new things and feels like he's out of a rut. |

# Appendix 2: Literature Review

## Introduction

This report reviews the relevant academic and applied literature investigating what makes an effective health improvement service and the most effective drivers and pathways to using such services to ensure our customer research for Kent County Council builds on existing evidence.

Furthermore, it draws from literature from the behavioural sciences relevant to building healthier lifestyles while also analysing health intervention related literature through a behavioural economics lens. Knowledge and awareness of these insights create a deeper and stronger understanding of customer behaviour and the drivers and barriers to making lifestyle changes.

We focused our review around literature most relevant to our two research objectives and two key research questions:

**Research objectives:**

- Understand **drivers and barriers** to using health improvement services and interventions among the audience (people engaging in multiple unhealthy behaviours)
- Explore and identify how **socio-economic, mental health and wellbeing, environmental and psychological** factors impact on the customers' ability to achieve and maintain behaviour change.

**Key research questions**

- What **steps** have people taken in the past to address unhealthy behaviours, and how successful have they been? What were the problems? Why did they give up? What were the triggers that made them (a) want to change in the first place, and (b) subsequently give up?

- What **pathways** (or "customer journeys") do people tend to take when they want to address these behaviours? Where did they go/look for information last time? How useful was the information that they received? Was it lacking in any way? Would they do anything differently next time? What would have made a difference for them?

Keeping these objectives and questions in mind, the report is split into three sections:

- **Section 1: Drivers to engagement with health improvement and uptake of services**

- **Section 2: Barriers to engagement with health improvement and uptake of services**

- **Section 3: Triggers and barriers to maintaining healthy behaviours and continued use of health improvement services and interventions**

## Section 1: Drivers to engagement with health improvement and uptake of services

### 1.1 Leveraging the 'teachable moment' - Cardiff and Vale University Health Board initiative

A 'teachable moment' is one when we are in a highly receptive state to education, guidance or 'need to know' facts. The theory of teachable moments is supported by conceptual models that emphasise the importance of cues or 'cueing events' in building motivation to change behaviour.[11] A teachable moment is likely to be more effective when three elements are strong as a result of the cueing event:

1) **Increased perception of personal risk** and outcome expectancies. The probability of an event such as cancer or a heart attack feels more likely when a warning is vivid, salient or personal. In behavioural science, this is known as **availability bias**.
2) **Strong affective or emotional responses in relation to the event**. Our behaviour is often driven more strongly by our emotional reaction to something than by the logical and rational evaluation. In behavioural science, this is known as **affect bias**.[12]
3) **Self-concept or social role is redefined**. For example, having a baby means becoming a mother or a father and as a result someone may feel a greater sense of responsibility and changed identity.

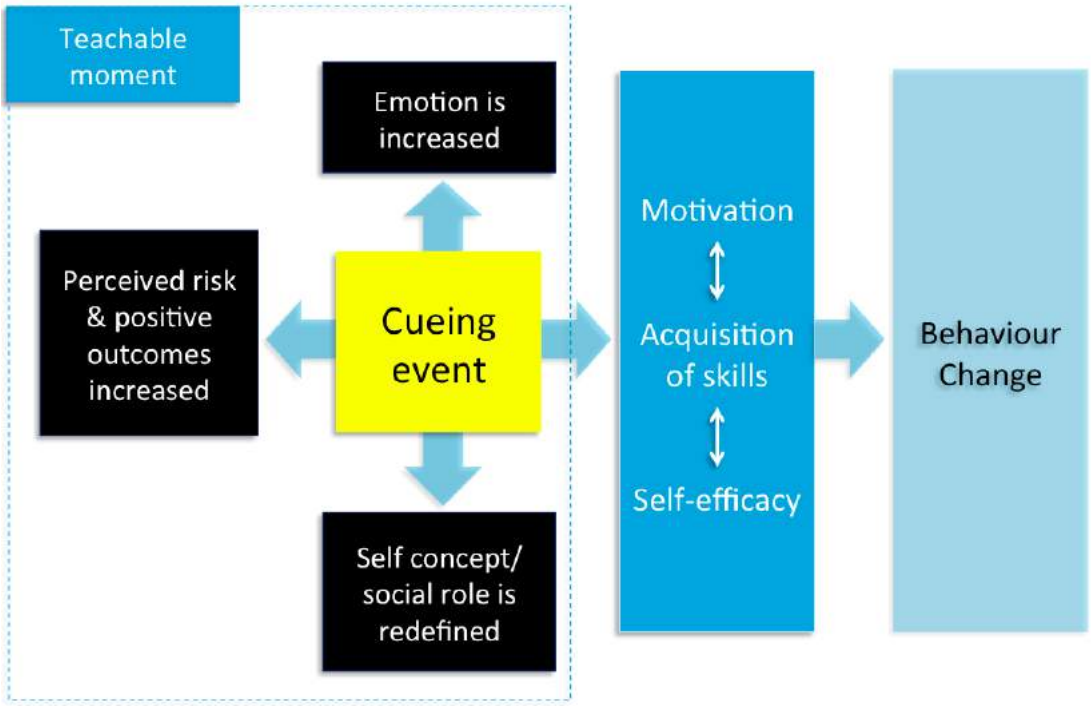


***Figure 1: Model of a teachable moment, adapted from McBride, Emmons and Lipkus, 2003***

Such cues prompting increased motivation for living a healthier lifestyle may be having a baby, retiring or an illness or injury. Health education often seems to work best when a teachable moment is at hand and the topic is relevant to the learner.

[11] McBride, C. M., Emmons, K. M., Lipkus, I. M., Understanding the potential of teachable moments: the case of smoking cessation., Health education research, vol. 18 no. 2 (April, 2003), pp. 156-70, ISSN 0268-1153

[12] Much of behavioural science is based around the idea that we have a dual system of reasoning – an automatic, emotional, intuitive System 1 and a conscious, rational, deliberative System 2. Whilst System 2 is very good at assessing information methodically and logically it is less good at actually making decisions using its assessment. Our decisions are often more System 1 driven.

'Teachable moments' are being leveraged by Cardiff and the Vale University Hospital who implemented the '**Optimising Outcomes Policy**' in December 2013. The policy aims to help patients improve their chances of successful surgery by improving their health beforehand. The daunting and serious prospect of undergoing a surgical procedure may be a '**teachable moment**' in which patients may be more receptive to building knowledge and accessing services to make their lifestyle healthier. So a supportive conversation about the benefits of lifestyle behaviour change could be more effective.

