Lancashire Active Lives and Healthy Weight Service

Engagement Report 2015

Lancashire County Council

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Purpose of Report

The purpose of this report is to summarise, evidence and provide conclusions and recommendations from the engagement work undertaken by Lancashire County Council as part of the re-commissioning and redesign of Active Lives and Healthy Weight services.

Acknowledgments

We would like to thank all of the people who gave up their time to participate in this engagement process and to facilitate it. Many people in Lancashire gave up their time to come along to focus groups or fill in a questionnaire and share their experiences and feelings, for which we are very grateful. We would also like to thank all of our colleagues from various organisations who organised groups and gave us access to their networks in order to distribute questionnaires to the wider public.

We would especially like to thank everyone who helped us to engage with young people in Lancashire, including carers and young people services staff. Without their help we would not have been able to access the wealth of ideas and enthusiasm that our young people have, and which can be seen in the findings below.

Our thanks also goes to colleagues in the Lancashire County Council Policy, Information and Commissioning team for their help in designing the questionnaires.

Background

Lancashire is made up of twelve districts, which consist of a range of urban, rural and coastal communities. Lancashire is home to some of the wealthiest and some of the most disadvantaged communities in the country. In some of the Lancashire local authorities, male and female life expectancy at birth rates are amongst the worst in England and Wales (Lancashire County Council, 2015).

Being overweight or obese reduces life expectancy and contributes to long-term health conditions. Obesity is the second most common preventable cause of death after smoking. Each year in the UK an estimated £5.1 billion is spent on obesity related health problems (Department of Health, 2011).

There is a global downwards trend towards physical activity despite its known benefits. The causes of physical inactivity are mostly due to changes over recent years which have made daily living and working environments increasingly sedentary (WHO, 2007). In the UK, physical inactivity is the fourth largest cause of disease and disability (Murray et al, 2013) and is responsible for 1 in 6 deaths (Lee I-M, et al. 2012). Over one in four women and one in five men do less than 30 minutes of physical activity a week (Health and Social Care Information Centre, 2014).

In Lancashire 64.7% of adults are classed as overweight or obese. There is a variation between districts with Fylde, Rossendale and Chorley all having 69.1% of adults classed as overweight or obese and Lancaster and Preston with rates of 58.2% and 56.2% respectively. This compares with an English average of 63.8% (all figures PHE, 2012).

In Lancashire 28.5% of adults are classed as physically inactive, which is defined as doing less than 30 'equivalent' minutes of at least moderate intensity physical activity per week in bouts of 10 minutes or more. There is again variation between districts with 35.2% of adults in Pendle classed as physically inactive contrasting with 22.4% in the Ribble valley. This compares to 27.7% in England (all figures PHE, 2014).

The key strands of this re-commissioning project are

- Changing the footprint of services to five areas, broadly in line with Clinical Commissioning Group (CCG) footprints, to cover all 12 Lancashire districts and enable seamless integration with services that exist in these areas.
- Seamless integration of obesity prevention, opportunities for physical activity and weight management.
- Coherent commissioning covering the whole of Lancashire.
- Maximise the use of available digital technology and social media
    - to ensure the service is well promoted within Lancashire enabling mass participation and
    - to provide innovative ways of reaching out to communities and further ensuring mass participation
- Implement a variety of behavioural programmes to encourage better self-management of individuals and peer support to sustain behaviour change.
- Provide targeted community Active Lives and Healthy Weight Service interventions for obesity prevention, opportunities for physical activity and weight management.

The key drivers for this project are

- To support broader public health agendas as outlined in National and Local Priorities.
- To provide equitable services across Lancashire based on local needs.

- To ensure a consistent range of provision across physical activity, obesity prevention and weight management
- To ensure there is provision across the life-course.
- The desire to continue the shift towards an asset-based approach.

National Priorities

The Active Lives and Healthy Weight Service will contribute to improvements in the following national frameworks relating to increasing physical activity, preventing obesity and maintaining a healthy weight.

- Improving Outcomes and Supporting Transparency – A Public Health Outcomes Framework for England (2013-2016)
- Fair Society, Healthy Lives – The Marmot Review
- Healthy Lives, Healthy People: A Call to Action on Obesity in England
- Everybody Active, Every Day – An Evidence Based Approach to Physical Activity
- Moving More, Living More
- Five Year Forward View – Prevention Agenda

Local priorities for Lancashire

Priorities in Lancashire are

- To improve related measures in the Public Health England outcomes framework
- To reduce health inequalities
- To prevent long-term conditions associated with obesity and physical inactivity
- To use the Marmot Principles

In addition, the Active Lives and Healthy Weight Service supports the Lancashire Health and Wellbeing Board's Health and Wellbeing Shifts

- Shift resources towards interventions that prevent ill health and reduce demand for hospital and residential services.
- Build and utilise the assets, skills and resources of our citizens and communities.
- Promote and support greater individual self-care and responsibility.
- Commit to delivering accessible services within communities.
- Make joint working the default option.
- Work to narrow the gap in health and wellbeing and its determinants.

With all the above in mind, Lancashire County Council has engaged with a wide range of stakeholders to gather their views on current provision and future service re-design. These stakeholders include service users, provider organisations, clinical commissioning groups, interested organisations, adults, children and young people in Lancashire.

Who we engaged with

Who	When	What
North Lancashire Antenatal class members	05/08/2015	Focus group
Leyland Community Weight Management Service Users	10/08/2015	Focus group
Lancaster and Morecambe Physical Activity Service Users	11/08/2015	Focus group
Preston Weight Management Service Users	12/08/2015	Focus group
Chai Centre Female Users, Burnley	13/08/2015	Focus group
Chai Centre Young Male Users, Burnley	13/08/2015	Focus group
Burnley Physical Activity Service Users	13/08/2015	Focus group
Young Inspectors group, Preston	17/08/2015	Focus group
Older People's Gentle Exercise Group, Lytham	18/08/2015	Focus group
Asian Women's Group, Chorley	18/08/2015	Focus group
Asian Young men's Group, Chorley	18/08/2015	Focus group
Young People CCG group, Chorley, Preston and South Ribble	18/08/2015	Focus group
Young People, Care Leavers	20/08/2015	Focus group
Young People, Looked After.	20/08/2015	Focus group
Thornton Weight Management and Exercise Referral Service Users	20/08/2015	Focus group
Adults in Lancashire	August 2015	Online & Paper Questionnaire, 545 returns
Young people in Lancashire	August 2015	Online & Paper Questionnaire, 124 returns
Wider stakeholder group	August 2015	Online & Paper Questionnaire, 56 returns
Questionnaires were distributed through the following channels • Lancashire County Council Service Managers working across Start Well, Live Well and Age Well • Lancashire County Council Young People's Service • Provider organisations		

- Clinical Commissioning Groups
- District Councils
- Voluntary, Community and Faith Sector organisations
- Online platforms including stakeholder websites
- Social Media including multiple Facebook and Twitter feeds

Methodology

The project team used two main methods of engagement – focus groups and questionnaires. The questionnaires were available online and in paper form.

Focus Groups

The purpose of the focus groups was

- To gain an insight into the service user experience
- To gain insight from adults and young people in Lancashire around physical activity and healthy weight issues
- To find out preferred types of service provision
- To identify any gaps in service provision
- To identify barriers to engagement with services
- To suggest improvements which could be made to the current services

Using the themes and starting points outlined above, a set of standard focus group questions were developed using the headings

- Engagement/Motivation
- Information
- Barriers
- Types of activities
- Location/access hours/choice
- Family engagement

This was a guideline for the facilitators who could adapt the questions in relation to the group. The standard questions are attached as appendix I. Most groups consisted of facilitated conversations, whilst with some groups, particularly groups of young people, the team used a slightly different method using flipcharts and visual representations of the themes to engage the group. Two learning experiences the project group took away from this round of research was the value of participatory appraisal methods and the possibility of engaging younger children using these methods.

Notes were taken by at least one member of the project group with the other acting as facilitator and asking questions. All notes were checked by the facilitator for confirmation once they were inputted. Typed notes were then analysed for themes, and any comments relating to a particular theme were collated in an Excel spreadsheet by focus group. This thematic summary of the focus groups is embedded in the appendices of this document. The results of the thematic analysis are contained in this report.

Groups were made up of both service users and non-service users. For a full list of groups visited please see section 'Who We Engaged With'.

Questionnaire

The project team developed three standard questionnaires based on the criteria outlined above for

- Adults in Lancashire, including service users
- Children and young people in Lancashire, including service users
- Wider stakeholders

The Lancashire County Council Policy, Information and Commissioning team assisted with the design of each questionnaire.

The questionnaire was distributed in both paper and online formats to increase participation. The links to the online questionnaires were distributed via various methods and the paper questionnaire was distributed via colleagues in a wide range of organisations, as described in the 'Who we engaged with' section. All online responses were collected confidentially by Lancashire County Council via the link provided. Paper questionnaires were returned by post or email copies and were then entered onto the online system to allow easier analysis. The quantitative data (multiple choice answers) was analysed using Microsoft Excel. The qualitative data (descriptive responses to open questions) was analysed thematically.

Focus Groups Thematic Analysis

Key Themes

Access, Information, and Barriers to Services

Referral Route

In weight management and exercise referral groups, most participants had been referred through primary care, although there were some self-referrals. Most participants felt that primary care was a key place to receive information about services and to be referred into services, whether officially or unofficially. Participants thought that self-referral should be easier. There was a feeling in these groups that the method of broaching the subject of weight and activity levels was very important. Many felt judged for being overweight and had negative experiences of healthcare professionals treating them badly; this was perceived as related to their weight.

Non-service users wanted to see a wide range of ways to hear about and access services. More detail on this can be found under 'Information'.

Information

In weight management and exercise referral groups, most received information about services via primary care. Most participants had not heard of the services before being referred and some had to ask repeatedly for help before being referred. Most thought that primary care staff and buildings should be a key source of information about services. Focus group participants suggested other sources of

information about services. These suggestions were local free magazines, local papers, community buildings such as libraries, supermarkets and schools, and informal networks within communities. These informal networks can include contacts such as school nurses, religious groups and peers.

There was a mix in adult groups between those who used the internet routinely to gather information and those who didn't. All the young people spoken to use the internet to gather information. This was usually their first line for finding out information however they mentioned that many activities they took part in were through other sources of information such as word of mouth and family members. Social media was widely cited by young people as a preferred method of getting information, as was enthusiasm for using mobile technology such as phone apps to get information and participate. The idea of incorporating good related national campaigns such as #thisgirlcan was also received enthusiastically. More detailed ideas for different methods of engagement and communication can be found in the embedded focus group documents, especially from young people who had a wealth of ideas.

All groups agreed that information about services needs to be improved in healthcare, related professional settings and in communities. One adult group highlighted the difference in levels of information about stop smoking services and healthy weight and physical activity services; they felt that everyone knew about stop smoking services but that most people didn't know that weight management and physical activity services existed.

Participants suggested that the information provided

- Be clear and avoid jargon
- Tell you what's involved in going to the service/group
- Tell you who the service/group/activity is aimed at e.g. age range
- Tell you the cost
- Give you information that will allay any potential anxieties or fears, for example that it is a friendly group/small group, that you don't need to be fit or need special clothes

The branding of the service was important to focus group participants, with support for positive and inclusive branding, which is clear and consistent. Some participants felt that care needed to be taken that the language used did not put people off or make them think that a service wasn't 'for someone like them'.

Motivation

In weight management and exercise referral groups, many participants were motivated by their health. This was wanting to maintain good health, especially in older age, or to treat ill-health including conditions such as diabetes and cardio-vascular disease. Many were also motivated by a desire to reach and maintain a healthy weight. Some participants had been overweight for a long time whereas others had relatively recently gained weight, mainly through ill health or disability.

Participants wanted to make a positive change in their lives. Some participants had more specific goals including reducing certain medications, being able to take up a

sport again or to reach a certain weight to allow them to be referred for medical treatments such as fertility treatment. Participants agreed that self-motivation was key to succeeding in their goals and that involvement in groups added to their motivation and kept them on track.

For the older people we spoke to, the physical problems of ageing and a desire to maintain their fitness and physical vitality were major motivators to engage with services. Preventing falls was another driver for older people. Improving mental wellbeing was cited by all age groups as a motivation to stay active and to eat well.

Younger people also cited health and fitness goals as motivators, as well as the desire to get out and do things and to do something different. Some young people cited competition as a helpful motivator for young people. This would not have to be just in traditional sports but could also be utilised in online tracking of health and fitness goals, for example the 'Running Bug' social network for people who run.

Services that use a life course approach will be able to tap into the different motivations of people in different stages of their life, and so be able to engage people at any stage of life.

Barriers to accessing services

We asked focus group participants what stopped them from accessing services, or what put them off joining in with activities related to physical activity and healthy eating. We asked service users about what their feelings and apprehensions were before coming to groups. Barriers to accessing services mainly fell into two areas; practical and psychological. Barriers applied across both physical activity and healthy eating/weight management activities.

Practical barriers include

- Transport
- Costs
- Convenience of location
- Time
- Other commitments, such as work or caring responsibilities
- Ill-health
- Tiredness (cited by an antenatal group)
- Not knowing about services
- Lack of childcare
- Lack of carers to accompany people (mentioned by an older people's group)
- Disability and lack of understanding of various long term conditions (cited by both adults and young people)
- Accessibility for people with limited mobility

Psychological barriers include

- Lack of confidence

  - In self
  - In appearance (mirrors in gyms were a barrier for some)
  - In ability to participate
- Anxiety, including social anxiety
- Low mood or mental ill-health
- Not knowing what to expect
- Preconceptions of what to expect, for example expecting everyone in a gym to be young and fit
- Negative previous experiences, for example with slimming clubs
- Worrying how they'll be treated

Other barriers were

- Being put off by the name of groups/branding
- Lack of information
- Thinking the services weren't aimed at them, for example men assuming that all the participants would be female

Choice

Choice in what services or activities to access, and choice over how or where to access them, were key desires cited by participants. They felt that the more choice they had then the greater control they felt, and the more likely they were to engage. Service users were often not given any choice over the time or location of services and activities. Choice in what activities to do factored strongly in participants' assessment of services or preferences for future service use. Participants felt that if they were able to choose activities that they would be more likely to engage and to stick to their plans. Groups who had not accessed services would expect to have a choice over elements of any activities or services they were interested in. This shows that people want to be active participants in services, not passive recipients, and that services need to be service-user led.

