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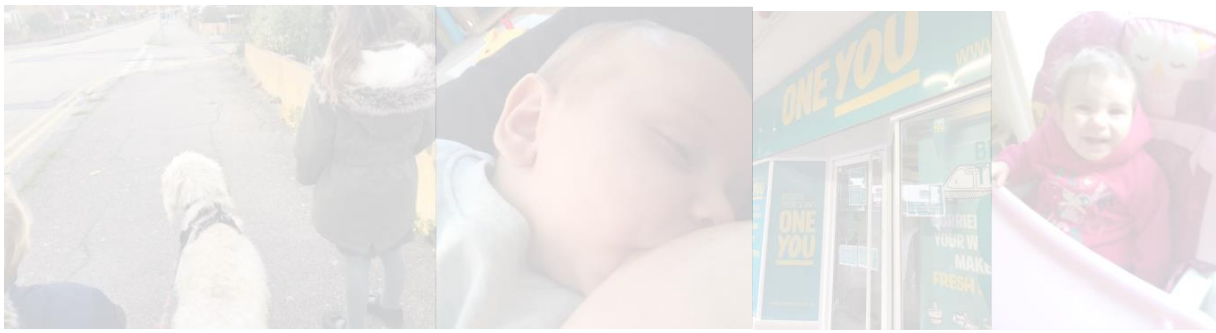
PREVENTION: HEALTHY BEHAVIOUR CHANGE WITH FAMILIES



Insights and experiences
March 2018

CONTENTS

1. INTRODUCTION AND BACKGROUND:

Kent County Council's initial specification and requirements sought external professional support to undertake annual audits and updated user view summaries for the Joint Strategic Needs Assessment (JSNA) chapters and work to improve the quality of the data and level of service user involvement over 3 years.

Activmob were commissioned to undertake this work and following an audit conducted in Year 1 and with the agreement of Kent County Council Public Health Department there was agreement to the rational for change to the approach and objectives to the work.

Year 1 identified a **low baseline** for current inclusion of 'stakeholder voice' within JSNA chapters. These results were discussed along with the barriers experienced by Chapter authors in including 'stakeholder voice'. Barriers for the Kent Public Health Team included low skill level and capacity to undertake the capture of stakeholder voices. Finally it was anticipated that planned further restructures and capacity issues would impact **further** on the Department's ability to the undertake stakeholder voice aspect of JSNA.

The Department also agreed at DMT that the JSNA product would change significantly and no longer be chapter based.

The revised requirement was that a "**Stakeholder Voice Summary**" should be written to provide additional evidence to support the assessment work of the JSNA annual Exception Report. This requirement was refined to provide a "Stakeholder Voice Summary" for the **Prevention** work stream of the Kent & Medway STP led by but Council's Public Health Departments with an explicit need to provide evidence to inform prevention interventions earlier in the life course.

Activmob

Activmob have continued to work with Kent County Council Public Health Department to achieve the revised requirements. Activmob is a social enterprise that specialises in innovative approaches to engaging and working with service providers and '*hard to reach'* or service resistant citizens.

This report summarises the findings from the work undertaken by Activmob between September 2017 and January 2018.

2. OBJECTIVES OF THE STUDY:

To engage and encourage families to share their experiences and views on:

- Their views on the health and wellbeing of their family and what impacts on this.
- Their perception of what is healthy.
- How they could improve their overall health, wellbeing and happiness.
- Their priorities and what changes they and their family might like to make in the future.

Undertake interviews across geographical areas with high levels of deprivation and / or health inequalities. (Thanet, Maidstone and DGS)

3. METHODOLOGY AND WHAT WE DID:

Activmob has been recognised for developing and deploying a successful product methodology called ***'Insight Action'*** and has a proven track record of using the methodology on a number of projects over the past 6 years.

Insight2Action was inspired by grounded theory following the Braun and Clarke inductive thematic analysis model. This is an inductive methodology developing theory from a body of data, rather than the preconceptions of researchers. The process is iterative, in that ongoing sampling; data gathering and data analysis inform each other over time. Tentative theoretical explanations are generated during analysis and subsequently tested through further data gathering. In this way, a circular process ensues in which theory is gradually and robustly developed.

The researchers favour the exploratory nature of an inductive approach to undertake research. It allows people to share what they think is important to truly understand the issue and designing a fit for purpose solution. The nature of this work means that theories develop from the body of the data collected, rather than testing out preconceived theories or assumptions.