Evidence shows that smokers are more likely to suffer complications during surgery, have a higher risk of infection and will spend longer in hospital. Weight can also dramatically increase risks levels in a variety of elective surgery.

Patients who smoke or have a body mass index of over 40 are referred by their GP to an **8 week smoking or weight reduction course** and must show evidence of completion of the course before their outpatient appointment.

The policy is based on the knowledge that people are four times more likely to quit smoking with a **support programme** than going it alone (see also section 2.3). The majority of people attending weight management courses also lose weight.[13]

Other examples of 'teachable moments' for living a healthier lifestyle might be when trying to have a baby. If a couple is struggling to conceive and/or hold a pregnancy then they may be more receptive to initiatives to spur a healthier lifestyle. A heart attack or cancer scare may also be a significant cue.

A meta-analysis reviewing all **smoking cessation studies** using teachable moments as a cue for giving up smoking found that cessation rates were higher with teachable moments such as pregnancy, hospitalisation and disease diagnosis.

Cessation rates associated with pregnancy stood at 10–60% and hospitalisation and disease diagnosis at 15–78% – **much higher** than cessation rates for clinic visits (2–10%) and abnormal test results (7–21%).[14]

**THOUGHT-STARTER FOR PRIMARY RESEARCH:** Are making healthier lifestyle changes triggered by intervention at a 'teachable moment' within the target group - what?

### 1.2 Habit disruption

Related to teachable moments are life events such as going to college or university, having a baby, retiring, changing job or moving house. These can help to disrupt lifestyle habits for example by **breaking up their routine** so that they might begin to walk or cycle to work rather than drive when they move house or change jobs.

We can also **incentivise** habit disruption immediately after such life events. For example, a study on travel habits found that free bus passes in Stuttgart helped to create a new habit of using public transport among people who had recently moved to the city. Use of public transport rose dramatically from 18% to 47%.[15]

[13] Cardiff and Vale Optimising Outcomes Policy
http://www.cardiffandvaleuhb.wales.nhs.uk/optimisingoutcomes;
http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/OOPS%20FAQ_FINAL%2017022014.pdf

[14] McBride, C. M., Emmons, K. M., Lipkus, I. M., "Understanding the potential of teachable moments: the case of smoking cessation", Health education research, vol. 18 no. 2 (April, 2003), pp. 156-70, ISSN 0268-1153;
http://her.oxfordjournals.org/content/18/2/156.full

[15] Bamberg, S., "Is residential relocation a good opportunity to change people's travel behavior? Results from a theory-driven intervention study." Environment and Behaviour 2006 38:820

**THOUGHT-STARTER FOR TRIGGERING ENGAGEMENT WITH HEALTH IMPROVEMENT SERVICES:** Could KCC leverage these habit disruptions and life changes to help people link up to or register for health improvement services? For example, after moving house someone may register with a new GP, or receiving a starter pack from a Housing Association?

**1.3 Piggybacking health improvement services to an existing health service**

There is some evidence that health improvement services can be '**piggybacked**' to health services already being accessed by citizens. For example, it can often be a challenge to ensure women have their smear tests regularly. The **Isle of Wight Sexual Health Service** (SHS) is an integrated nurse-led service encompassing family planning, genito-urinary medicine and unplanned pregnancy/abortion care as well as cervical screening initiatives to reduce the risk of cervical cancer.

A nurse-led initiative targets hard-to-reach women in particular, engaging in opportunistic cervical screening and consequent follow-ups for eligible women for example, when they came into the centre for reasons other than cervical screening, such as unplanned pregnancy or urgent sexual health needs e.g. contraception or STD tests or treatment. From January to June 2013, the centre reported that **38% of all cervical screening was opportunistic**.[16]

**THOUGHT-STARTER FOR PRIMARY RESEARCH / NUDGING UPTAKE OF HEALTH IMPROVEMENT INTERVENTIONS:** Could health improvement services be 'piggybacked' to existing services already attended by the target group?

**1.4 Cross category 'why wait' intervention to create drivers for change**

Health education can be useful and valuable but there may still often remain an '**intention-action' gap** – where although citizens are more aware of their need to live a healthier lifestyle, they fail to put into place the necessary steps to make the needed changes to their lives, due to procrastination and lack of any feeling of urgency, or they may feel overwhelmed and daunted by how many changes they need to make.

A similar situation can occur in household financial management. People are often enrolled onto financial literacy programs where although they may learn more about managing their finances successfully, they may fail to put any of what they learnt into action. Evaluations of such education programs frequently find little or no impact on consequent savings rates for example.

***BE Inspired Intervention***: To counter such inaction, the behavioural science think tank **ideas42** partnered with the Financial Literacy Center and the Social Security Administration to design and pilot-test a comprehensive, in-person "**financial health check**" (FHC) program as an alternative to traditional classroom-style training.

Rather than giving attendees a list of actions to complete following the session, the program encouraged attendees to take positive concrete actions **while still in the coaching session**. These included the financial coach helping participants pay off credit card debt, identify and meet their savings goals, and schedule direct debits and standing orders to reduce late fees and penalties.

***Results***: After two years, individuals who received the financial health check were nearly twice as likely to have accumulated savings of $500 or more compared with similar individuals who did not receive the FHC. Within the treatment group, 28% had saved $500, while only 16% of the control

[16] Steph Barnes, Senior Staff Nurse at St Mary's Hospital Sexual Health Service. Presentation at the Post IFCPC Congress Session, May 2014 and Barnes, S. "Benefits of opportunistic cervical screening at a sexual health clinic" *Primary Health Care*. 25, 4, 18-22, May 2014; http://journals.rcni.com/doi/10.7748/phc.25.4.18.e904

group had saved $500.[17]

**IMPLICATIONS FOR DESIGNING NEW SERVICE & DEVELOPING MARCOMMS:** Information provision and improved understanding of risks are unlikely to be sufficient for creating actual behaviour changes. Hand-holding and guidance to reduce barriers such as procrastination, low confidence and general worries and anxieties are expected to be important for the audience.

**1.5 Leveraging authority figures and organisations in the community**

We are often swayed by authority, giving particular weight to one source of information over another because we view it as being more legitimate or coming from a greater source of expertise. Authority figures such as community health trainers may be one route to greater awareness and engagement with health services.

In 2005 a **Health Trainer service** was set up in the North West to tackle health inequalities. Health Trainers are recruited from local communities and work to support health related lifestyle change. A major part of their role is the work they do on a one-to-one basis with populations most likely to live unhealthy lifestyles. They offer practical support to behaviour change in order to achieve goals. Recent national figures show that over 167,000 clients have accessed the Health Trainer service since its inception, whilst there are over 1,750 Health Trainers currently working in the service.