Activities

The facilitator asked groups what sort of activities they had liked in services or would like to do, both in relation to healthy eating and physical activity. The groups answered both with what had been effective for them and what they thought would be effective in any future service use. The facilitator also asked what they hadn't liked in services or what would turn them off.

Positives

Healthy Eating

Positive activities to do with healthy eating included education on nutrition and food. Participants said they especially found helpful or would like to see the following

- Labelling and nutritional information
- Portion sizes
- How to cook
- Healthy food swaps
- Quick healthy recipes
- Using fresh foods instead of processed foods
- Cooking for babies and children

Weight management service users said that they liked that the programmes they had accessed were different to 'slimming clubs', which many had previously used. In particular they liked that

- There were no scales or public weigh-ins
- The programme wasn't a 'diet' but a healthy way of life
- There were no bad or good foods just balanced or unbalanced diets

The service users said that these differences helped them to make long term behaviour changes, and helped keep them from 'yo-yo' dieting. They said that this also addressed unhelpful feelings of shame and guilt relating to food.

Young people particularly wanted to see food growing activities, including for teenagers, as participants stated this usually ended in primary school.

Physical activity

Participants in the focus groups liked that physical activity did not just mean doing traditional sports and that there is a different idea of what physical activity can be. Participants often had previous negative experiences of traditional sports and physical activity. They said that this different idea of physical activity means that it can be fun and that it can be integrated into your everyday life.

Participants said that they found the following to be positive elements of doing physical activity

- Doing unusual or new activities such as wheelchair rugby (cited by young people both with and without disabilities)
- Doing different levels of difficultly according to fitness/mobility level (all groups)
- Doing exercises to increase balance and core strength (cited by older people)
- Releasing frustration though physical activity (cited by young people)

Participants came up with a wide variety of activities they would like to see; young people were especially creative and contributed a lot of new ideas. These can be seen in the embedded documents.

Common positive factors

Common positive aspects of all Active Lives and Healthy Weight-related activities or services included

- Supportive staff
- Peer support
- Going at your own pace
- Integrated services i.e. including aspects of both physical activity and healthy eating
- Links to wider wellbeing services or groups for example reading groups or social events such as coffee mornings
- Doing activities with similar people e.g. age group, other parents, from the same community
- Socialising at the same time
- Going with people you know

Participants from weight management and exercise referral services were extremely positive about the staff of those services. They felt that empathetic, supportive, respectful and friendly staff were key to motivating them, changing their behaviour and maintaining those changes. The psychological support they felt from staff and peers was another key factor in their success or otherwise. Stability and continuity of staffing was also felt to be important – individuals and groups built relationships with members of staff and liked to have just one regular member of staff or at least only a small group of core staff. Young people who are looked after spoke about the importance of support from their foster families or residential home staff in encouraging and enabling them to take part in activities.

Participants spoke of the importance of peer support. This could be either in person or via phone or internet. Peers offered support from a position of knowledge, especially relating to the psychological aspects of behaviour change. When using or developing online support it was very strongly felt that closed groups or some sort of access control should be used. This is to avoid abuse or harassment, which unfortunately is common in online communities. Weight management service users especially spoke of experiencing negative comments and abuse due to their weight or appearance and were keen to avoid this and create safe spaces to give and receive peer support.

A common theme from all participants, both adult and young people alike, was that individuals like different things and so having a range of different activities available was important. Aspects of services in which their individual preferences were taken into account were rated highly by service users. In terms of physical activity, many of the women talked about liking to do things in groups and doing fitness classes whilst some of the men spoke about preferring working out alone in a gym with just an instructor available if needed.

Participants were also clear that they wanted services to incorporate all related aspects of living a healthy life and wanted services which integrated aspects of physical activity and healthy eating.

Negatives and gaps in services

Most of the people who had experienced services were very positive about them, however there were some negative experiences which they shared with the facilitator. These were

- Dirty facilities
- Uncomfortable facilities, for example cold water in a pool
- Cancelled sessions
- Poor communication, for example with cancellation letters not arriving
- Lack of integration between weight management and physical activity elements
- No choice over location or time of services
- Long waiting lists

When participants had not accessed services the facilitator asked them what had or would put them off using a service. The responses closely matched those cited above.

Wider wellbeing

Current service users reported marked increases in their health and wellbeing from engaging with services. This included mental health as well as physical wellbeing. For older people, some physical activity groups had replaced activities that people used to do and missed, such as walking their dog. Services in a group setting helped combat social isolation and loneliness. Adult participants in focus groups wanted to see an integration of services, not just integrating healthy eating and physical activity but also integrating other aspects that increase wellbeing. Suggestions include a social aspect to groups or for older people incorporating a mental challenge such as puzzles or board games to exercise the brain too.

Location, facilities and access hours

Participants were asked by facilitators about their preferred locations and access hours. All groups said that location is a strong influence on whether they participate in an activity or service. Participants said they wanted locations that were

- close to home
- easy to get to via car or public transport
- had easy parking
- safe to come to and go home from
- community locations – comfortable, inclusive and often already familiar

Groups discussed using the outdoors and the local environment to take part in activities. Many participants were enthusiastic about using local green spaces, parks

and countryside to be more active however some were less enthusiastic about using the outdoors in typical Lancashire weather.

Participants had a wide variation as to what times of day they preferred to use services. Different groups had different needs, for example working age people needed services that fit around their work responsibilities whereas many participants, young and old, had caring responsibilities. Providers should be aware of service users' need for flexibility to meet the needs of the population across the life course.

Family Engagement

Facilitators asked participants about family engagement in services including what sort of family participation they have experienced or would like to see. Some service users had been invited to bring a family member along to services whilst others had not. Where family members were involved, it tended to be partners or people of the same generation rather than cross-generational. On the whole, the young people facilitators spoke to, who were mainly in their teens, definitely did not want their families to be involved. Some older people felt having the support of a partner was helpful whilst others felt that it was better to do things separately as they then had something to talk about together. It was felt that if families can be engaged then it would be easier for healthy lifestyles to be maintained however, whilst participants wanted services which catered for the whole family, they did not necessarily want the whole family to attend the same service at the same time.

Expectant parents spoke of wanting to do activities with their new babies and where they would be able to take their new babies along. Multiple groups of participants spoke of maternity leave as an opportunity to create new, better, habits and set a good foundation for children's healthy lifestyles. Healthy weaning and cooking for children were cited as important family aspects to services. There was concern among many participants about the extensive use of technology and that having a negative impact on time spent interacting as a family and time spent being active. There were also concerns about children being restricted from going outside due to safety fears.

Culturally specific aspects of services

Many groups spoke of their desire to have activities which suited their preferences and cultural expectations, for example a group of older white British people spoke of having cooking classes using basic ingredients which were familiar to them whilst expectant parents spoke of wanting to be active with other new parents. Many specific desires came from the same root, namely the need to feel comfortable and to feel that the activity is relevant to you and your life, but these needs are expressed differently in different communities and it was felt that the solutions need to fit the communities. For example, older people across different Lancashire communities cited gentle activities such as walking as being attractive to them. Barriers to accessing services often also had culturally specific factors.

As Lancashire has a large population of people with an Asian heritage, the project group took care to arrange focus groups with men, women and young people of Asian heritage. These took place in east and central Lancashire. Many of the findings from these groups mirrored other findings however there were some factors

that were specific to the Asian community and which are worth highlighting in this report.

Information

There was a strong desire for information around all topics related to physical activity and healthy eating however the importance of word of mouth communication was emphasised in these groups, especially where there are small Asian communities. Many of the older people in the Asian community, especially women, could not speak English and could not read in any language. They would not use the internet to access information so conventional methods of communication could often miss a large segment of this population. It was suggested that it would be effective to have information in common Asian languages and to use common community spaces and networks such as mosques and temples to disseminate information.

Access to Services and Barriers

Two culturally specific barriers cited were around language and gender. As mentioned above, English is not spoken by many elders in the community and some people in the community cannot read in any language. This was cited as a barrier to accessing services. Raising the level of English in the community would enable people to more easily receive messages about healthy lifestyles and also take part in services and activities.

Gender was an issue as it was cited as a cultural norm to take part in activities in single gender groups only. Women, especially older women, would feel nervous about removing headscarves or other clothing without complete confidence that they were in a female-only space. This also put women off taking their children to do activities such as swimming. Doing activities in single-gender groups was also welcomed by groups not of Asian heritage, especially young women.

Families were spoken about as key to accessing services, as decisions as to what activities were appropriate were often a family or elder's decision. Young people especially needed their family's permission to do activities and it was strongly felt that if these activities were deemed culturally inappropriate then the young person would not be able to attend. Unfamiliar or far away locations were unlikely to be approved of.

In regards healthy eating activities, it was mentioned that lack of halal food would be a barrier to accessing services. Activities that used unfamiliar ingredients, as opposed to familiar ingredients often used in Asian cooking, would also act as a barrier. However, especially for women, cooking was a culturally common shared interest and activity which helped them to open up and feel comfortable. Times of activities clashing with prayer or worship time was also mentioned as a barrier.

Social isolation was cited as a barrier to accessing services. Some individuals need to build trust over time, with a desire to access only trusted spaces and groups. There was also concern that many older women did not leave the house much so were very unlikely to access services, and often had a sedentary lifestyle. It was felt however, that this was slowly changing.

Questionnaire Findings

Three questionnaires were designed by the project group in collaboration with Policy, Information and Commissioning colleagues. The three questionnaires were targeted at the following groups

- Adults in Lancashire
- Children and young people in Lancashire
- Wider stakeholders

Questionnaires were available online and in hard copy. Please see 'Methodology' section for more details. Copies of the questionnaires are embedded at the end of this document.

Adult questionnaire findings

Respondent Profile

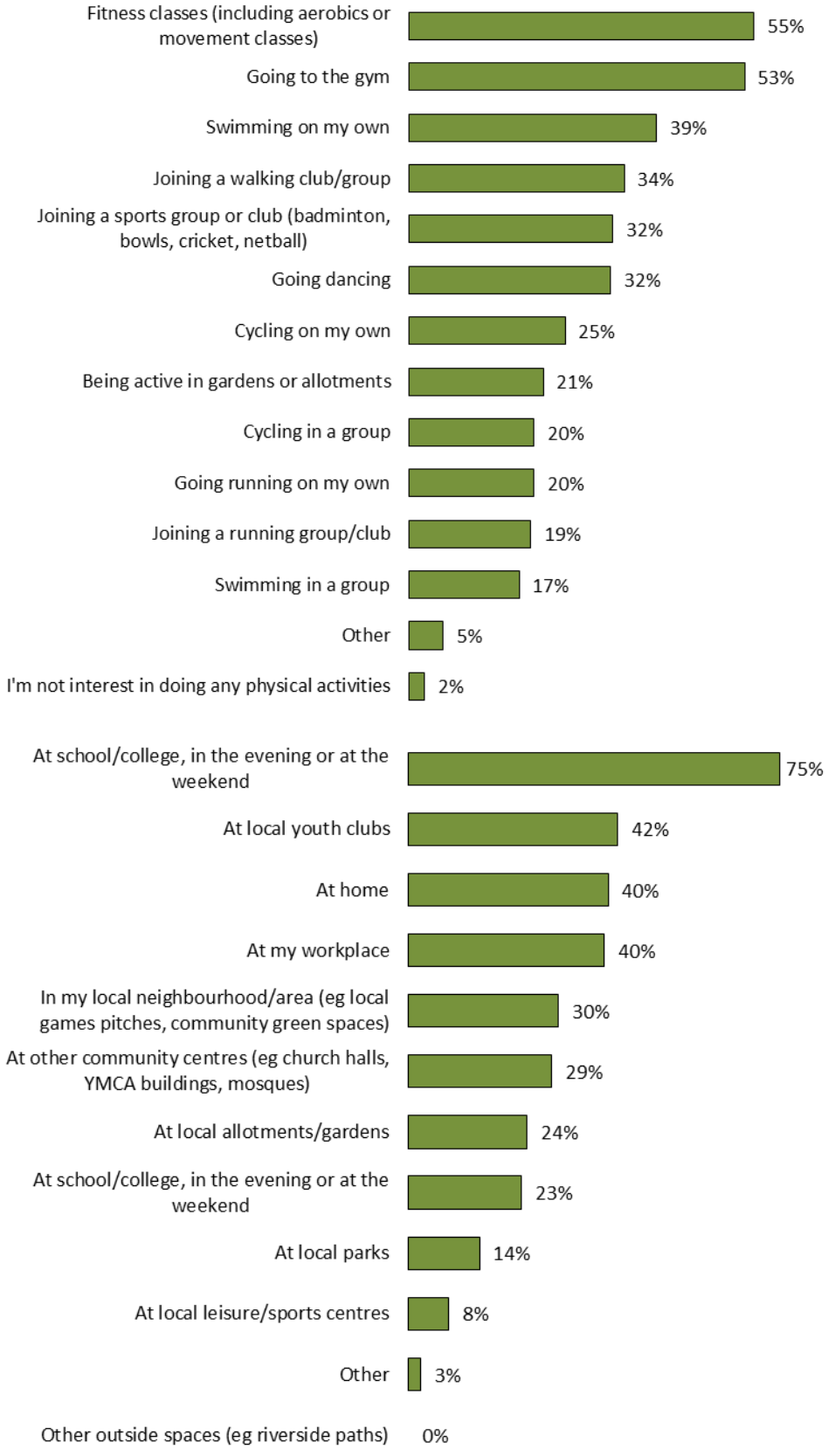
There were 545 responses to the adult questionnaire.

The age of respondents ranged from 20 to 65+, with the majority of respondents between the ages of 35-54. 13% of respondents considered themselves to have a disability. 73% of respondents were female. Only one respondent identified as transgender. The majority, 90%, of respondents identified as heterosexual. 86% of respondents described themselves as White and 12% as Asian, with 2% Other. 24% subscribe to no religion, whilst 62% identified as Christians and 10% as Muslim. Other religions made up 4% of respondents. There were respondents from each Lancashire district, with the highest number of responses from Chorley and South Ribble and the lowest number of responses from Fylde. Full data can be found in appendix II.