Previous projects have been successfully undertaken engaging and capturing insights and experiences from individuals of all ages and groups on a range of difficult emotional topics, including bereavement, smoking, pregnancy, serious mental health and complex family issue.

PREPARATION TASKS:

The following bespoke documents and tools were drafted, shared and agreed with KCC to be used to conduct the interviews in a professional manner and in line with the Activmob '*Insight2Action*' methodology. Copies can be found in the Appendices.

- **Briefing Sheet** – to be used to share with potential families and outlining the objectives of the interviews, what to expect and an opportunity to answer any questions.
- **A Topic Guide:** used to guide a conversation / interview which were semi structured. Topics for the interviews were discussed and agreed with KCC.
- Interview documentation including **Consent Form** (signed for each family) and a **Demographic sheet** to capture some key demographics about the interviewees.
- The '***Activmob Family Health Wheel'*** tool was adapted and used as an engagement aid for interviews.

RECRUITMENT:

Activmob '*Insight2Action*' methodology includes using an '*asset based'* approach to sourcing and recruitment of interviewees. Over the past 6 years, Activmob has build up an extensive network of 'trusted assets' or people /places that people in Kent may go to. These are often ***informal assets*** but seen by those who may not traditionally engage as somewhere they feel safe and relaxed. Researchers made contact and approached these known '*trusted assets'* within the agreed areas to allow us to visit either:

- At organised pre arranged times to go and meet with the families – such as an activity being held which families attended on a regular basis.
- Informal visits to informal community places and spaces that our experience tells us families go to and approach families informally.
- Families were offered either face to face or telephone interviews.

Families within the 3 target areas (DGS, Maidstone and Thanet) were eligible to participate.

CONDUCTING INTERVIEWS – OUR APPROACH

Interviews were conducted wherever the interviewee (and family in some cases) felt most relaxed and chose. Options for venue included within small friendship groups maybe in an activity setting, in a private home or at a pre arranged time over the phone. Timings were discussed and at the convenience of the interviewee.

For the interview itself, researchers wanted to understand the context around the family, how they view the world, how they interpret things, what has influenced what they think and do and what their priorities are. The Topic Guide enables the researcher to conduct a semi structured interview with prompts but also allows the flexibility for families to share what they want to share on the topic and what is important to them as well as encouraging a flowing and enjoyable conversation for the family. For the face-to-face interviews, other members of the family (all ages) were encouraged to participate and contribute in part of fully.

All families gave their time freely with no incentive offered.

DATA COLLECTION & DOCUMENTING

Researchers used a simple Data Capture Sheet to document key insights and experiences either during the interview of immediately after. The Sheet used the same headings from the Topic Guide. All participants also provided some demographic sheet that was captured.

For each interview, the researcher used the *Activmob Family Health Wheel* as a tool to engage both the main interviewee and other family members to participate. The Tool has been developed by Activmob through undertaking insight interviews. The Tool, based on core coaching techniques, has evolved and improved through testing and refining with people across a range of individual topics and health behaviours in other studies undertaken by Activmob. In the past it has been successfully used as a Tool to encourage people to participate in a conversation in a non judgemental and threatening way. The version used for this study was adapted to encourage a family response rather than an individual. A short information sheet is attached as an appendix to this report for more information.

The tool really helped the team to have a full conversation with families about all their behaviours – even the ones they were less keen to discuss at the start. It also enabled researchers to explore in more depth the rationale for how families scored themselves and how it reflected different family members.

The Tool also helped the Team ensure were not allowing their own standards on healthy behaviours to influence what they wrote down or asked.

During the course of the interviews, the Topic Guide was developed and strengthened in response to early feedback and emerging themes. Specifically, the adapted Topic Guide provided more opportunity to explore families' commitment and barriers to committing to a behaviour change.

Finally, individually and as a Team we reflected on the positionality and impact we as interviewers had had on interviews and on the impact the setting and style of interview may have had on data – i.e. home vs. group setting, telephone vs. face to face, individual family member vs. more than one family member present. The Team read each other's interviews, challenge each other to ensure everything was captured.

We also recognise that by engaging the family and in particular adapting and using the Activmob Family Health Wheel led to families raising their self-awareness of health and wellbeing.

CODING / ANALYSIS / THEMING

Activmob use a comprehensive approach to coding, analysis and theming of all insights and data captured as part of the "*Insight2Action*' method. This begins with familiarisation with the data - reading and re reading the interviews and completed Family Health Wheels. All interviewees are given a unique number, which is used for the interviewee write up, Family Health Wheel and completed Demographic Sheet thus ensuring anonymity of the participant.