An assessment of a health trainer programme for the North West found that:

- Clients mainly heard about the service via a promotional event (40%), or a referral (34%). A similar nationwide report found that 31% heard about the service via a promotional event, 38% through referral and 14% via word of mouth.
- 48% of clients signed up did not require a formal personalised health plan.
- For those with a **personal health plan, 48% achieved it**, 26% part achieved it, whilst 15% of clients did not achieve it. Nationwide figures are similar, at 47%, 27% and 16% respectively.
- Half of all clients who had a personal health plan in relation to smoking achieved it, whilst 17% part achieved it. One-third (33%) did not achieve their personal health plan.[18]

Actual behaviour change data for the health trainer service is limited and vague.

**THOUGHT-STARTER FOR PRIMARY RESEARCH:** What can we learn from health trainer experiences of people with multiple unhealthy behaviours?

Other authority figures may be influential. A meta-review of studies investigating the impact of interventions on **six health-related behaviours** - smoking cessation, eating healthily, physical exercise, alcohol misuse and sexual risk taking and drug use - found that the interventions which were most successful across a range of health behaviours included those leveraging authority figures who guided behaviour:

- **Physician advice** or **individual counselling** were some of the most successful interventions. For instance, short-term counselling sessions seem to be beneficial in reducing alcohol consumption.
- **Workplace- and school-based activities** were also some of the most successful. One school-based intervention noted moderate success particularly if the family or local community were also involved. A workplace intervention showed evidence of a moderate effect on

[17] ideas42 The Financial Health Check http://www.ideas42.org/wp-content/uploads/2015/02/Project-Brief-FHC.pdf
[18] Mason et al "Health trainers in the north west: A report commissioned by the North West Health Trainer Partnership", 2011 http://www.nwph.net/Publications/healthtrainers.pdf

increasing physical activity levels with interventions comprised of self-help or educational programmes, and exercise programmes based around aerobics, walking, jogging, swimming, cycling, muscle strengthening, endurance, flexibility and stretching.

- **Mass media campaigns** and **legislative interventions** had small to moderate effects in changing health behaviours.
- Evidence for the effect of **motivational interviewing** and **health education** on increasing healthy eating behaviours was inconclusive.

The meta-review also concluded that none of the interventions they evaluated cast any light on evidence and insights which might help to develop an understanding of interventions in targeting **health inequalities**, for instance in '**hard-to-reach'** groups.[19]

**THOUGHT-STARTER FOR PRIMARY RESEARCH / KCC:** How can authority bias be leveraged to encourage people to access health improvement services, e.g. is a GP motivating as an authority figure? / How might KCC work with workplaces and schools to reach the target group?

**1.6 'Pinball communication' – continuous communication to build salience and engagement**

Although people may have good intentions to lead a healthier lifestyle they may often need considerable encouragement and regular communication to remind them of their intended change and reduce procrastination in implementing change.

Some initiatives to build and maintain engagement with a program or campaign through many channels have had some success in creating behaviour change or generating a decision. Below we outline two recent examples.

- **Leveraging multiple media channels:** In 2010, the **Teacher Development Agency** was seeking new teachers. Although many people expressed an initial interest in becoming a teacher, **few actually made the career change**. Behavioural science-led research identified a series of **behavioural barriers** to making a career change using a BE informed approach such as being scared about starting over emotionally and financially or that they might not make a good teacher, meaning that it was too big a decision to make all in one go and consequently people often delayed thinking about it further or put off the decision.

  So the Teacher Development Agency (together with advertising agency DDB) broke down the steps (known as **chunking** in behavioural science) prospective new teachers needed to take to change career into manageable goals and carefully designed communications across many different media outlets to create successive prompts and triggers to action along the behavioural journey to conversion – nudging and steering along the way.

  The **communication strategy** was to nudge people along the journey:

  - **Drip feed** versus big burst strategy as people don't make life decisions in handy campaign cycles.
  - **Using a wider range of media to reach people in more places**, increasing channels from typically 7 to 15
  - **Prioritisation of media** most likely to get people to do something; e.g. search engines and online job sites
  - **Ad space was cannily scheduled at times** and in places most likely to capitalise on people feeling dissatisfied with their current careers – aka the 'working blues' strategy. Ads were placed in Monday morning commuter newspapers, posters sited on underground and rail platforms; advertising scheduled for the 'dark' times in

[19] Jepson et al "The effectiveness of interventions to change six health behaviours: a review of reviews" BMC Public Health 2010, 10:538 http://www.biomedcentral.com/1471-2458/10/538

January, or after the clocks went back in October. TV advertising was maximised between Sunday and Tuesday when people feel least content and it used social network sites where people time-waste in working hours.
    - **Real teachers were deliberately featured** in the ads to reassure career switchers that teachers were people like them.

Results were impressive. The campaign evaluation showed that every behavioural metric had improved: from web visits, to enquirers, to eligible enquirers, to applications. They achieved a minimum payback of £101 for every £1 spent and increased teacher enquiries and applications to record breaking levels on a smaller spend.

- **Leveraging partnerships:** The Change4Life campaign for healthy living enlisting a wide variety of partners - commercial, community, charity, including well-known figures to endorse - to create the widespread belief that 'everyone is doing this now' (a concept called social norms in behavioural science).

  It established **business4life**, a coalition of 36 companies in the food and drink, media, retail and fitness industries, established by the Advertising Association to work in partnership with the Department of Health (DH) in support of the campaign.

**THOUGHT-STARTER FOR PRIMARY RESEARCH:** What (local) communication channels and businesses/organisations do the target group already engage with? E.g. Housing Associations, Supermarkets, GP?

### 1.7 Gain framed health messages

Insights from behavioural science show that how information is presented – '**framing**' - can influence decision making. For example, a food product described as '90% fat free' will feel more appealing than food described as 'contains 10% fat'.

Recent research has suggested that **positive or gain-framed health messages may be more effective** than **negative or loss-based messages** for some audiences.

For example, a gain-framed health message is generally focused on the benefits and be:

- *"By eating healthily, people can gain positive body image or energy."*
- *"Eat broccoli and you'll live longer."*

Whereas a negative or loss-based message might be based more around fear:

- *"You'll put on weight if you eat unhealthily"*
- *"Don't eat broccoli and you'll die sooner!"*

A recent study conducted by Lizzy Pope and Brian Wansink concluded that for populations less involved or less knowledgeable about healthy behaviours and lifestyles, **gain-framed messages** were likely to be more effective. Because they do not have the specialised health knowledge that experts have, fear-based and loss-framed messages are less likely to be successful.[20]

**IMPLICATIONS:** Gain-framed messages are likely to be more successful with the audience, although they may not connect well with policy makers and social marketeers who are more literate in (un)healthy lifestyle behaviours and health knowledge!