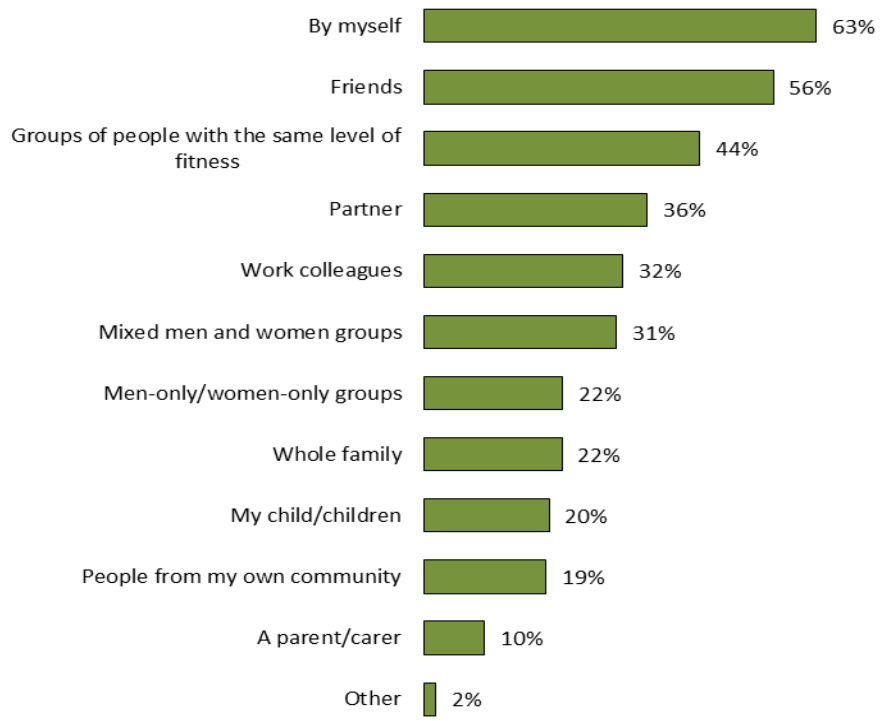
Physical Activity

The questionnaire asked what sort of physical activities would interest respondents, where they would like to do them and who with would like to do them with. The questionnaire asked what information respondents would like to get about physical activity and where they would like to get that information. It also asked whether there were barriers to them participating in physical activities. Responses can be seen in the following pages.

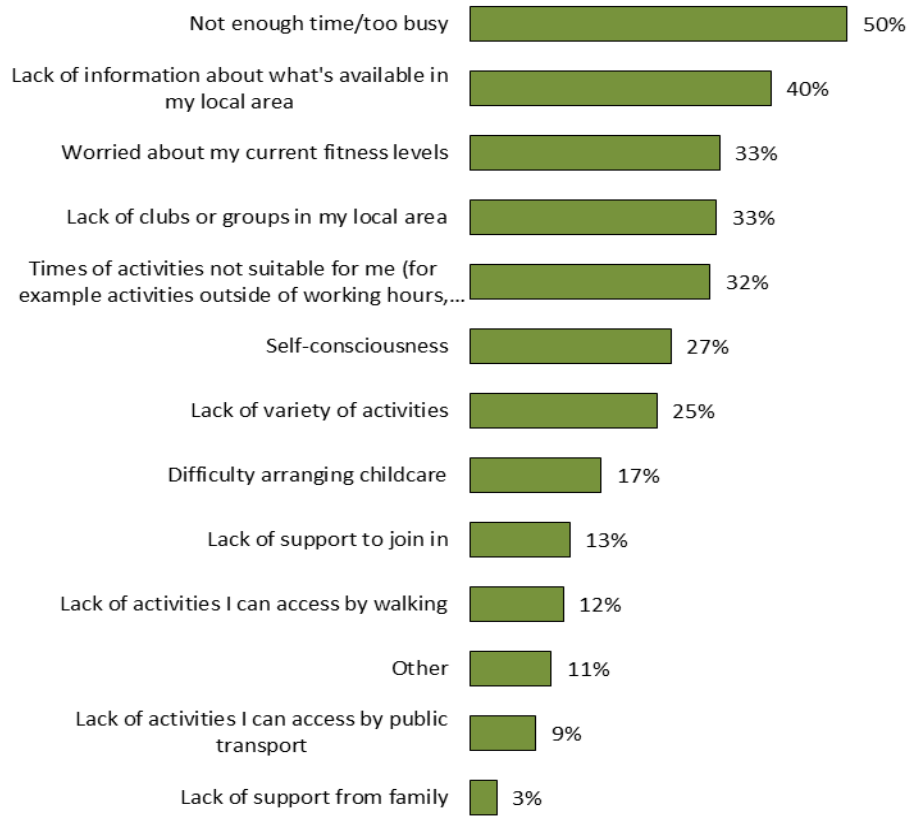
Preferred types of physical activities and preferred locations/settings



Preferred companions for physical activities



Barriers to being physically active



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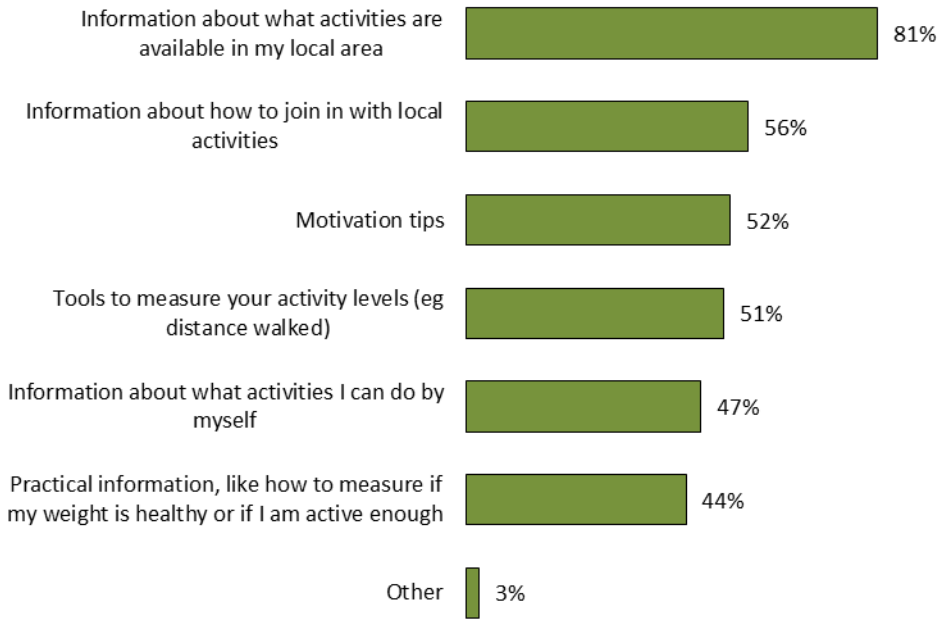
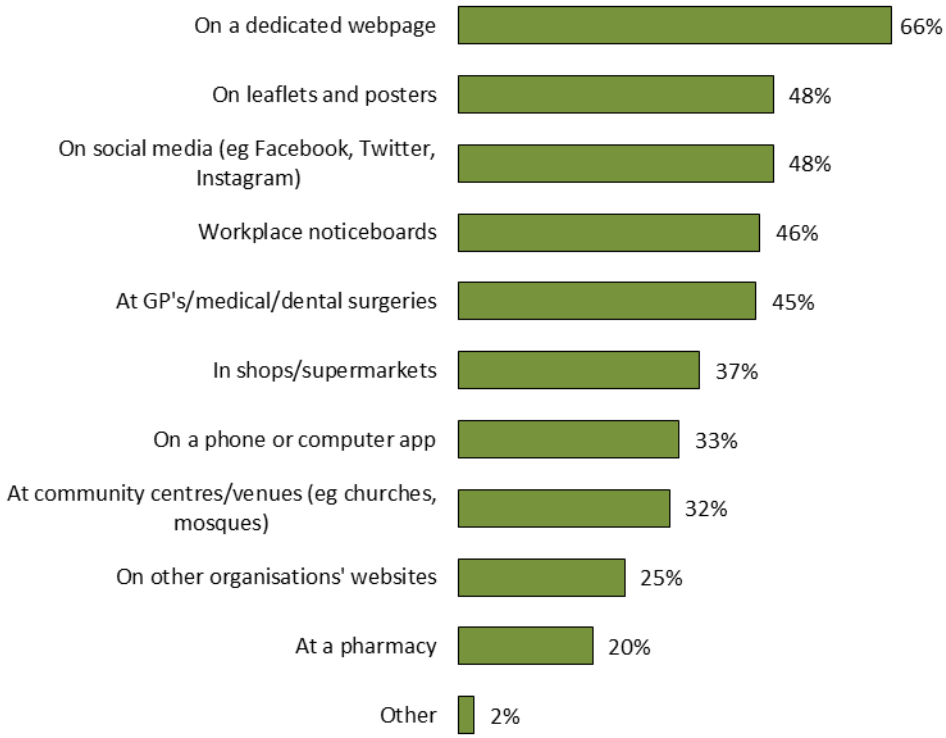


Preferred information sources



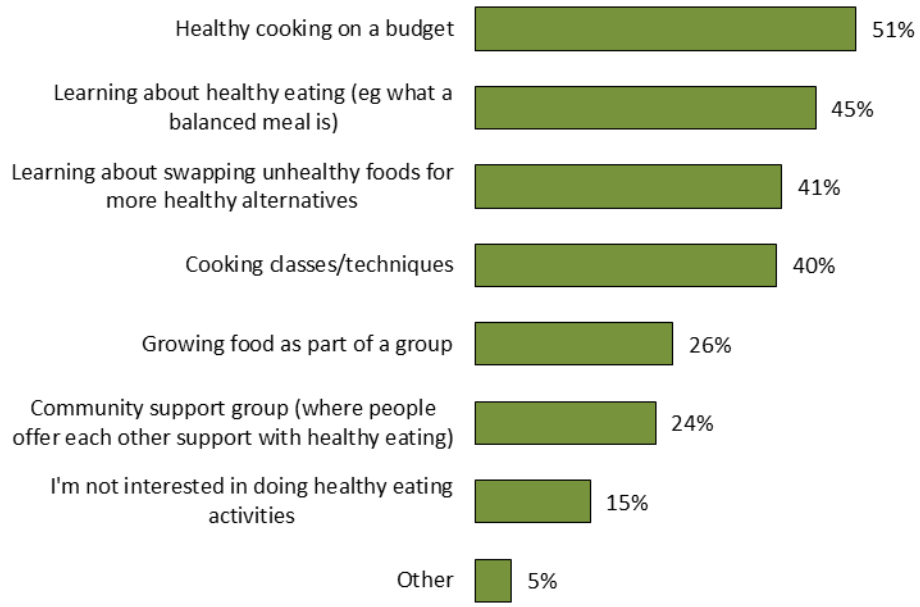
Respondents suggested the following be used as part of services around physical activity

- Encourage little and often, with information on easy to do at home exercises
- Activities should be available for all fitness levels
- Show the benefits of moving around as part of everyday life, not just traditional forms of exercise
- The majority of low-level activities, needed to start someone who is completely sedentary, are focussed on older people and miss younger people

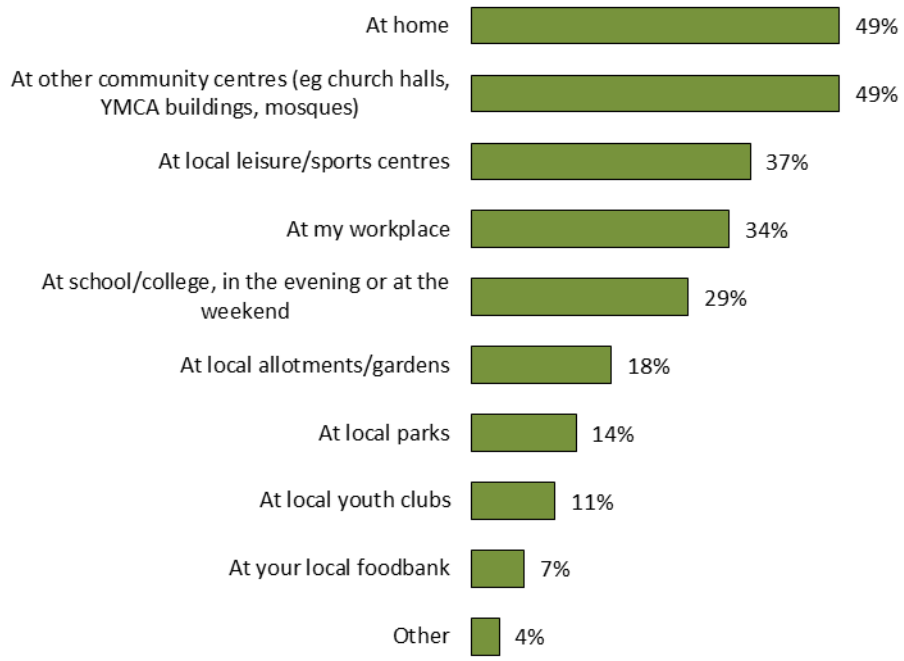
Healthy Eating

The questionnaire asked what sort of healthy eating activities would interest respondents, where they would like to do them and who they would like to do them with. The questionnaire asked what information respondents would like around healthy eating and where they would like to get that information. It also asked whether there were barriers to them participating in healthy eating activities. Responses can be seen in the following pages.