All data items are manually coded and collated into headings from Data Capture Sheet and pulled together into relevant data extracts - for example by behaviour type. From here, senior Activmob staff individually search for themes from the coded data. This is completed once individually then as a Team capturing emerging themes on flip chart paper and post it notes and using the evidence from the coded data to support the themes. By theme we are looking for a meaningful pattern of data relevant to the research question that we can construct from the coded data and from more than one interview.

Finally, when we have the themes written up, these are reviewed back against the coded extracts and full data set for 'fit'. Themes are written up with a narrative, supporting quotes and a case study in some cases.

CREATION OF PERSONAS:

With the fairly large number of families and other residents who participated in this study, the research Team began to see a number of 'Personas' or 'types' emerging from the data – each - **showing different realities**. A **persona** is a semi-fictional representation of a customer / resident based on the data and evidence we collected through this study with the customers / residents involved. The persona representation aims to provide insight into demographics, behaviour patterns, motivations, pressures, and what would work and missed opportunities to support them in making a positive behaviour change.

APPRAISAL CHECKLIST

As with all our studies our methodology and approach always seeks to draw out themes and conclusions from evidence that is credible, transferable and dependable. The following demonstrate how this is reflected within our approach:

- **Triangulation**
- 2 of the team independently read the raw data and draw out emerging themes, compare and analyse any differences.
- Pull together evidence (inc quotes from many interviews) that support emerging themes.
- Personas generation – and checking back against full data set and with each other as a team
- **Negative case analysis**
- Purposefully identify any interviews that **don't fit** the emerging themes.
- **Open approach to documenting flexibility in research design**.
- Clearly documenting how data was collected and recorded and how analysis was done.
- **Check back with % of additional families on emerging themes**
- **Impact researchers may have**
- Consideration and reflection of who (sex, outlook, voice and accent, dress, language use, values)

4. DEMOGRAPHICS

The Table below provides a summary of key demographic data collected for each family interviewed. Key points are:

- 49 families interviewed of which 33 women were main interviewees.
- Over 131 family members lives from pregnancy to grandparents involved in the study.
- Interviews conducted in DGS = 16 | Maidstone = 15 | Thanet = 18
- Work situation: of the 63 participating adults (who disclosed) – 20 full time | 24 part time | 19 not working or unable to work.
- Housing situation for families – 6 in own home | 18 in social housing | 25 in private rental | 5 additional family members not living in family home
- Benefits situation – 8 not in receipt of benefits | benefits include housing, ESA, DLA, Family Tax Credits, PIP, Income support.
- Health score (as scored by participant): range from 1 – 8 and average 5.5

The majority of interviews were held in community based setting such as church coffee mornings, children centre groups, Young And Active Parents groups YAPS, children's soft play areas, community cafes and Healthy Living Centres. A smaller number were held in the family home or over the telephone.

Family	Adults	Under 4	4 - 11	11 - 16	16 - 18
Makeup and AGES	72	27	16	9	7

Gender (adults)	Male	Female
Main person	16	33

Occupation - For all members of the family:

Full Time work	Part time	Currently not working	Carer	Unable to work	Nursery	Primary	Second	College / training	Uni
20	24	16	1	5	8	15	6	2	1

Areas

Area	DGS	Thanet	Maidstone
	16	18	15

Ethnicity:

Asian	Black African	White British	European	Chinese	Mixed	Other	Prefer not to disclose
1	1	Remaining					

Health Score Measure Question out of 10	1 – is lowest – 10 – is best
Range from 1 – 8	Average 5.5 (across 49 scores)

Free School Meals

7

Housing Tenure

Tenure	Own Home	Social Housing	Private rent	College accommodation	Sofa / friends (fam members)	Other
Numbers	6	18	25	1	2	1

Benefits

None	ESA	Job Seekers	Carers	DLA	Housing	PIP	Tax Credits
8	13	3	1	5	14	11	19

Interview Location:

Location	Community Setting	Group Setting	Telephone interview	In own home
Number	14	13	10	12

5. FINDINGS – HEADLINES

HEALTH BEHAVIOURS AND FAMILIES

- Conversations using the Activmob *Family Health Wheel* Tool highlights how different behaviours impact on families:
- Alcohol the new 'crutch' for dealing with stress **but not discussed openly**
- Smoking the **behaviour to stop with clear understanding of why**
- Exercise/ healthy eating and weight are behaviours families feel they need to do something about but struggle with **low commitment and lack of awareness** of what to do '*what is enough'*
- Wellbeing (including relationships, children having friends and being happy) **top priority** for families '*at allcosts'*.
- **Language important** around behaviours - mental health only identified as important for those with a mental health LTC. However words like 'wellbeing' 'happiness' ' family relationships' 'sleep' ' stress' ' anger' all identified as important and having high impact on family.
- Many could **identify** the changes they **should** make:
    - **STOP**- the behaviours that '*change my behaviour in a negative way'*
    - But what they **chose** to do is **START** other things '*that are easier"*
    - Plenty of positive and creative ideas from families on behaviours to **START** to improve family health and wellbeing – but barriers, commitment and lack of resources to achieve.