[20] Pope, L., Wansink, B. "When do gain-framed messages work better than fear appeals?" Nutrition Reviews, Vol 73(1), 2014

## Section 2: Barriers to engagement with health improvement and uptake of services

### 2.1 Cognitive ease of understanding health risks

People frequently hear that living a healthier lifestyle means they are likely to live longer. But due to Behavioural Economics (BE) concepts such as **power of now** (also known as **discounting the future -** when we place a higher value on the present than we do on the future), **availability bias** (when vivid, salient events seem most likely) and **optimism bias** (when we believe positive events are more likely to happen in the future than negative ones) we can struggle to act on that information in the here and now. The end of our lives feels very distant and irrelevant to our lives now. As one doctor in the media once said "I would rather have the occasional bacon sarnie than be 110 and dribbling into my all-bran."[21]

*Barriers from poor communication of mortality risks*

Compounding these biases are the meaningless statistics people are quoted, which are framed in such a way that makes it difficult for the average intelligent person to know what they mean for their lives today. For example:

- "In the UK, 73,000 deaths every year are caused by coronary heart disease"; or
- "About half of all lifelong smokers will die prematurely, losing on average about 10 years of life."
- "An extra portion of red meat per day is associated with a 13% increased risk of death."
- Also note the confusion over the bacon and cancer risk announcement from the IARC in October 2015. The general public (and media) found the statement released very hard to grasp.[22]

Further, if we were to try to live a bit more healthily - have one less drink or an extra portion of veg today - what difference would that mean for the likely length of our life? We lack real-time feedback.

**THOUGHT-STARTERS FOR PRIMARY RESEARCH:** How top of mind and motivating is mortality risk for changing unhealthy lifestyle behaviours among the audience?

### 2.2 Limited 'bandwidth' - Scarcity hypothesis

Research by Eldar Shafir and Sendhil Mullainathan, two prominent behavioural scientists, highlights that busy people and poor people have a diminished psychological capacity or **reduced 'cognitive or mental bandwidth**' because they are more focused on completing immediate tasks at hand or making ends meet.

In their 2014 book '***Scarcity***' they explain how this can make it more of struggle to plan ahead (which we know is important for behaviour change) or keep up weekly appointments since decision-making and memory capacity is affected.

**IMPLICATIONS:** Some target customers are likely to experience this loss of 'cognitive bandwidth' by virtue of money worries and day to day living being more difficult. Fixed/limited timetables for accessing services are likely to be a barrier to services.

**THOUGHT-STARTERS FOR PRIMARY RESEARCH**: where and how can the health improvement behavioural journey be simplified, e.g. easier access to support, more salient interventions?

[21] BBC "Choose the yum and risk the yuk" David Spiegelhalter, 6 May 2009 http://news.bbc.co.uk/1/hi/health/8019357.stm

[22] WIRED "Bacon causes cancer? Sort of. Not really. Ish." October 2015 http://www.wired.com/2015/10/who-does-bacon-cause-cancer-sort-of-but-not-really/

**2.3 Peer influence and normalisation of unhealthy habits**

One major influencer of the lifestyles we lead may be our peers – the friends and family that we spend time with. A significant 2007 study found that our friends influence how much we weigh and how thin/overweight we are.[23] A further study conducted by medical anthropologist Alexandra Brewis-Slade at Arizona State University investigated the links and causes behind this correlation and tested three pathways through which peers may affect each other's body size.

1. **Shared beliefs:** People may begin to share the same ideas of their friends after discussing what the proper body size is. People may then adapt their food and exercise habits in order to reach that agreed body size.
2. **Social norming:** We want to do what others do, and that can extend to looking and behaving like them as well, even if we do not necessarily agree with how they look and behave. We simply want to be accepted. Further, people may feel bullied into looking like their friends and family members and so people may eat and exercise to look like them.
3. **Habit adaptation:** People may change their habits to mirror those of their friends without necessarily thinking or talking about an ideal body weight. For example, at a restaurant if your friends all decide to order dessert, you do too, even though you might not usually eat dessert.

By recruiting 112 US women, half of whom were obese or overweight and interviewing them to find out the 20 people in their lives they were in regular contact with, the researchers were able to deduce that pathway three was the most influential.[24] Brewis-Slade commented in an interview:

"*I would have thought that pathway number two was the most powerful, since it's really about your struggle to meet other people's expectations, but it turns out it's not the best explanation. The key message is that behavior and what people do together is important. So parents might want to go bicycling with their kids, go to a salad bar with kids, focus on what they do together*."[25]

**IMPLICATIONS:** Which specific habits are more social versus individual (e.g. morning versus evening smoking routines)?
How might the behaviour change pathways and opportunities for KCC differ for each?

However, a study conducted with 3610 women, aged 18-46 in Victoria, Australia found evidence of a correlation between **healthy lifestyle behaviours** and **perceived social norms** – what they *felt* or *perceived* others were doing - from those in their neighbourhood. Women were asked to rate to what extent:

- *"I often see other people walking in my neighbourhood."*
- *"I often see other people exercising (e.g., jogging, cycling, playing sports) in my neighbourhood."*
- *"Lots of women I know walk or cycle."*
- *"Lots of women I know do other forms of exercise or play sport."*
- *"Lots of women I know don't do much physical activity."*
- *"Lots of women I know... eat fast food often" or ...drink soft drinks often."*
- *"Lots of women I know eat healthy food when they are out".*

[23] Christakis, N. A., and Fowler, J.H., "The Spread of Obesity in a Large Social Network over 32 Years", New England Journal of Medicine 2007; 357:370-379, July 26, 2007
[24] Hruschka, D., A. Brewis, A. Wutich, and B. Morin. 2011. Shared norms provide limited explanation for the social clustering of obesity. American Journal of Public Health 101:S295-S300. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3222514/
[25] Harvard Health Publications "How your friends make you fat: The social network of weight" May 2011 http://www.health.harvard.edu/blog/how-your-friends-make-you-fat%E2%80%94the-social-network-of-weight-201105242666

Women were also asked to rate to what extent members of their family:

1) did physical activity with them;
2) encouraged them to be physically active; and
3) discouraged them from sitting around too much (e.g. watching too much TV).