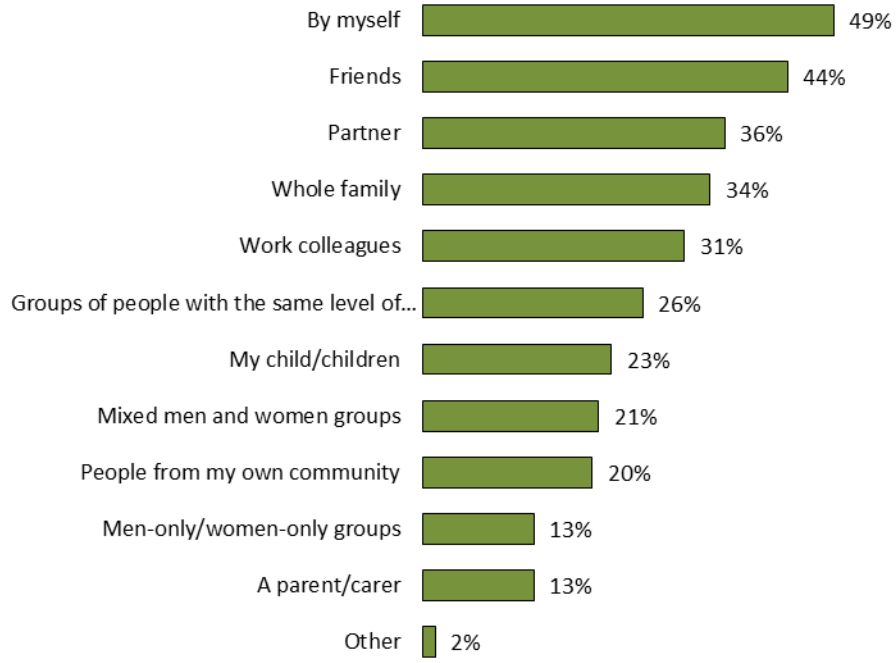
Preferred types of healthy eating activities



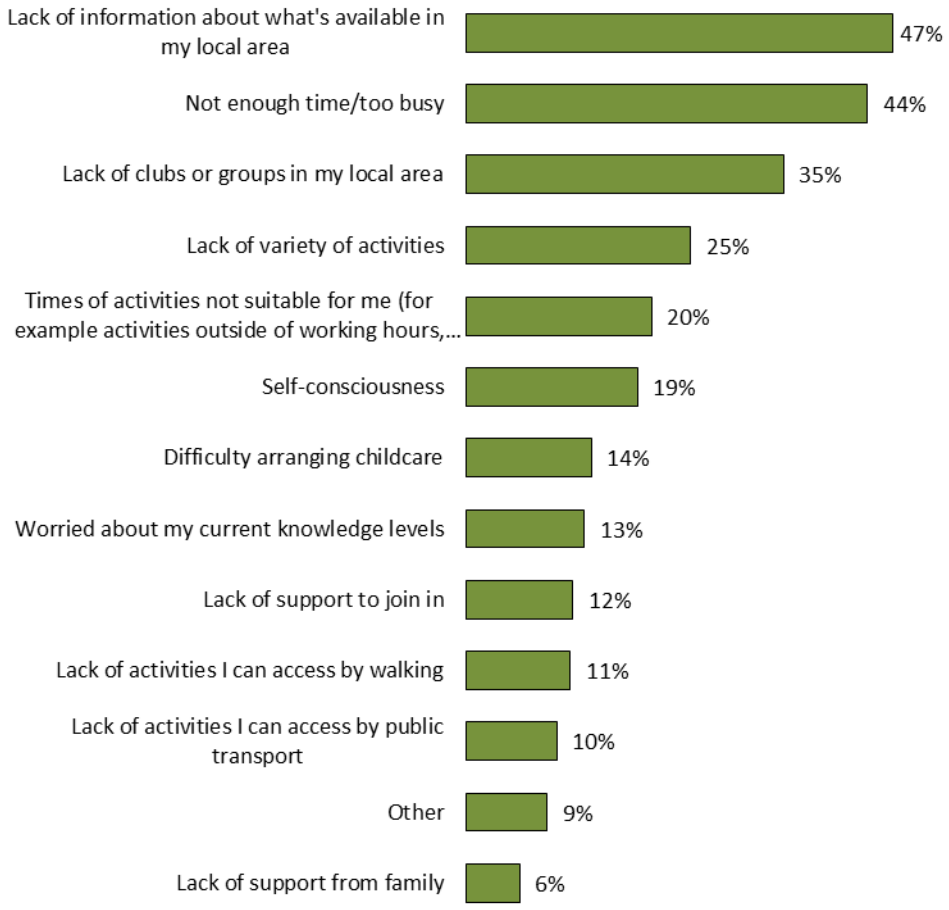
Preferred locations/settings



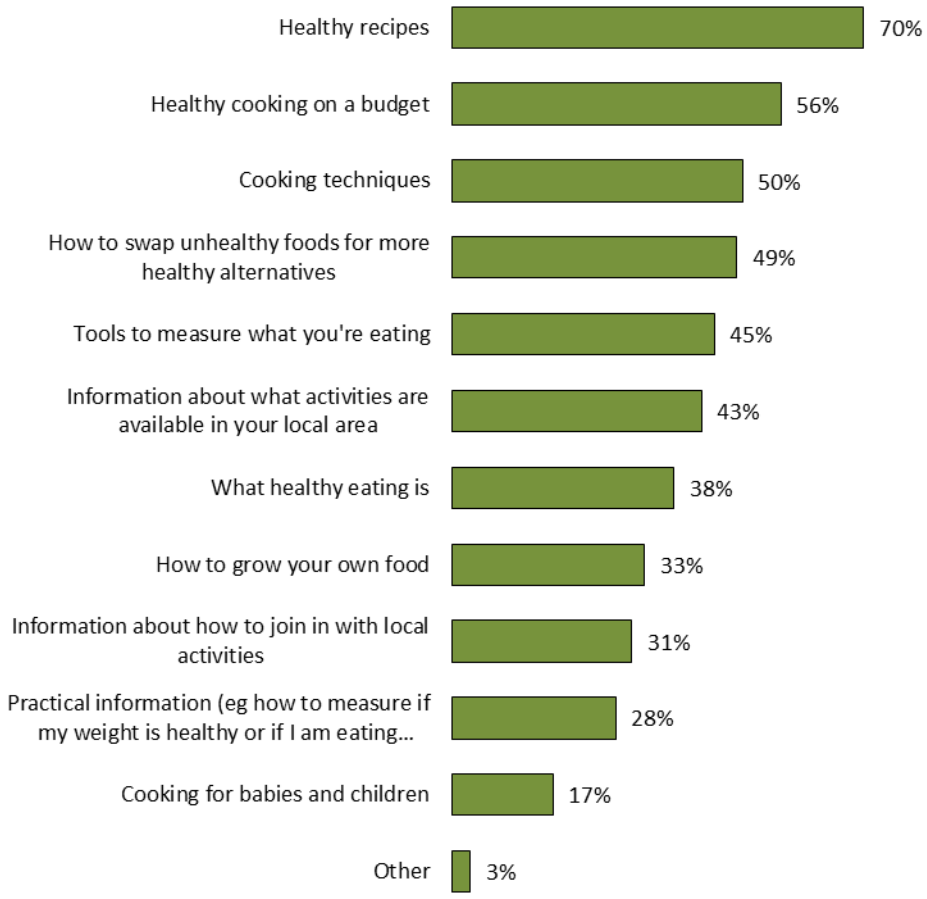
Preferred companions for healthy eating activities



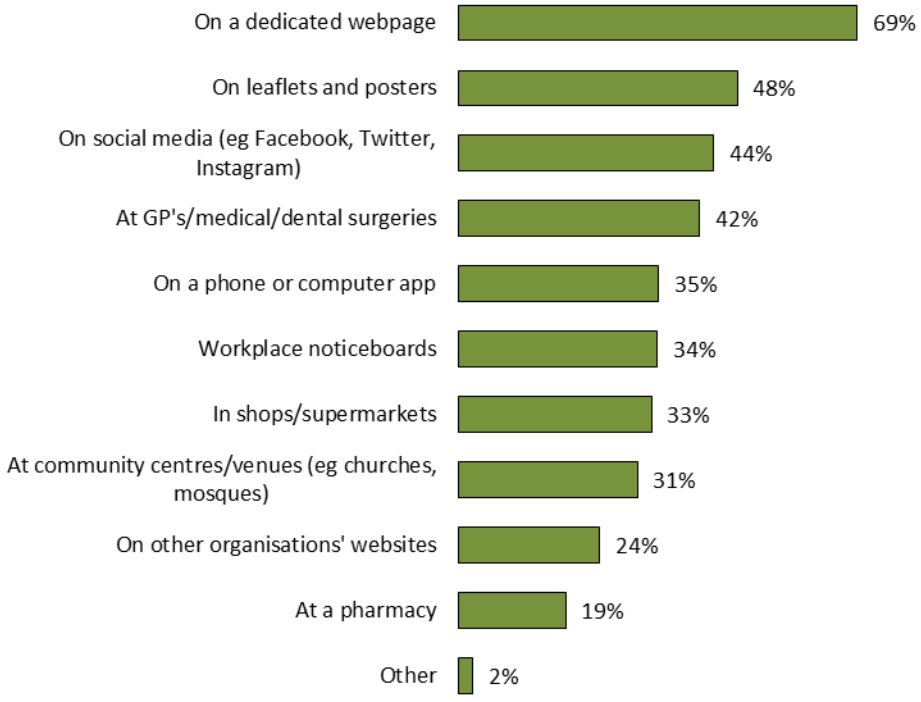
Barriers to taking part in healthy eating activities



Preferred information about healthy eating



Preferred information sources



Respondents suggested the following be used as part of healthy eating services

- Healthy cooking, including helpful details such as bulking out food with vegetables, using local or cheaper produce, using store cupboard foods
- Information and support across the whole healthy eating journey, from choosing products to eating the finished product
- Cater to all abilities
- Healthy eating and cooking embedded in school curriculum
- Support food banks by providing recipes to include in food parcels
- Whole family advice or courses
- Use easily available, low cost and commonly known ingredients
- Use most recent evidence around healthy eating
- Information on why certain foods are less healthy

Previous Service Experience and Barriers to Services

The questionnaire asked respondents if they had been to any healthy eating or physical activities services before and, if so, what they were. 41% of respondents said they had done at least one activity against 52% who said they had not. If they had accessed services they were asked what they had liked or disliked about these services. If they had not accessed services, respondents were asked if anything was stopping them from accessing services.

The majority of the adults who commented used the gym as a setting to undertake physical activities and courses such as fitness classes and weight management programmes. Community centres and local buildings were common venues with respect to cooking classes and educational sessions around healthy eating taking place. Local centres were also common venues for BME (mainly Asian) women to congregate for activities such as cooking classes. Other services accessed include couch to 5k, park runs and cycling through local authorities. National campaign Change 4 Life was accessed for information via information packs and website.

Respondents found it important that the staff providing services to be very friendly and supportive. Many felt this to be the case, however some respondents had found that some staff were unhelpful and insensitive to their needs.

Adults liked services to be local and deemed these to be 'accessible'. They also found the services and activities to be well informed and found the services to be fun and motivating, which improved outcomes.

Adults enjoyed working in group-based activities, socialising with like-minded people and enjoy learning new concepts such as healthy cooking and dietary facts.

Negative experiences of services included

- Overcrowded sessions
- Frequency of activities was not consistent and regular
- Programmes that were 'too short'.

Both respondents that had accessed services and those that had not cited the following as barriers

- Access hours – the timing of groups and activities did not work for them
- Location – inaccessible locations or takes too long to get there
- Cost – cost too high
- Time – busy lives and work or caring commitments

Adults who had not accessed services overwhelmingly felt that there is a lack of information about services and activities locally available to them. The majority felt that their actions would be different had they known what is available to them. Some respondents felt conscious of what others would think of them and therefore felt uncomfortable. This restricted their access to services.

Other comments

The questionnaire asked respondents if they had any other ideas or comments how we can help and support people in Lancashire to eat healthily and be more physically active. The responses to this question have been analysed thematically and have been put into categories. The results are as follows. The results broadly back up those of the focus groups.

Barriers

In addition to those mentioned above, barriers to a healthy lifestyle and accessing services cited by respondents are

- Location
- Waiting times
- Access hours
    - Need around work hours
    - Compatible with family life
- Rude or unhelpful staff
- Childcare
- Cost
    - Low cost or free trials encourage people to start physical activity
    - Free physical activities often during working hours
    - Cost often excludes the very people who need help most
    - Subsidies should include those in work
    - Costs of healthier foods seen as a barrier
- Gyms feel intimidating
- Obesogenic environment

Service provision

The inequitable provision in Lancashire was noticed by respondents who felt that services

- Need a wide variety of activities to motivate
- Need to listen to what individuals want
- Need wider referral routes
- Need to give guidance to move on after formal programmes have finished
- Need to integrate and link all elements of physical activity, weight management and healthy eating
- Need to offer one-to-one support

Using local assets

Respondents felt that local assets should be used by services who should

- Use local parks and green spaces
    - Help create and maintain green spaces
    - Support local people to use and maintain local land
    - Use local spare land for food growing
    - Link in with allotments
- Link into existing groups or centres e.g. Women's Institute, children's centres, third sector
- Use an assets-based approach, ask people what their knowledge is and build on it
- Keep local assets/open spaces running
- Use common areas such as town centres and supermarkets to hold events and engage people
- Run or support regular drop in community events such as park walks
- Use 'activators' to enthuse and link people with activities

Peer support

Respondents felt that peer support was very important and said

- A friendly welcome is very important
- It is motivating to see peers involved (rather than just professionals)
- Peers provide camaraderie
- Using informal networks can alleviate anxiety
- Peers can mentor and share skills, for example cooking skills
- You can have peer and community support groups with visiting experts

Links to Other Services

Respondents suggested how providers can link with other services

- Look at existing groups and services and link to these or support in other ways
- Link to food producers to reduce cost of healthy food especially in deprived areas
- Seek referrals from wider sources, for example children's centres
- Encourage community medical services at venues, for example leisure centres, especially if these are available outside of normal working hours. In this way people can access medical advice to support health and fitness rather than only when they can justify taking time off work for a medical appointment. In addition, people that do not usually go to these venues have a reason to be there and can see what activities are going on
- Improve links with mental health services to help people determine if diet and exercise are significant contributory factors to their mental health, and motivate them to make improvements. Include links to direct people towards support to address non-medical contributory factors and to advise them about what mental health services may be available if required.