ENGAGEMENT AND SUPPORT FOR FAMILIES

- Families said the '**system' is bad at engaging** with families on their health and wellbeing:
- Experiences include feeling judged, many **missed opportunities**, feeling let down and fearful.
- Big opportunity to improve and equip staff to engage **more effectively**
- What people want is what we all would want – a conversation with someone who gets to know you, has a connection, builds trust and makes links with services that are person centred.
- No longer about 'one size doesn't fit all', but **HOW or APPROACH** of a service - highlighted by range of **personas** emerging from the interviews and the particular behaviour being addressed.
- Self Care - Is more acceptable with some topics like alcohol where people empathise, than food/weight where people can be quite judgmental.

IMPACT OF WIDER SYSTEM

- Analysis from the interviews highlights the need for a Whole System Thinking approach to change the environment around families in order to make it easy for them to make the right choices.

6. INSIGHTS AND EXPERIENCES – KEY THEMES

This section of the report provides details of the key themes that have emerged from the interviews with both families and front line workers. The themes have been grouped into the Topic areas used for the Topic Guide.

TOPIC 1 - FAMILY HEALTH WHEEL

An early question during each interview was for each family to score themselves out of 10 as to how healthy they thought they were. The Family Health Wheel was then used as a way of documenting and exploring in more detail the rationale behind the health score across all family members. The Tool was used to capture current behaviours as well as desired behaviour change goals for the family.

The Tool had a very powerful affect on many families who said that this was the first time that they had done this exercise and talked about it. They felt that it had raised their self-awareness of health and wellbeing of their family.

CASE STUDY

I am a married 41yr old mum of 3 grown up children, aged 21, 18 and 16. I really though we were quite healthy. None of us had any illnesses or we were not really over weight.

I was very shocked to see that my family health wheel sat mostly within amber and red! It was a real eye opener and I think the kick I needed to make some changes in our lives that we would benefit from.

I looked round the wheel and see that none of us eat properly or do we do any physical activity, and this was something I could focus on changing. I got home and spoke with the family, they didn't see the importance of it, but I think that's because they didn't see the wheel. I decided that I could start doing something now and when the rest of the family were ready, they could too.

The healthy eating would be more of a problem, as the family were not ready to change, so I focused on physical activity for myself. I found a boxercise class and a hit class locally and decided to go along. As the weeks went by, and I started to feel better, my eldest daughter decided to join me. After about a month I started to gradually change my eating and cut out sugar and add in more fruit and veg, then my husband mentioned that he needed to eat a better diet, so he joined in.

We now all have completely changed our family eating habits, No more fizzy, sugary drinks, or fried foods. We all focus on balanced and healthy meals and regular exercise 3 times a week.

Current Behaviours

	• Still used for some as a stress reliever, for most of these they are trying to reduce and control what they have but when weighing it up against other things (like drugs) '*it's not too bad*' • Less of a social thing to do than drinking alcohol – very personal choice. • Still limited understanding of impact on health and priority is to cut down. • For non-smokers – arrogant that they feel healthy as they don't smoke – so they see this as the number 1 bad thing. • Cutting down message = enough, never quite getting to a quit.
	• The new crutch for people that is legal and acceptable – up to a point – and then it is not discussed or people are not asked. But for the rest of us (majority) it is acceptable and as long as you have a few days off during the week it's the right thing to do. • Something you do socially and with others. • No link to health at all unless you are one of the ones we don't talk about! • Norm to be a drinker – socially – pressure.
	• Women tend to rate themselves lower on exercise, know they should and feel guilty that they done to enough. • For most it is not a priority for themselves and people just don't have time etc to do anything. • Men this is more important and something they do and potentially maybe the motivators and drivers for the active family examples? • If you are 'busy' you are active.
	• When it comes to eating, there is always a reason for not doing it: especially for parents (mums and dads) – it's the issue of what else is available cheaply, fussy eaters, time, keeping kids happy and snacks. • A lot of parental pressure and guilt across families to do the right thing. • Most recognise they should do better. Most don't put healthy eating at the most important thing for their families as there is little awareness of link with long term health. • For men in particular it becomes important following a health scare. This is the behaviour that most people spoke of. • Still, issues around measures of healthy diet- all relative to your experiences, as a child, recently with what family will or won't eat.