The research team's results found that physical activity (beyond walking or cycling), walking and consumption of fast food were all positively correlated with perceived social norms.[26]

However, this study was limited in its reliability and accuracy due to its **heavy reliance on self-report surveys** for behaviour, asking respondents to look as far back as a month for some activities and eating habits e.g. frequency of eating fast food. Recall over that length of time may be unreliable.

Moreover, social norms were also estimated via self-report which could also be unreliable. Because women were asked about *perceived* social norms, healthier women **may have noticed those *like them***, behaving and eating healthily and unhealthy women may have only noticed other unhealthy women *like them*. For example, if we run, other runners (especially those we know) may be more **salient** to us. Unhealthy people may also spend more time in less healthy and more sedentary environments such as fast food outlets or on public transport rather than in more active environments such as the gym or out walking. Therefore they may have more opportunities to notice other people doing unhealthy behaviours which could affect their perception of the norm.

**THOUGHT-STARTER FOR PRIMARY RESEARCH:** What are the perceived social norms of the target group? How does this correlate with individual behaviours?

Is there an opportunity to shift perceived social norms to motivate positive lifestyle changes?

**A study** conducted in 2012 by Michaela Kiernan at Stanford University and a team of colleagues looked at the **role of social support** in losing weight and leading a healthier lifestyle. 267 overweight or obese women (mean BMI 32.1 ± 3.5) in California were divided into two groups to take part in a 6-month, group-based behavioural weight-loss program. Kiernan also collected data measuring to what extent women had social support or 'sabotage' from friends and/or family.

- The women who "never" experienced family support were least likely to lose weight (only 45.7% lost weight.)[27]
- Women who experienced both frequent friend and family support were more likely to lose weight (71.6% lost weight).
- Yet women who "never" experienced friend support were most likely to lose weight (80% lost weight). The researchers hypothesised that this may be because the group-based programs provided support lacking from the women's friendships.

Qualitative research was also conducted with the women, illustrating both supportive behaviours from family or friends and sabotage:

- **Family sabotage**: *"Some other family members though do try to sabotage my efforts by piling mounds of food on my plate and won't take no for an answer."*
- **Friend sabotage**: *"My friends are conscious of healthful eating and great cooks…but mostly sedentary, fond of sugar and alcohol and talk about being active, more than actually being so, including me!"*
- **Friend support**: *"Well my friend just joined a gym and she is working out and eating well. She*

[26] Ball et al "Is healthy behavior contagious: associations of social norms with physical activity and healthy eating" International Journal of Behavioral Nutrition and Physical Activity 2010, 7:86 http://www.ijbnpa.org/content/7/1/86

[27] Losing weight was classified as losing 5% or more body weight in the 6 months of the programme.

*asked me to join and walk together at work and eat more health[y]."*

- **Family support**: *"I walk with my husband mostly every day; we walk our dogs."*[28]

Kiernan comments:

"*Overall, family and friend support for lifestyle change are rare for women starting a weight-loss program. … the perceived lack of social support at the start of a program suggests there is room for the design of innovative social support strategies tailored to vulnerable subgroups in future programs."*[29]

**THOUGHT-STARTER FOR PRIMARY RESEARCH:** To what extent does the target group receive support or sabotage in their lifestyle from their friends and family?

Could health improvement services leverage the social support gained from healthy lifestyle programmes conducted in groups?

**2.4 Too many goals**

Researchers have found that people can be less motivated and feel too daunted when they are set (or set themselves) a multitude of goals. Dilip Soman and Min Zhao from the University of Toronto investigated this phenomenon by looking at whether saving towards a **single goal** rather than **multiple goals** results in higher savings rates.

The researchers hypothesised that focusing on a single goal puts people in an "implementation action-oriented mind-set" as it simplifies the choice to save, the single goal is more salient than multiple goals.

In the single-goal group, participants were told to save toward their children's education.
In the multiple-goal conditions, they were provided with two additional savings goals: to save more so that they could also (1) finance any health care needs they might have and (2) provide a nest egg for when they retire. Participants in the control condition were given no specific goals.

Constraining workers to save toward only one goal resulted in a higher savings rate over a six-month period, they saved at a rate of 10.6% compared to the multiple goal group at 5.3%. Previously both groups had been saving at a rate of around 3%.[30] Focusing on a single goal, may lead to larger effects and greater success.

More broadly, Professor of Psychology, Albert Bandura has shown in many studies that people's beliefs about their likely chances of achieving a goal directly influence whether people set goals at all and what sort of goals they set.[31] So if people *believe* they can stay healthy or become healthier they are likely to be more successful.

[28] Kiernan et al "Social Support for Healthy Behaviors: Scale Psychometrics and Prediction of Weight Loss Among Women in a Behavioral Program" Obesity Volume 20, Issue 4, pages 756–764, April 2012 http://onlinelibrary.wiley.com/doi/10.1038/oby.2011.293/full#t2

[29] Society of Behavioural Medicine News Release, April 2010 "A New Look at Social Support for Long-Term Weight Management" http://www.sbm.org/emails/message/Social%20Support%20for%20Weight%20Management.html

[30] Soman, Dilip & Zao M. "The fewer the better: number of goals and saving behaviour" Journal of Marketing Research Vol. XLVIII (December 2011), 944–957; https://www2.rotman.utoronto.ca/facbios/file/JMR%20saving%20final.pdf

[31] Bandura, A, Freeman, W.H., & Lightsey, R. (1999), "Self-efficacy: The exercise of control" Journal of Cognitive Psychotherapy, 13(2), 158-166

**IMPLICATIONS:** These insights are important for guiding the sequence in which different behaviours should be tackled for greatest success, and how many should be addressed at once.

A new service that tackles multiple behaviours will need be positioned so that it doesn't feel like a daunting and unachievable life overhaul for the audience

### 2.5 Discounting the future

We tend to talk about all of us being affected by **present bias / discounting the future** to some degree – when we put more value on the present than we do on the future. This may be why we intend to go for a run, but postpone it until tomorrow, preferring to go to the pub this evening instead. But present bias can be broken down further and psychologists have classified people into three different camps:

- **Type 1 – Rational**: Some individuals are just not tempted – e.g. to spend impulsively or eat a big meal. They act rationally without any effort or prior thought or commitment devices.
- **Type 2 – Naïve present biased:** Some individuals do not possess enough self-awareness to predict future temptation episodes and are described as naïve. They are overconfident or over-optimistic about their ability to resist temptation and are always doing impulsive things, getting tempted or procrastinating and not doing what they said they would do. They do not utilise commitment strategies because they overestimate their discipline and are overconfident about their ability to resist.
- **Type 3 – Sophisticated present biased**: This type knows he may not behave himself in the future and is correctly pessimistic about his future behaviour. This type has a positive demand for commitment strategies because of their self-awareness of potential self-control problems. They learn fast from past mistakes or are self-aware enough of their own emotions that they can predict and correctly anticipate how they will feel in the future. They actually want to 'bind their hands' and perhaps limit their ability to do the 'wrong behaviour'.