People with disabilities and long term conditions

Respondents felt there was a gap in provision and barriers to access for people with disabilities and long term conditions. In particular, respondents said

- They need more information on food for people with long term conditions, for example the best diets for people with diabetes
- Many activities are physically inaccessible for example, getting into a swimming pool can be impossible for some
- Support all groups to include children and adults with special educational needs and disabilities, for example with training for staff on how to be inclusive and open
- Providers should target groups more at risk of obesity, for example people with learning disabilities
- A tailored approach is needed for people with disabilities and long term conditions
- People want information on what physical activities are possible to do safely, not just what they can't do
- People want information for carers, for example how to batch cook and freeze portions of food, and activities that can be fitted around caring to give them a break

Culturally appropriate services

Some respondents from the Asian community felt there were culturally specific issues such as

- The desire for gender segregated groups
- Using trusted community locations – some women said they were not allowed by families to access other locations
- How to eat healthily with traditional foods for example, replacement of traditional ingredients such as ghee (clarified butter)
- Bilingual information needed

These results concur with those of the focus groups, please see section 'Culturally Specific Aspects of Services' for more details.

Communication and information

Respondents suggested that in order to make communication and information more effective the service use the following ideas

- Promote activities in an innovative and appealing way
- Provide FAQ pages to answer common misunderstandings
- Link to mental health information to address one root cause of unhealthy lifestyles
- Have accessible materials including resources that can be used at home
- Use online platforms to replace sessions or appointments for busy people
- Use social media to spread ideas and information
- Use existing campaigns such as 'Change 4 Life'

Families and Children/Young People

Suggestions from respondents as to how to engage with families and children/young people are

- Show families how to be active for free for example by using local parks
- Provide along-side children's and adults' activities
- Provide childcare

Workplaces

Respondents said that in order to prevent obesity, increase physical activity levels and help people maintain a healthy weight, employers should be engaged and workplaces should be used. Respondents suggested the following ideas for workplaces

- Provide fitness equipment in workplaces e.g. exercise bikes

- Encourage activities & groups on physical activity and healthy eating within the workplace
- Encourage workplace discount schemes for physical activity
- Encourage and support employers to provide lunch break and after work activities

In support of this, evidence suggests that it may be possible to increase the impact of weight management interventions by scaling up participation through workplace schemes (Department of Health, 2015).

Other influences

Respondents also identified wider influences on lifestyles, that fall outside of the service's scope, and made suggestions for how these should be changed. These include

- Local government to reduce the number of fast food outlets
- Combatting poverty and how this affects food choices
- Changing the high cost of healthy eating vs unhealthy eating
- Introducing taxation on 'junk food' such as a sugary drinks tax [Public Health England are currently researching the impact of fiscal measures such as these]

Children and Young People Questionnaire

Respondent profile

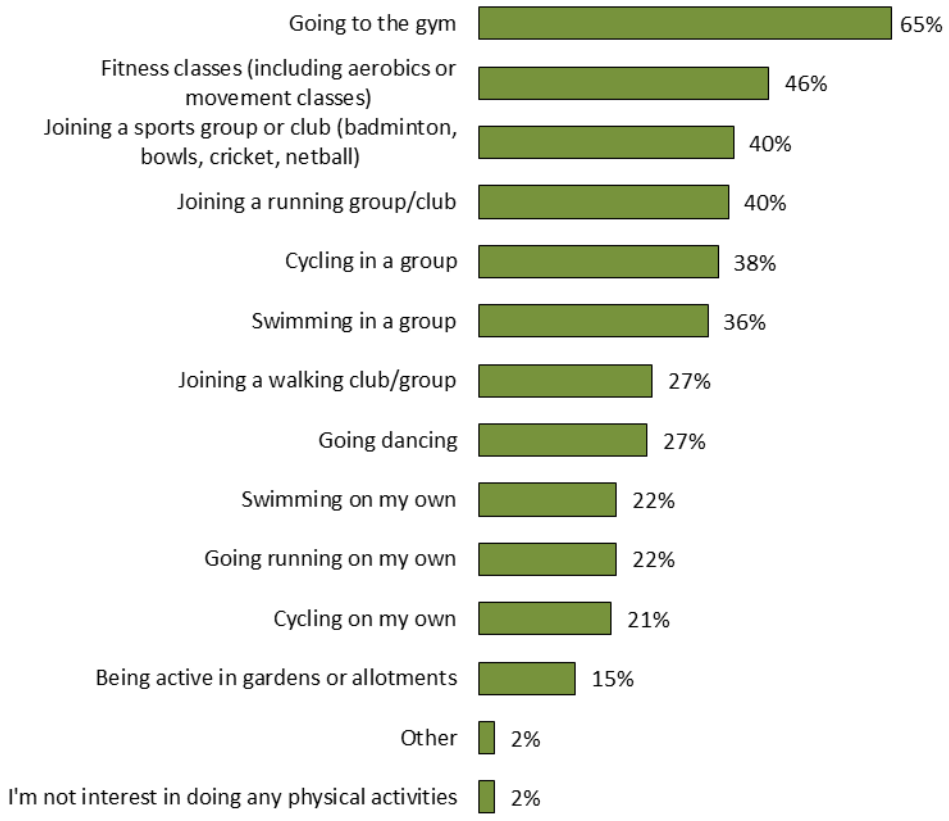
There were 124 responses to the children and young people's questionnaire.

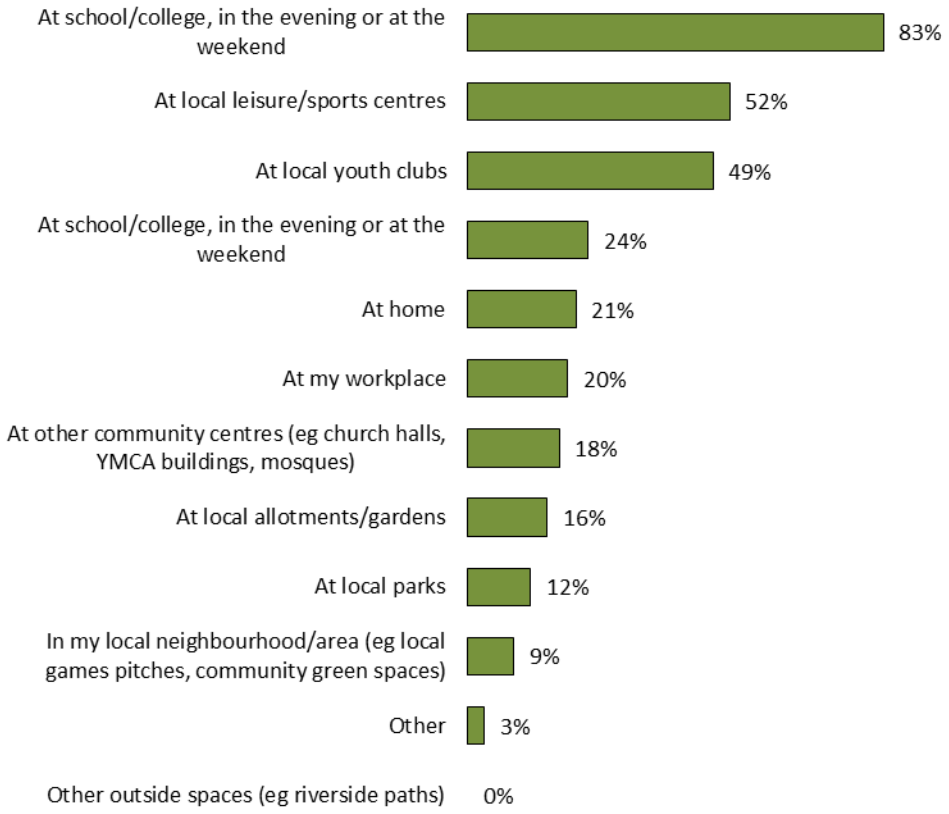
The age of respondents ranged from under-10 up to 19 years of age, with the majority aged between 15 and 19. Only 6% of respondents considered themselves to have a disability. The respondents were almost evenly split between male and female, 48% and 52% respectively. One respondent identified as transgender, with 23% preferring not to say how they identified. 84% of respondents identified as heterosexual, with 13% preferring not to say. 34% of respondents identified as White, whereas 66% identified as Asian. 13% of respondents don't subscribe to a religion whilst 23% identified as Christian and 61% as Muslim. The majority of respondents were from the Chorley district, with the rest fairly evenly split over the other eleven Lancashire districts. Full data can be found in appendix III.

Physical Activity

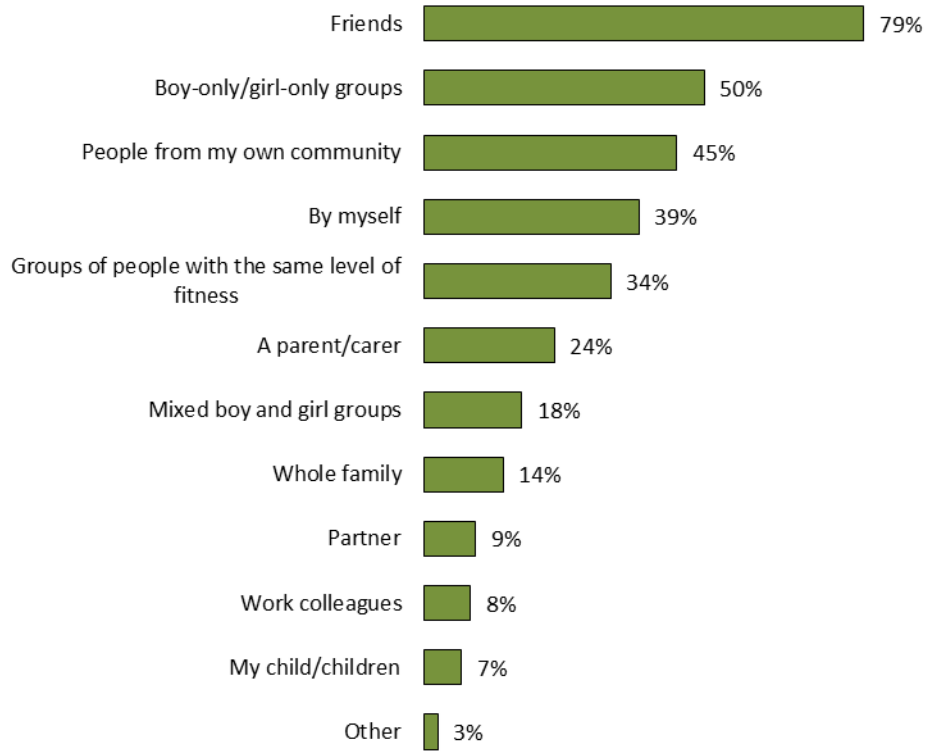
The questionnaire asked young people what sort of physical activities would interest respondents, where they would like to do them and who they would like to do them with. The questionnaire asked what information respondents would like to get about physical activity and where they would like to get that information from. It also asked whether there were barriers to them participating in physical activities. Responses can be seen in the following pages.

Preferred types of physical activities and preferred locations/settings

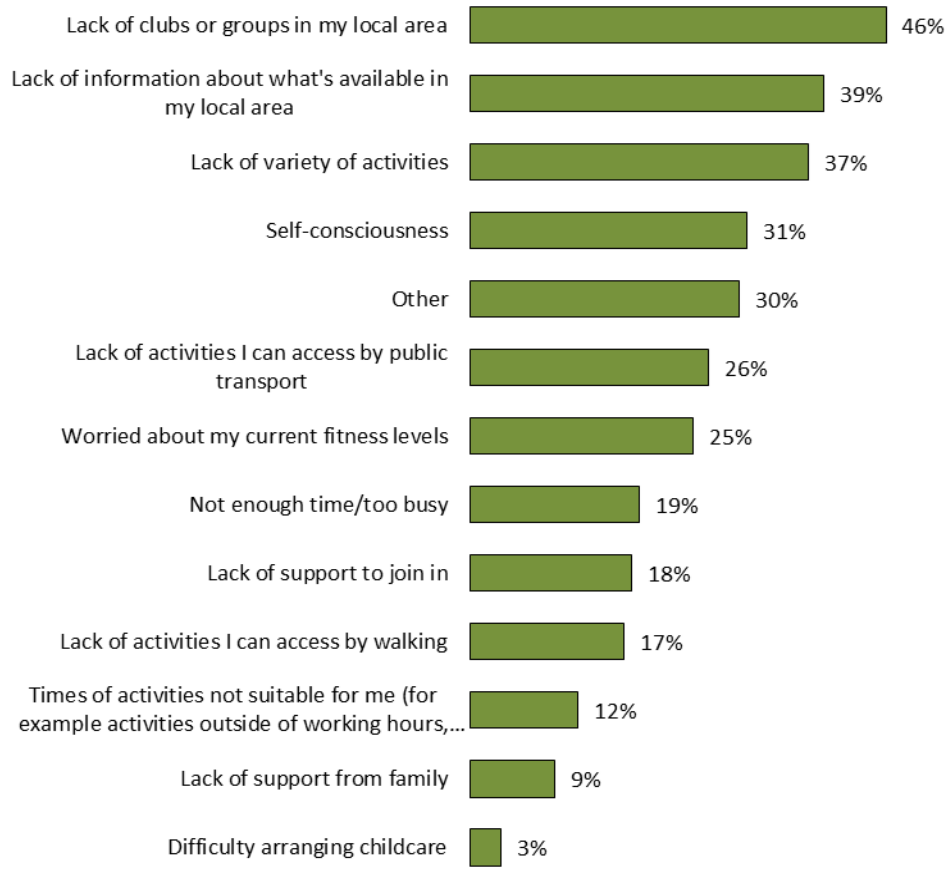




Preferred companions for physical activities

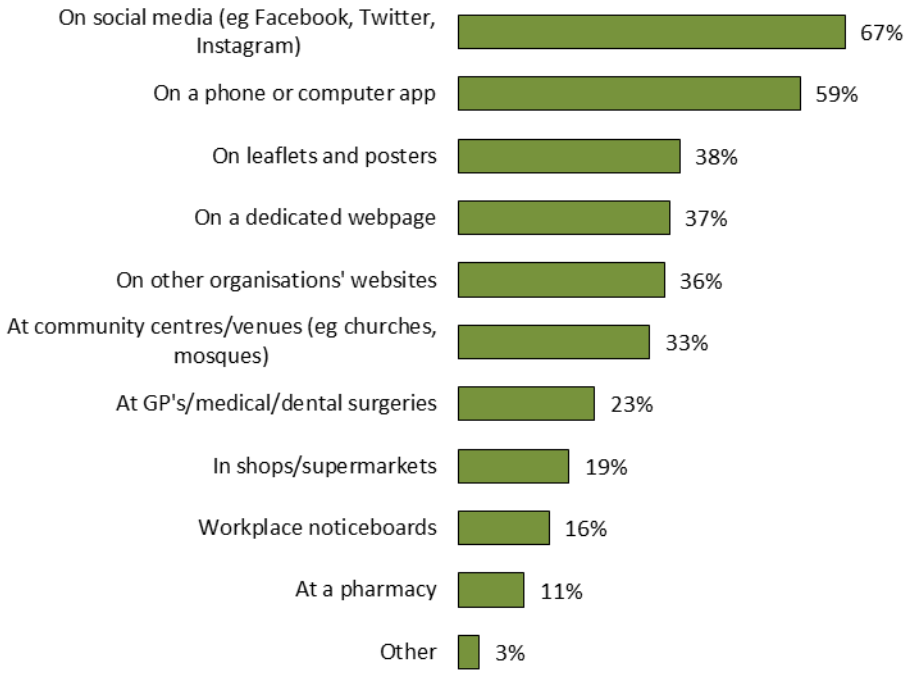


Barriers to being physically active



Preferred information about physical activity

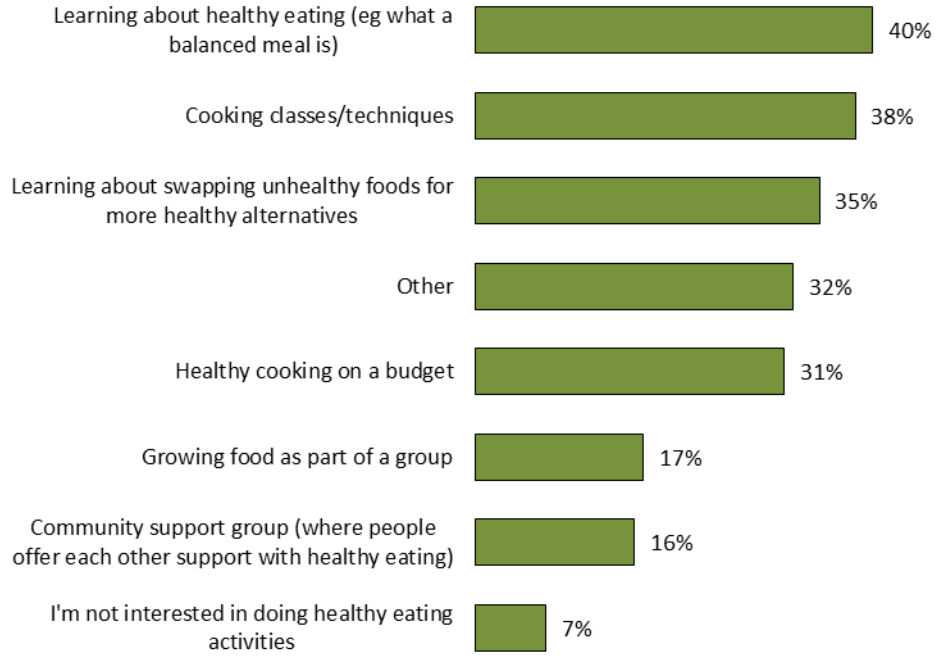
Preferred information sources

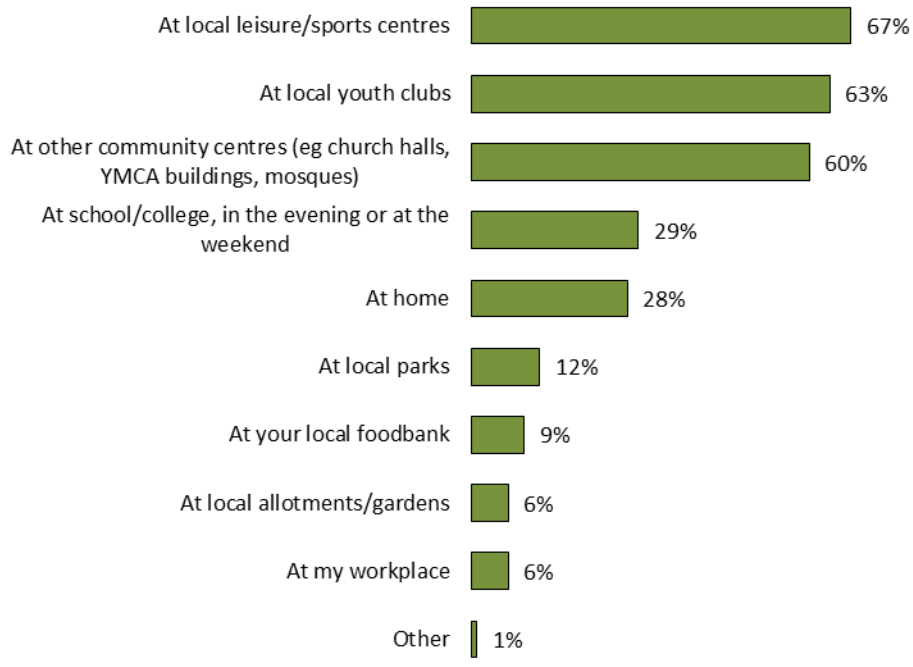


Healthy Eating

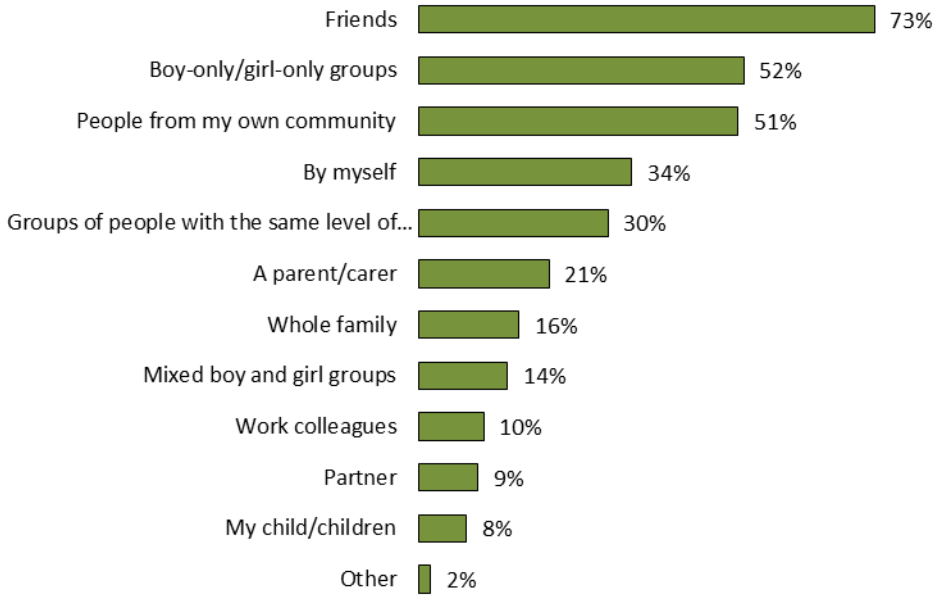
The questionnaire asked what sort of healthy eating activities would interest respondents, where they would like to do them and who they would like to do them with. The questionnaire asked what information respondents would like around healthy eating and where they would like to get that information. It also asked whether there were barriers to them participating in healthy eating activities. Responses can be seen in the following pages.

Preferred types of healthy eating activities and preferred locations/settings

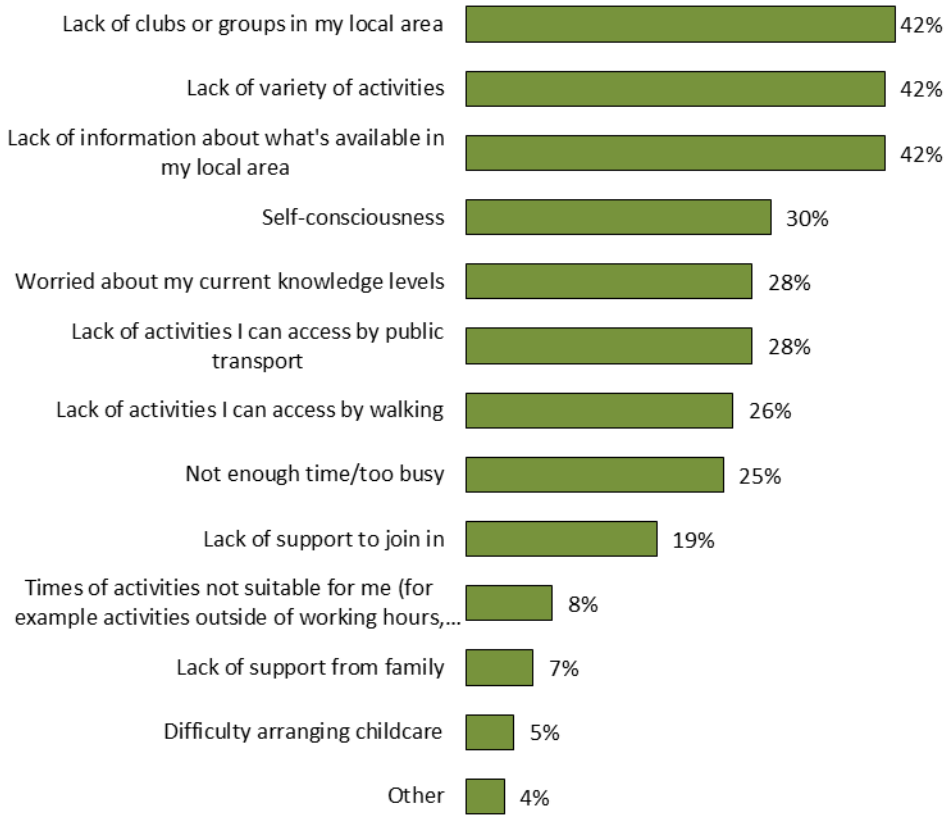




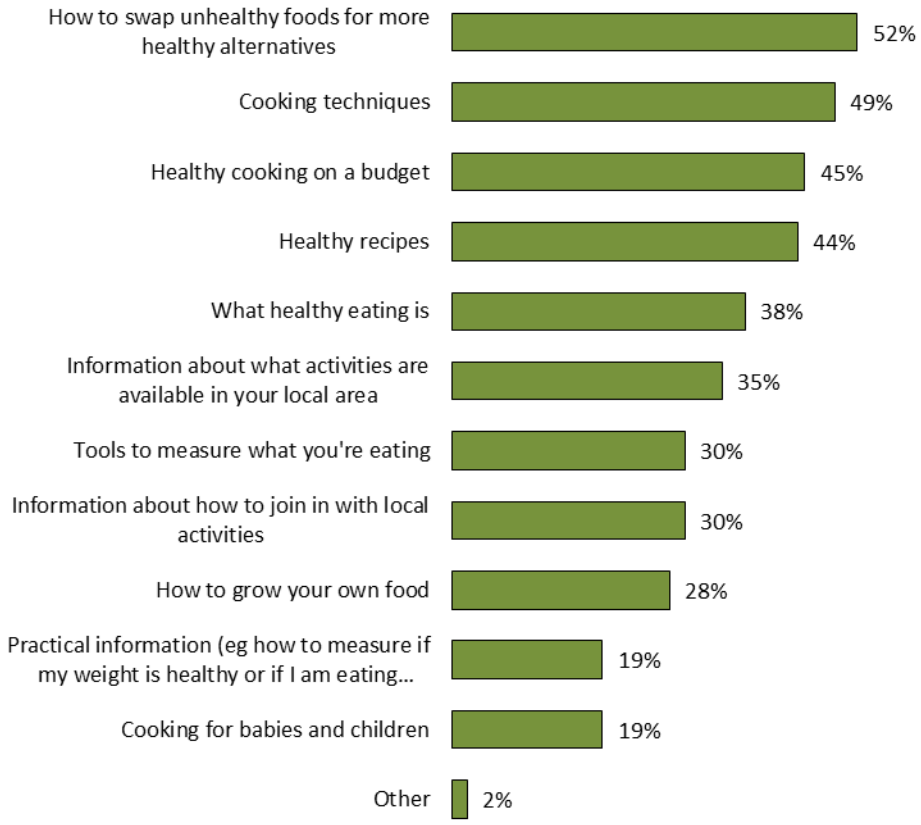
Preferred companions for healthy eating activities



Barriers to taking part in healthy eating activities



Preferred information about healthy eating



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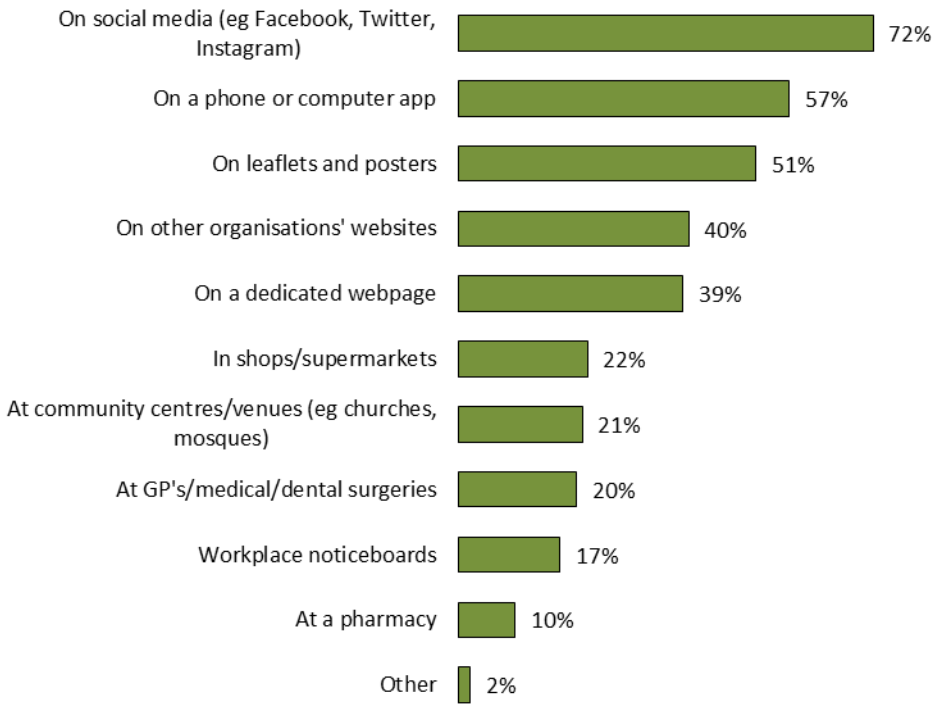

Previous Service Experience

The questionnaire asked if the respondents had accessed any healthy eating or physical activity services before, and if so, what sort of service it was. 68 respondents (65%) said they had, against 24 (23%) who had not, and 12 (12%) who were not sure.