Recent research has found that **self-awareness of one's biases can be a better predictor of behaviour than the degree to which someone is affected by the bias**.

**THOUGHT-STARTER FOR PRIMARY RESEARCH:** Which type is the typical person engaging in multiple unhealthy behaviours in Kent?

**IMPLICATIONS:** Health services and KCC could specifically consider such individual heterogeneity when thinking how to communicate and target customers.

### 2.6 Hot cold empathy gaps

We have a tendency to underestimate and mispredict our behaviour and preferences in hot versus cold states (e.g. when with friends in the pub (a likely hot state) versus at work the next day (a likely cold state).

People underestimate how their preferences will change as their state of mind changes, and how strong temptation may be at a later stage or how much regret they will experience back in a cold state.[32]

[32] Loewenstein, G., "Out of control, Visceral influences on behavior", Organisational Behavior and Human Decision Processes, Vol. 65, No. 3, March, pp. 272–292, 1996 AND Loewenstein, G. (2005). Hot-cold empathy gaps and medical decision-making. Health Psychology, 24(Suppl. 4), S49-S56.

**THOUGHT-STARTER FOR PRIMARY RESEARCH:** How might opportunities for social marcomms differ depending on whether people are in hot or cold zones, e.g. pub versus doctor's surgery?

**2.7 Low income barriers**

Given the target group, further significant barriers to engagement with health improvement / uptake of services may be:

- the cost of accessing and buying healthier food;
- the cost of physical activity classes or equipment such as a fitness clothing, trainers etc.;
- the cost of taking time off work to keep medical appointments[33] e.g. attend health checks that could represent a 'teachable moment' and be used to refer people; and
- the cost of accessing services e.g. travel to and from community centres.

**THOUGHT-STARTER FOR PRIMARY RESEARCH:** Which (if any) of these barriers need to be overcome? What types of community outreach could address them?

**Stimulus suggestion:** examples of how community outreach could work, e.g. disruptive mobile stations on housing estates, outside pubs, inside libraries or children's centres?

[33] Pharoah R. and Hopwood. October 2014. ESRO/KCC Striving to Survive: Report and recommendations from research into the impacts of living and working on low pay in Kent

## Section 3: Triggers and barriers to maintaining healthy behaviours and continued use of health improvement services and interventions

### 3.1 Texts building commitment to a healthy lifestyle

Making a **commitment** to do an action can make us feel more binded to its completion to sustain our self-identity and achieve a goal, known as **commitment bias** in behavioural science. Professor Ivo Vlaev at Warwick University recently applied this insight to weight loss maintenance. Given that many people who successfully lose weight tend to put it back on, particularly if they return to their old environment or routines, he wanted to see if leveraging commitment bias might help people to maintain their new healthier weight.

In a 12-week study aimed to test interventions on obese teens who had recently taken part in an intensive 8-week weight loss camp but were now back home (in their old environment), researchers found that teens who were sent text messages where they were required to reply with a binding commitment to eat and live a healthier lifestyle, were more successful in maintaining their new body weight, post-camp. Their BMI **remained unchanged** (i.e. lower than before the weight loss camp and the same as when they completed the camp), whereas those only receiving a reminder text tended to regain the weight they had lost.

A typical message leveraging commitment bias was:

*"Can you promise to eating at least 3, 4 or 5 fruit or veg a day for the next week. Please text back the number of fruit you would like to commit to eating per day. Text back CAMP followed by yes or no to 8810."*

…whereas the simple and less effective reminder text might say:

*"You should try and eat at least 5 fruit and veg a day!"*[34]

A significant advantage of this intervention was that the messages were generic and therefore fairly low cost to implement, since they can be automated.

**THOUGHT-STARTER FOR DESIGNING THE SERVICE:** Could KCC leverage this intervention to maintain levels of engagement with a health improvement service from the target group?

**THOUGHT-STARTER FOR PRIMARY RESEARCH:** how do customers respond to the idea of receiving and sending back texts to support making healthy lifestyle changes?

### 3.2 Giving real-time feedback via activity trackers

Recently, fitness trackers such as Jawbone, Fitbit or Nike+ FuelBand have become popular in the UK. These devices which typically involve a wearable device worn on the wrist can help **motivate** users to become more active by providing **real time feedback** about how much physical activity has been taken during the day and week and regular prompts to do more or 'pats on the back' to commend past behaviour.

There are also over 100,000 mobile based health apps such as SmokeFree28 and DrinkLess which aim to change behaviour in users so that they live a healthier lifestyle.

[34] Vlaev, I. "The use of commitment techniques to support weight loss maintenance in obese adolescents" Unpublished manuscript

However, there are some caveats and limitations in their use. One, peer-reviewed data on the latest fitness trackers' and health apps' efficacy is limited, because technology has often moved faster than rigorous scientific research can measure long term behaviour change.[35]

Second, whilst many devices may have positive short term effects on behaviour change, one of their pitfalls is that people get bored easily and may stop using them, meaning the apps may have little impact on long term behaviour and habits. As Greg Welk, Iowa State University's Professor of Kinesiology, says

*"I think the key to a consumer is not so much if the activity monitor is accurate in terms of calories, but whether it's motivational for them and keeps them accountable for activity in a day".*[36]

Furthermore, most wearable devices can be around +/- 10-22% inaccurate e.g. overestimating or underestimating exercise and activity during the day.[37] As one article and review of trackers pointed out "*Your wrists aren't your feet*". One tester found both Jawbone UP Move and the Fitbit Charge HR recorded 600 steps when he waved his arms around for 5 minutes! However, any tracker that can measure heart rate and therefore come closer to calories burnt may be the most useful.[38]

Susan Michie, Professor of Health Psychology at University College London and an expert in digital health says that very few smartphone apps are properly evaluated to understand a) whether they work for long term behaviour change and b) if so, why they work and what insights from behavioural science are leveraged.[39]

**THOUGHT-STARTERS FOR PRIMARY RESEARCH:** Is there an opportunity for KCC leverage smartphone apps to maintain engagement in health improvement services?

How do the target group respond to smartphone apps now? Are they familiar with any healthy lifestyle apps?

How appealing and relevant are digital tracking devices? What barriers to use exist?

### 3.3 Framing and feedback on healthy behaviours using the 'Microlife'

David Spiegelhalter, Winton Professor for the Public Understanding of Risk at Cambridge University (above), wanted to improve health risk communication and make health statistics more vivid and immediate to people. So he divided the duration of the expected adult life into 1 million equal parts meaning that each part is worth 30 minutes. This 30 minute part he named a Microlife.

Next he delved into reams of medical papers and statistics to work out the impact of individual behaviours, from smoking, and drinking, to watching TV, eating red meat or exercising and calculated

[35] http://www.theguardian.com/lifeandstyle/2015/sep/28/fitness-trackers-healthy-helpers-motivation-inefficient

[36] Techworld "Wearable fitness trackers vary in their accuracy, US study finds" August 2015 http://www.techworld.com/news/wearables/wearable-fitness-trackers-vary-in-their-accuracy-us-study-finds-3623570/

[37] Techworld "Wearable fitness trackers vary in their accuracy, US study finds" August 2015 http://www.techworld.com/news/wearables/wearable-fitness-trackers-vary-in-their-accuracy-us-study-finds-3623570/

[38] WIRED, "No, Phones Aren't More Accurate Than Fitness Wearables" March 2015 http://www.wired.com/2015/03/fitness-tracking-test/

[39] UCL Rosetrees Symposium, 22nd October 2015, Professor Susan Michie: "Promises and pitfalls of using smartphone apps to change behaviour" http://www.ucl.ac.uk/medicine/medicine-events-pub/rosetrees-ucl-interdisciplinary-symposium-oct-15

how many microlives would be gained or lost on a daily basis from each behaviour. For example we can lose microlives:

- Smoking 2 cigarettes loses you 1 Microlife
- Watching 2 hours of TV loses you 1 Microlife
- An extra portion of red meat per day loses you 1 Microlife
- Every 5kg you are overweight also loses you 1 Microlife per day

Conversely, we can gain microlives:

- Eating 5 portions of fruit and veg per day gains us 3 Microlives
- Exercising for 22 minutes per day gains us 2 Microlives
- Exercising for 1 hour per day gains us 3 Microlives (there are diminishing returns)
- Drinking 1 unit of alcohol per day gains us 1 Microlife (but each extra drink takes 1 Microlife away)

By framing complex statistical information in a simple way, Spiegelhalter not only increases cognitive ease, but he also gives a simple method of measuring feedback by chunking the data into something more meaningful for an individual. Losing a microlife also leverages loss aversion - we don't want to lose what we already have and live less time than we are thought to have.

While this approach is appealing, it may create (what are known in behavioural science as) '**licensing effects'** among participants who feel eating a healthy meal for example, then *licenses* them to have a few drinks. The approach may also be too complex for the target group.

However, there may be similar, even simpler approaches which could make uptake of healthier lifestyles easy and simple to understand. For example the Weight Watcher 'points' system for different foods has relatively lower cognitive demands.

**THOUGHT STARTERS FOR PRIMARY RESEARCH:**
Do KCC know of similar, but simpler approaches to communicating health risks and benefits, which could be designed or adopted and leveraged?

To what extent do 'licensing effects' exist and how do they manifest in relation to multiple unhealthy behaviours with the target group?

### 3.4 Built environment and design

The environment around us, particularly the **indoor and outdoor built environment** can have a considerable impact in encouraging or discouraging physical activity and there are many opportunities to modify our environment in different ways to influence and change behaviour. As Buckminster Fuller, an American architect, author, designer and inventor, noted:

*"I made up my mind . . . that I would never try to reform man—that's much too difficult. What I would do was to try to modify the environment in such a way as to get man moving in preferred directions."* (The New Yorker, 1966)

Australian researchers Neville Owen, Jo Salmon and Michael Fotheringham[40] divide up the activities conducted in the built environment into five different contexts:

- **Community** – e.g. availability of exercise classes, infrastructure which encourages walking and makes it easy and pleasant, availability of parks and playgrounds
- **Home** – Chores can often be active, as is gardening. Moreover the storage of food items in the kitchen can encourage healthy or unhealthy eating.[41]
- **Occupational** - Modern workplaces now design campuses with walking routes around the building to encourage employees to have 'walking meetings'. Offices may also be able to encourage face-to-face meetings and communication which involve the need to move about the building to locate and meet one's colleague.
- **Educational** - Schools and colleges may also be able to schedule classes and lectures which require students to change rooms or buildings in between rather than remaining in the same seat for several hours.
- **Transport** – e.g. Bike rental schemes are making it easier to cycle rather than drive or use public transport. Apps such as Google Maps and CityMapper have also made it easier to walk or cycle to a destination.

More generally, layouts, communication styles and daily schedules that make activity easy to do such as encouraging and nudging people to walk around, use the stairs or stand rather than sit may be useful in encouraging a more active lifestyle. The Design Council's Active by Design program is engaged in many of these design challenges.[42]

**THOUGHT-STARTERS FOR PRIMARY RESEARCH:**
What role do the audience think their surroundings play in their lifestyle?
Are there ways in which health improvement services may be able to encourage users to think about making use of the built environment around them to lead a more active lifestyle?
How might KCC improve the built environment in the long term to encourage physical activity?

[40] Owen, N., Salmon, L.J., Fotheringham, M.J. "Environmental determinants of physical activity and sedentary behaviour", 2000, Exercise and Sports Science Reviews, 28(4), 153-158
[41] New Scientist "Forget the fads: the easy way to control your eating" January 2015 https://www.newscientist.com/article/mg22530030-700-forget-the-fads-the-easy-way-to-control-your-eating/
[42] For more details see http://www.designcouncil.org.uk/what-we-do/active-design

### 3.5 Habit Change

Much research finds that in order to maintain behaviour change and lead a healthier lifestyle in the long term, people need to have permanently changed their habits so their behaviour is automatic and effortless. A recently published a paper by behavioural scientists Erin Frey and Todd Rogers[43] looks at what makes nudges and behaviour change interventions persistent and long term. Frey notes that:

*"The factors that make an intervention successful in the short term are not necessarily the same factors that allow it to generate persistent behaviour change in the long run."*

In the paper, they identify **four pathways**, one of which is habit formation:

(1) habit formation,
(2) changing what or how people think,
(3) changing future costs, and
(4) external reinforcement

Long lasting habits are built through context-dependent repetition and following **two steps** – first identify the **triggers (or cues)** and second, the **rewards** for a new habit – which help to build repetition and create a long term habit by developing automaticity – a key feature of any habit.