The children and young people who had accessed services had on the whole accessed services relating to both healthy eating/cooking and physical activity. These included cooking with other young carers, cooking and growing your own food, aerobics, and circuit training.

The things the respondents liked about the services were

- Learning to cook on a budget
- Learning about healthy cooking & eating
- Keeping fit and active
- Doing fun games
- It was free
- It was in my own language
- The variety of activities
- The advice provided

One young person said about a service that *"they showed you healthy eating isn't just salad but lovely everyday things. [It] opened my mind to different and healthier ways of eating/snacking"*

The things the respondents didn't like about the service were

- High cost
- Service was stopped
- Embarrassment
- One respondent said that some foods would not be very satisfying to eat

The respondents who had not accessed services were asked whether anything stopped them doing so.

- Three respondents were unaware of what local services were available
- One respondent mentioned lack of availability

Other comments

The questionnaire asked if respondents had any other ideas or comments about how the service can help and support children and young people in Lancashire to eat healthily and be more physically active.

The respondents wanted to see

- More local activities
- Food workshops/cooking classes
- Teaching people to cook basic healthy meals

- Rewards for responsible food retailers, for example those who provide healthy kids meals
- Tips and recipe cards in supermarkets
- Sessions for larger people, to gain confidence
- A dance festival
- TV adverts
- Different types of sports and exercise

The respondents said that the service should

- Use schools as a venue to put out healthy messages
- Support more single gender groups [when asked about barriers earlier in the questionnaire, 25 BME respondents (20% of respondents) stated the lack of culturally appropriate services as a barrier to taking part in physical activity. This related primarily to having same sex groups but also culturally appropriate surroundings]
- Open up sport and exercise to young people even if they're not going to be very good at it

Cost was repeatedly mentioned by respondents, who felt that accessing activities was often too expensive, especially for young people who are often still students and don't have their own money.

Wider Stakeholders questionnaire

The wider stakeholder questionnaire was designed to capture the views, experience and knowledge of people in areas of work related to physical activity, obesity prevention and weight management. The questionnaire was also circulated to include people who work with target groups, even if their area of work isn't directly related. There were 56 respondents who came from a range of organisations including Clinical Commissioning Groups (CCGs), healthcare providers, leisure trusts, local government, provider organisations, and voluntary and charitable organisations.

Stakeholders were asked questions on the following areas

- Service footprint
- Integration of physical activity and healthy weight
- Use of digital technology
- Behavioural change
- Other approaches
- Targeted interventions

Stakeholders were also asked for any other comments on how the service can help and support people in Lancashire to eat healthily and be more physically active. Most of these comments corresponded to the above themes and so have been added to the relevant areas.

Service Footprint

The Active Lives and Healthy Weight Service will be delivered over five geographic footprints, broadly in line with local CCG footprints. The questionnaire asked respondents if there were any important elements or complexities to consider when thinking about the five-footprint model.

Respondents felt strongly that whilst equitable provision was important, a key focus should be assessing local need and delivering services to that need. The idea of proportionate universalism, where universal services are provided at a scale and intensity proportionate to the degree of need (NHS Health Scotland, 2014) was popular. Assessing local need includes taking note of local cultural norms and needs, for example by providing single gender activities. This is supported by the results of both the focus groups and the other questionnaires. Respondents were also concerned that hidden deprivation, for example pockets of high deprivation within an otherwise affluent district, was addressed in the service.

Respondents also felt strongly that the service should take an assets-based approach and use the strengths, skills and knowledge which already exist within communities to deliver a service-user led, strength based service.

Respondents were keen that the service not duplicate other local services and that the service work in partnership, not competition, with other local groups and organisations. In this way the service can add value to existing provision and to the local community. Respondents felt that the service ought to use local networks and intelligence to inform service provision.

Respondents cited accessibility as a key issue for the service to consider. Accessibility covers a wide range of factors. Those mainly mentioned were relating to making the service accessible to people who face extra barriers to engagement, such as people who are socially isolated, people with physical and learning disabilities and people with a diagnosis of mental illness. Respondents suggested using existing networks of trust within communities to engage people. Another factor in accessibility was transport, especially for older people and people in rural areas.

Respondents said that consistent messages across the county and across organisations within a service area were important. Consistency in messages would reinforce and add value to work across the sector.

Integration

A key element of the Active Lives and Healthy Weight Service is integration of obesity prevention, opportunities for physical activity, and weight management. The questionnaire asked stakeholders how the service can best do this.

The strongest response from stakeholders was that the service must work in a spirit of partnership with other organisations so that each organisation complements the other. Stakeholders felt that the service should build strong links to other groups and coordinate activity and signpost where appropriate. Prioritising partners who integrate all elements covered would also aid integration. Respondents felt that the service should utilise existing expertise in wider organisations and gain strategic level buy-in for integration of obesity prevention, opportunities for physical activity and weight management. Respondents also noted the need for clear pathways and clear, wider referrals routes.

In addition to using professional expertise, respondents said that the service should ensure that community assets are fully utilised, that the service is community based and that staff are from and representative of local communities. The service should fully utilise the human and personal qualities of staff and volunteers to engage people in services.

Respondents said that the service should take a holistic approach to services with levels of intervention appropriate to need and find a way to deliver sustainable support over the long term.

Respondents cited the need to use national guidance such as NICE guidelines to guide integration. Respondents also said that the service should link into national campaigns which complement or share the aims of the service. Messages should be consistent, with a suggestion from some respondents that there should be use of one brand.

Other factors respondents felt the service should consider are

- Co-morbidity
- Special needs such as disabilities and factors such as mental health, especially how they act as barriers
- Easy access
- User friendly services
- Barriers and wider influences on weight and health

- Good communication with partners and public
- Having one point of contact
- Oversight

Use of Digital Technology and Social Media

Another cornerstone of the Active Lives and Healthy Weight Service is the use of available digital technology and social media to ensure the service is well promoted within Lancashire. This is to enable mass participation and to provide innovative ways of reaching out to communities. The questionnaire asked stakeholders how the service can best do this.

Respondents spoke of the importance of using social media to send out information on both the service and key health messages, highlight the benefits of a healthy lifestyle, promote the service, and provide motivation and support. Respondents said that the service should use its own dedicated social media accounts and also work in partnership to use other organisation's communication teams to use their accounts. The service should link with and be complimentary to other local and national campaigns and strategies. Social media use should work with the norms, trends and potential within online communities, for example using Facebook challenges, using visual communication and tapping into people's desire to share achievements. Staff responsible for social media use should be competent and active participants in online communities, with dedicated accounts maintained with high quality and regular activity. Social media advertising should also be considered. Respondents cited the potential of digital technology to provide peer support, although it must be noted that service user focus groups were very clear about the need to have restricted access groups to prevent online abuse and harassment.

Respondents said that other digital platforms and networks should also be used, for example service websites, local area websites, online communities and workplace digital networks. A widely cited platform was the video hosting website YouTube. The site allows users to search and view videos and also to set up their own channels. YouTube tutorials are popular and widely used to find information and to learn new skills. Out of hours support is another potential use for digital technology.

The wide use of digital technology among children and young people was cited as an opportunity for services to engage people from an early age and prevent obesity and low levels of physical activity. Digital technology can also be used to engage people who don't think services are for them or do not know that they want or need help to live a healthy life.

Many respondents spoke of the ability to use technology in direct service delivery. For example, using technology to track and monitor service users' progress. This includes using technology to replace traditional paperwork and provide for more accurate data collection, analysis and measuring progress against targets. For example, instead of relying on self-reporting of physical activity levels service users can use existing technology, such as 'wearables' and associated 'apps' to track their activity. Wearables are pieces of equipment that a person wears on their body, such as a watch, which measure exercise data such as heart rate, step count and distance travelled. These wearables communicate with phone or computer apps (computer programmes designed to be easy to use on mobile technology) to collect

and analyse large amounts of data with ease. The apps then give easy to understand information to the user. Diary functions on apps could also be used to monitor motivation and wider wellbeing.

Computer and mobile apps can also be used to track and analyse any sort of data, for example recording food intake. There is already a wide market in apps and so it may not be necessary for the service to develop its own app. The wider public can also be encouraged to use apps that cover the whole spectrum of obesity prevention, physical activity and weight management. QR (quick response) codes, which are like bar codes that can be scanned by a mobile phone app which then automatically takes users to further information, can also be used.

Technology can be used to make services more efficient and effective. For example, text reminder services allow the service to send out appointment reminders by text message. This can both lower non-attendance rates and allow the service to fill appointments that otherwise would be lost. Technology can also be used to sustain success after structured interventions and link in to further activities to maintain behaviour change and a healthy lifestyle.

Respondents were concerned about digital exclusion, where people lack the resources, skills, or both to engage with digital technology. Digital exclusion disproportionately affects people who are already in the most vulnerable and disadvantaged groups in society (UK Cabinet Office, 2014). Respondents felt that a drive to use digital technology should not mean that people are left behind. Respondents said that services should help people to access social media and other digital technology but also that it should not be a replacement for face to face engagement. Using digital technology should be one tool to help people and traditional media should also be used.

Behavioural Change Programmes

The service is expected to incorporate behavioural change programmes to bring about sustained long-term improvements in diet, physical activity, and the weight of individuals. The questionnaire asked stakeholders for their opinion as to what types of behavioural change programmes would be most effective.

Respondents were clear that any behaviour change programme must be based on the best quality evidence and within national guidelines such as NICE guidelines. Techniques suggested by respondents include

- Motivational interviewing
- Cognitive Behaviour Therapy (CBT)
- Solution Focussed Therapy
- Mindfulness
- Brief advice/interventions

Having a flexible approach to how a programme works was considered important as was embedding flexibility and innovation into the service, for example using popular programmes such as Couch to 5k.

Well trained staff with excellent interpersonal skills were also considered key. Staff need to offer support and expert advice in an empathetic way.

Many respondents said that a key 'pull' factor to engaging service users in behavioural change is to emphasise the social aspect of groups, with wellbeing outcomes a secondary benefit of an enjoyable activity. The use of relaxed community venues can help the feeling of an enjoyable social event. Using shared interest or peer groups, for example perinatal activities, can also encourage participation and help to maintain and normalise behaviour change. Having varied activities within the programme would give the service the widest reach. Programmes which included activities that could be done at home or in a preferred location were also favoured. Respondents emphasised the need to engage children, young people and their families at a young age, identifying children at risk early on and take opportunities to change family behaviour.

Respondents also felt that programmes should be service user owned and led and tailored to their needs. Specific audiences may need a different approach; an example given was using visual progress charts for people with learning disabilities. A tiered approach was favoured, with those with the highest needs having the greatest level of support. Respondents said that programmes should include educational aspects, the consequences of inactivity and poor diet, and the theory of behaviour change. Any programme should integrate all relevant areas including weight management and physical activity. Respondents felt that programmes should include practical sessions, such as supermarket trips, to embed learning in everyday life. Programmes should be able to show measurable results for the service user.

Other Approaches

The questionnaire also asked stakeholders what other approaches they thought the service should use to deliver sustained improvements long-term improvements in diet, physical activity, and the weight of individuals.

Again, respondents spoke of using evidence based approaches and using national guidance. Many respondents also cited a need for programmes to be aware of an individual's wider determinants of health such as poverty, housing situation, tobacco use and co-morbidities such as mental ill-health. Sustained behaviour change is complicated and made harder by these wider determinants and the service should contribute where possible to improving these. Some respondents said that success should also be measured through wider wellbeing measures. On a related note, practical points that act as barriers to service users, such as accessibility of location and cost of physical activities should also be addressed by the service, in order to sustain behaviour change.

Respondents said that a local focus was needed, using local knowledge and intelligence to inform service provision. The service should link to local partners and organisations for example community health centres and voluntary/faith sector organisations. Having strong links into these organisations and their activities was seen as a way to sustain individual behaviour change in the long-term. Having a robust referral system, which includes non-traditional referral routes, was also felt to be important. Integrating pathways, for example with diabetes or stroke care, would aid long term positive impacts on health. Consistent messages across organisations were felt to be important.

Linking in with local community groups was felt to be a key way to reach out into communities with the most need, and respondents felt the service should be

innovative and creative in how they do this. Respondents said that the service should target specific groups with appropriate messages and activities. This could mean targeting groups with a common characteristic, such as perinatal women and carers, or ensuring services respond to the cultural norms of a community, for example gender segregation. This reflects what respondents in other questionnaires said. Respondents also suggested taking activities out to communities and using community champions.

Respondents said that using volunteers was a useful approach. These peer supporters can use different approaches, for example mentoring and coaching, to support service users, encourage and sustain behaviour change and act as champions for healthy lifestyles. Local voluntary groups could also be invited to speak or be available at services, where they could aid participants in other areas of need. In addition, encouraging volunteering as a healthy activity among target groups was also favoured.

Another approach favoured by respondents was a settings based approach, for example liaising with employers in workplaces to ensure healthy choices are available and that the workplace is a health promoting setting, for example through offering workplace walks. The service should also encourage and support initiatives to create and maintain healthy villages, towns and cities.