It takes time to build a new habit, embed it in routines and make it automatic. Realistically, no new behaviour is going to become part of someone's life overnight. A study conducted by Phillippa Lally and colleagues at the Health Behaviour Research Centre at UCL in 2009 found that it took anywhere between **18 days (2.5 weeks) and 254 days (over 8 months) to cement a new habit**. The average was **66 days**. And these were pretty simple new behaviours such as eating a piece of fruit with lunch or drinking a glass of water after breakfast.

Moreover, if someone is changing a habit, rather than adding a new one, their brain will never forget the old habit – the same neurological loops are still there – and the old behaviour will come creeping back very easily if they let it. So to build a new habit, it is necessary to **keep on doing it** – for many days – until it becomes automatic.[44]

**IMPLICATIONS:** It may be hard for the target group to maintain behaviour change in the long term - customers with multiple unhealthy behaviours may have very strong or **'sticky' habits**, as the routine for one habit (e.g. drinking) may trigger another (e.g. smoking).

Any evaluation of the KCC intervention should ideally measure long term impacts on engagement and lifestyle change.

What techniques can KCC make use of to help target customers embed new behaviours and make them a habit? E.g. commitment devices; shifting perceived social norms; feedback to provide habit loop 'reward'

### 3.6 Small wins / Success breeds success

There is evidence in health and also other areas of research such as financial management, that focusing on creating success in changing one behaviour first – often a small and simple change can help people feel motivated and positive enough to go on to change other behaviours.

[43] Frey and Rogers "Persistence: How Treatment Effects Persist After Interventions Stop" Policy Insights from the Behavioral and Brain Sciences 2014, Vol. 1(1) 172–179
[44] "How are habits formed: Modelling habit formation in the real world" by P Lally, Chm Van Jaarsveld, Huw Potts, J Wardle, European Journal of Social Psychology (2010), Volume: 1009, Issue: June 2009, Publisher: JOHN WILEY & SONS LTD, Pages: 998-1009

For example, the initial achievement of a **single goal** can build confidence and motivation to complete subsequent goals in paying off debt. Researchers David Gal and Blakeley McShane at the Kellogg School of Management, looked at a strategy they dubbed the 'snowball effect'. Studies of goal attainment show that we need to '**chunk**' or break up big tasks, inserting sub-goals or interim targets to feel like we are making good progress towards our overall goal, are capable of meeting that goal and are getting closer to our goal (in this case of paying off all our debts). But not only do we need to chunk big tasks, but **it is also good to create small wins first**. We need success in our initial baby steps and early interim goals to feel like we are making progress.

So Gal and McShane, having found convincing evidence using a dataset of over 4000 debtors signed up to a debt management firm, propose that rather than tackle the high interest rate debts first, debtors should tackle and pay off the small debts (whatever the interest rate). This approach made people more likely to complete all their debt repayments over the course of a few years. Total debt typically ranged from $14,000 to $31,000 spread across four to seven different lenders. They suggest that success in those small, early repayments created a **sense of progress and motivation** which then led people to feel able to tackle and complete their entire debt repayments.[45]

**IMPLICATIONS:** These insights are important for guiding the way and sequence in which different behaviours should be tackled for greatest success.
- What is an easy, simple 'health' win?
- What constitutes small wins versus larger goals for target customers with multiple unhealthy behaviours?
- How much consistency versus heterogeneity is there across the audience?

### 3.7 Chunking

A large task or goal can be daunting and put people off. Insights from behavioural science demonstrate that breaking a goal down into parts makes it seem much more achievable and manageable – known as '**chunking**'.

For example, **Change-4-life's** healthy eating plan uses the 5-a-day (five pieces of fruit or veg) to help chunk healthy eating.

**THOUGHT-STARTERS FOR PRIMARY RESEARCH:** How could KCC 'chunk' the journey to health improvement to keep people motivated? What role could a series of steps or points system play in tackling multiple unhealthy behaviours holistically?

[45] Gal, D. and McShane, B.B. "Can small victories help win the war? Evidence from consumer debt management." Journal of Marketing Research Vol. XLIX, 487-501, August 2012

Appendix 3: Glossary of Behavioural Science Concepts

| | |
|---|---|
| Chunking | A large task or goal can seem daunting and put people off e.g. losing weight. Breaking something down into parts makes it seem much more achievable and manageable. E.g. Change4Life's 5-a-day (pieces of fruit & veg) to help chunk healthy eating. |
| Cognitive Ease and Cognitive Strain | Cognitive ease, or 'processing fluency' is the ease with which we are able to process information. When we experience high cognitive ease, we do not have to increase our attention but can automatically process new information. Therefore when we experience cognitive strain, we are forced to use more mental energy to compute new information, e.g. lots of nutritional text on the back of food products. |
| Willpower and self control | A finite resource whereby a person exerts their will over their mind and feels in control of their actions. Avoiding versus resisting temptation is a more effective strategy, e.g. the famous Marshmallow Test. Having self-control in one area of your life tends to spread across other areas of your life and conversely lethargy spreads more lethargy. |
| Licensing Effect | A non-conscious tendency to permit an immoral or indulgent behaviour (like eating junk food) after doing something more virtuous (like going to the gym or helping out a friend). This swinging between good/beneficial and bad/indulgent behaviours is often described as being like a behavioural pendulum. |
| Coaction or 'snowball effects' | The extent to which taking action on one behaviour increases the chances of taking action on a second behaviour. Research in both health and financial contexts shows that small wins builds motivation to complete multiple and often larger goals and can help to guide the sequence in which to tackle different unhealthy behaviours for greatest success. |
| Power of Now / Discounting the future | People have a tendency to discount future costs including heath risks (which can be hard to imagine) in favour or living for today (which can feel more real), e.g. drinking excessive levels of alcohol for enjoyment / distraction in-the-moment rather than considering future health implications. |
| Social Norms | People tend to look to others to guide their behaviour and often emulate others or 'follow the herd'. 'In-group' norms can play a critical role in people's attitudes and behaviours towards unhealthy living e.g. if my friends drink, so will I! |
| Priming | People are surprisingly susceptible to subconscious influences on behaviour via smells, words or images, both positively and negatively, e.g. smelling waft of McDonalds as one walks past, or seeing people smoking in the high street. |
| Giving Feedback | In order to form neural habit loops (build new habits), we need consistent, positive feedback. Star charts have long been used by schools to reward positive behaviours and more recently wearable fitness technologies use feedback to inspire people to increase activity levels and engage in healthy behaviours. |