Life-long participation in healthy lifestyle activities was something respondents felt the service should encourage. To do this the service should work with people across the life course, including working with schools and gaining momentum in the early years of life. Supporting public initiatives and mass events is also a way to do this, along with key messages and work targeted across the life course. Also, taking a full-family approach, where the service targets or works with the family as a unit was felt to be important. For service users, incentivising long-term engagement, for example with reduced cost access to fitness groups, was felt to be important.

Stakeholders were in agreement with respondents from the other questionnaires and the focus groups that choice is important in engaging people and maintaining that engagement. This includes choice of location/setting and choice of activities and programmes.

Stakeholders said that positive and clear branding of the service is important. Communications should include consistent, easy to action messages which emphasise the positive benefits of lifestyle change. A wide reach of messages is needed, for example key messages could be publicised on bus or cinema tickets. Some respondents also felt that the long term negative effects of an unhealthy lifestyle should be publicised. Celebrating success stories and publically recording and rewarding achievements, were felt to be positive ways of communicating healthy lifestyle benefits. Local celebrities or positive role models, with achievable healthy lifestyles, could also be used to communicate with and engage communities.

Post programme support was felt by respondents to be very important in maintaining behaviour change. In addition to support from the service after any fixed term programmes, respondents said that programmes should be linked to other services and existing community networks to enable behaviour change to be sustained. Incentives, for example discounted fitness activities, could also be offered to help maintain lifestyle changes.

Targeted Interventions

The Active Lives and Healthy Weight Service will incorporate targeted interventions focused around physical activity, diet, and healthy weight. The questionnaire asked stakeholders which targeted interventions they thought the service should provide.

Respondents emphasised the need for targeted interventions which integrated all aspects of obesity prevention, opportunities for physical activity and weight management. Programmes should be tailored to the individual. Personal plans, made with input of the participant, will set and achieve realistic targets that are personal and meaningful to the individual. As noted above, interventions should be targeted and localised to the communities served.

Respondents said that physical activity aspects of targeted interventions should include non-traditional forms of exercise to enthuse and engage participants for whom traditional sports are a turn-off. Physical activity should also be tiered to fitness and confidence levels. This is backed up by the views of the focus groups.

In regards to healthy eating, diet and achieving and maintaining a healthy weight the following aspects were deemed important

- Healthy eating on a budget, recognising that money is a barrier for many
- Practical help with shopping, how best to shop for a healthy lifestyle
- Practical cooking and food preparation information and practice
- Help with menu planning
- Expert support, for example from a dietician

Another aspect that was considered important by respondents was an element of psychological support to assist behaviour change.

All targeted interventions should work around people's lives, such as working patterns and caring responsibilities. Childcare was repeatedly cited by respondents as a need to allow people to access targeted interventions. Taster sessions, to allow people to get information and gain confidence, were also suggested.

Please also see responses from focus groups and other questionnaires for more details on what targeted interventions should be used.

Locations and Settings

The questionnaire asked stakeholders what locations and settings they thought should be used to deliver services.

As throughout, the theme of using local settings and the importance of focussing on local need was prevalent in the responses to this question. Using familiar and comfortable local settings was considered very important. Respondents said that the service should use places where people gather naturally and feel at ease. The use of local community buildings was popular with suggestions including children's centres, schools, libraries, community centres, village halls, theatres, supermarkets and empty shop fronts. Services should go into communities, for example into local housing estates. Respondents felt locations without a clinical focus were best. Including a social setting or fostering a social atmosphere, for example by putting on tea and coffee, was felt to be a good way to build and support peer relationships and ultimately create a more popular and successful service.

Respondents also strongly felt that the service should use local outdoor spaces such as local parks, beaches, walking/cycle routes, allotments and gardens. They also felt that people should be supported to access healthy food locally.

Ease of access was a key theme, as it was for other respondents. Locations should be easy to access by public transport with well-lit and safe walking routes. One respondent suggested include local bus and public transport information in service information.

Other Comments

The questionnaire asked stakeholders for any other comments about how the service can help and support people in Lancashire to eat healthily and be more physically active. Most of these comments corresponded with the above headings and so have been included in the relevant area, however there were additional comments made which are detailed below

Respondents strongly felt that action was needed on the wider determinants of physical activity and healthy weight. These include

- Availability of fast food, for example concentration of unhealthy food outlets in a community
- The quality and simplicity of information on food packaging
- The contents of food, for example hidden sugar levels
- Access to healthy foods, for example food deserts, the price of healthy ingredients and cooking skills

Conclusion

The findings above gives a thorough picture of what people in Lancashire and colleagues in stakeholder organisations think about services for physical activity, obesity prevention and weight management. It is clear that individuals have different desires and motivations, however there were common experiences and needs across groups that influence the success or otherwise of any service or intervention.

There was wide support for referral routes to be widened and made as easy as possible. There was a desire across all groups for pathways between services to be clear and easy to navigate. Participants were motivated to access services or to change their behaviour by a wide range of factors, including ill-health. Participants' motivations were influenced by their specific life circumstances and services that use a life course approach are able to tap into the different motivations of people and so be able to engage people at any stage of life.

Participants faced numerous barriers to being physically active, eating healthily and accessing services relating to these. The barriers are both practical and psychological in nature. Practical barriers include lack of knowledge/information, cost, location, being busy, service hours and disability. Psychological barriers were just as important, with these mainly surrounding people's anxieties and confidence to join in activities. Anticipating and combatting these barriers is key to enabling mass participation.

Participants felt that there was a lack of information about Active Lives and Healthy Weight-related services. All participants wanted information to be clear, relevant to them, local and in a form they can easily access and use. Clear branding is part of this.

There was a clear desire from participants for services to be focussed on and responsive to local needs. This means listening to and responding to local communities and what they want. This also indicates taking an assets-based approach to capture and make use of the assets already available in the community. This includes linking to and working in partnership with local organisations and partners.

In addition to the findings above, the embedded, anonymised, responses have a wealth of suggestions for activities and approaches that the service can use. People want the opportunity to take part and they want the information and skills to do it. Key elements of what participants want are; choice, integration, a range and variety of activities, and accessible support geared to fitness level or need. The wider wellbeing of an individual is both an influencing factor and something that can be influenced by effective engagement in services. A person-centred approach is key to achieving a service that is responsive and effective.

The value of the people involved in services was clear. Participants spoke of the importance of empathetic, supportive and skilled staff. Participants also spoke of the power of peer support in motivating and maintaining the behaviour change needed to live a healthier life.

Using digital technology was widely supported by all groups, even those who were not regular users. Non-users of digital technology recognised the effectiveness of these tools in engaging young people especially and there was a strong preference in young people to use online platforms both as part of formal programmes and in

day-to-day healthy lifestyle related activities. Digital technology has the potential for wide use in direct service delivery, supporting and maintaining behaviour change and in enabling mass participation. Concern was raised about digital exclusion, and how increased use of digital technology may negatively impact In addition to the summary in the report, examples of how digital technology can be used can be found in the embedded, anonymised responses.

Recommendations

It is recommended that the Active Lives and Healthy Weight Service redesign take into account and actions the findings of this report. In particular, the service provider/s should:

1. Deliver a service which is flexible, culturally appropriate and accessible to meet local needs, taking into account:
    a. Evidence based interventions and local research
    b. Any local barriers which may exist
    c. Continuous local service user engagement feedback to ensure services are responsive and needs led.
2. Ensure that there is no 'wrong door' for service users.
3. Take a person-centred approach to service design and delivery.
4. Use an assets-based approach to service design and delivery.
5. Avoid duplication and work in a spirit of partnership with other local organisations and programmes.
6. Capture and use individual motivations to engage with services and sustain long term behaviour change.
7. Have a good knowledge of local communities and their needs including culturally specific needs.
8. Design and implement clear pathways and referral routes through to services.
9. Ensure that the service is fully embedded into relevant referral pathways.
10. Design and implement a clear communications and marketing strategy
    a. Work with Lancashire County Council to agree appropriate branding
    b. Target marketing to specific groups
    c. Provide clear, accessible information to the public and service users
11. Fully realise the potential of digital technology in all aspects of service design and delivery.
12. Measure performance consistently across the county and across physical activity, obesity prevention and weight management.
13. Work with Lancashire County Council to improve measurement of outcomes.
14. Measure and report how the service delivers wider health improvements, such as improvements in mental health.

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Copies of these documents can be requested from the authors

Appendices

I Focus group question structure

Engagement/Motivation • **(if participants have attended services) What motivated you to attend the service?** • **(if participants haven't attended services) What would motivate you to attend a service?**

Information • **(if participants have attended services) How did you find out about the service?** • **(if participants haven't attended services) How would you like to get information about services?**

Barriers • **(if participants have attended services) Was there anything that got in your way or was a barrier you had to get over**

to access? • **(if participants haven't attended services) Why haven't you accessed services, what's getting in the way? What would put you off?**

Types of activities (short explanation of the breadth of activities covered, contributing to healthy weight, healthy eating and being active) • **(if participants have attended services) What services have you used? What did you enjoy best? What didn't you like so much? Did you get a choice over activities?** • **(if participants haven't attended services) What types of activities would you like to see? What things would make you want to go to an Active Lives and Healthy Weight service? Would you like a choice over activities?**

Location/access hours/choice • **(if participants have attended services) Where do you like to attend activities? Is there anywhere that you don't like to use? What days/times of day work best? Did you have any choice in location/hours?** • **(if participants haven't attended services) Where would you like to attend activities? Is there anywhere that you wouldn't like to use? What days/times of day work best? Would you like a choice in location/hours?**

Family engagement • **(if participants have attended services) Were your family involved or supported? Tell us more about this** • **(if participants haven't attended services) How we can get whole family involved or support families to support the individual?**

II Adult Questionnaire Data

		Column N %	Count
How old are you?	20-24	5%	24
	25-29	8%	38
	30-34	8%	38
	35-39	12%	53
	40-44	14%	62
	45-49	14%	62
	50-54	16%	71
	55-59	9%	39
	60-64	4%	20
	65+	9%	41
	Total		448

		Column N %	Count
Are you...?	Male	27%	117
	Female	73%	324
	Total		441

		Column N %	Count
Have you ever identified as transgender?	Yes	0%	1
	No	95%	419
	Prefer not to say	4%	19
	Total		439

		Column N %	Count
How would you describe your sexual orientation?	Heterosexual/straight	90%	395
	Gay man	1%	4
	Lesbian/gay woman	1%	6
	Bisexual	2%	9
	Other	1%	3
	Prefer not to say	5%	23
	Total		440

		Column N %	Count
Do you consider yourself to have a disability?	Yes	13%	56
	No	87%	379
	Total		435

		Column N %	Count
How would you describe your religion?	No religion	24%	103
	Christian	62%	271
	Buddhist	1%	3
	Hindu	1%	6

	Jewish	0%	1
	Muslim	10%	42
	Sikh	0%	1
	Any other religion	2%	7
	Total		434

		Column N %	Count
Which of the following best describes your ethnicity?	White	86%	370
	Asian	12%	51
	Black	0%	2
	Mixed	1%	4
	Other	1%	4
	Total		431

		Column N %	Count
Which district do you live in?	Burnley	8%	35
	Chorley	19%	81
	Fylde	2%	10
	Hyndburn	8%	34
	Lancaster	15%	65
	Pendle	4%	17
	Preston	14%	61
	Ribble Valley	3%	14
	Rossendale	5%	20
	South Ribble	12%	53
	West Lancashire	4%	19
	Wyre	4%	19
	Don't know	1%	5
	Total		433

III Children and Young People Data

		Column N %	Count
How old are you?	10 or younger	1%	1
	11	1%	1
	12	5%	5
	13	7%	7
	14	7%	7
	15	10%	10
	16	24%	25
	17	17%	17
	18	16%	16
	19	14%	14
	Total		103

		Column N %	Count
Are you...?	Male	48%	52
	Female	52%	56
	Total		108

		Column N %	Count
Have you ever identified as transgender?	Yes	1%	1
	No	76%	81
	Prefer not to say	23%	25
	Total		107

		Column N %	Count
How would you describe your sexual orientation?	Heterosexual/straight	84%	86
	Gay man	1%	1
	Lesbian/gay woman	0%	0
	Bisexual	1%	1
	Other	1%	1
	Prefer not to say	13%	13
	Total		102

		Column N %	Count
Do you consider yourself to have a disability?	Yes	6%	6
	No	94%	99
	Total		105

		Column N %	Count
How would you describe your religion?	No religion	13%	14
	Christian	23%	25
	Buddhist	0%	0
	Hindu	2%	2
	Jewish	0%	0
	Muslim	61%	66
	Sikh	0%	0
	Any other religion	1%	1
	Total		108

		Column N %	Count
Which of the following best describes your ethnicity?	White	34%	36
	Asian	66%	71
	Black	0%	0
	Mixed	0%	0
	Other	0%	0
	Total		107

		Column N %	Count
Which district do you live in?	Burnley	1%	1
	Chorley	69%	75
	Fylde	1%	1
	Hyndburn	3%	3
	Lancaster	1%	1
	Pendle	2%	2
	Preston	11%	12
	Ribble Valley	3%	3
	Rossendale	1%	1
	South Ribble	3%	3
	West Lancashire	2%	2
	Wyre	3%	3
	Don't know	1%	1
	Total		108

Embedded Documents

I Focus Group Analysis

I.i Anonymised and themed focus group notes

anonymised
themed adult focus

anonymised,
themed CYP focus gı

II Questionnaires

II.i Adults

Active Lives and
Healthy Weight Adu

II.ii Children and Young people

Active Lives and
Healthy Weight CYP

II.iii Wider stakeholders

Wider stakeholders
Questionnaire V7.dc

III Questionnaire responses

II.i Summary, anonymised Adult Questionnaire responses

Adult responses
Q1-16 to embed.doc

II.ii Anonymised Adult Questionnaire responses questions 17-20 including summary

Adult Responses
Q17-20 including su

II.iii Summary, anonymised Children and Young People Questionnaire responses

CYP responses summary.docx

II.iv Anonymised Wider Stakeholders Questionnaire responses

anonymised Stakeholder respons