	• Not something people want to see for themselves, no impact on health – so try to link exercise and healthy eating with health and long term health but not weight. • Most want to lose weight (women), but always something else more important. More acceptable to be overweight – you just have different sets of clothes. • When talking through the wheel – although people would score amber – so recognising needed to lose weight – but not something they felt as a priority to deal with.
	• Identified by many (women) as something they recognise has a big impact on their wellbeing – across the whole family. • Sleep is something that they know physically if they have not had enough. Something people do not know how to improve even though it is key. • Sleep effects the whole family, all have different issues- if sleep is bad then everything else on the wheel goes to pot.
	• MENTAL HEALTH AND WELLBEING was at the heart of for most people in terms of what had a greater impact on the wellbeing of the family • It was the thing that parents put at the top of what is important for their children – to be happy and something they would do all they could to improve even if it meant being worse with other behaviours. *'it's more important they can go to KFC to meet friends and socialise than what they eat when they are there'* • For those who recognise they are living with a LTC / MH there is a clear recognition that this links them to other bad behaviours.
	• MONEY (dads) and not having enough, needing to provide no matter how much you have. For some is having a key impact on the health and wellbeing of the family. • For those families who are struggling, they recognise that it has the biggest impact on mental health first and foremost as well as not being able to do healthy things and choices.
	• FAMILY AND SOCIAL FRIENDSHIPS – (for mums) have a critical impact on families wellbeing and can have an overwhelming impact if there are problems. • At the same time, good relationships and support can be the thing that has the biggest positive impact on the wellbeing of a family. For many, nurturing and making time for family and social friendships is more important that any of the other things on the wheel

	• For those with a physical health problem, this was having the key impact on the health and wellbeing of the family. • For some a serious diagnosis had been the driver to make a change to healthier choices for all the family – in particular when the diagnosis is for men.
	• OTHER FACTORS: time, in particular to spend as a family, housing where people are unsuitably housed and use of social media, ipads, games – which is taking the need to communicate face to face away. People / children are experiencing things in virtual reality rather than for real.

Choosing behaviour to change

Using the completed Family Health Wheel Tool, families were asked to reflect on any behaviour they felt they wanted to change in the future. Families were asked to think about behaviour in terms of **stopping** it | **starting** to do something or **stopping a negative behaviour from starting.**

Many of the families did not like or feel that the term "stop" represented their family, as it suggested they had bad things they had to stop doing. However researchers continued using careful motivational conversation techniques to understand potential behaviour change goals within the family's context. This included re framing the question in a more positive way. Identifying a change and being committed to it are very different things, which we explored as the study progressed. Eg A father who scored himself as 7/10 for nutrition, picked 7 because he felt there was some improvement he could make to his current action, was a 3/10 in terms of commitment to change.

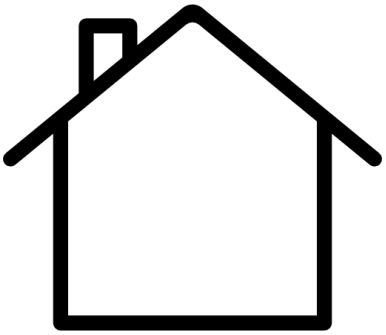
STOP	Most people had something they wanted to stop doing and had clear rationale and motivators to why. Participants acutely aware that they use unhealthy behaviours such as smoking, alcohol eating as a way of coping and dealing with stress and making themselves feel better. Smoking is seen as the number 1 behaviour to stop or change Food, although recognised as being used as a 'crutch' ' to feel better' or as a reward there is little desire or belief in ability to change this. Critical awareness and self awareness in stopping certain behaviours that result in a change in themselves that they don't like, or that can impact on their children. For example being drunk, being impulsive or being argumentative
START	There was an overwhelming recognition and ambition to start doing something to improve mental health, wellbeing or general self-development. • Be more happy- creating calmer environments • Learning- a new skill, music, reading • Earning money- saving for something • Sleep- sorting out sleep issues • *'me time'* Mental health, happiness, stress, anxiety and wanting to start doing something about it underpins all the wheel, but most marked themselves green for!! Generally across other behaviours sense of lack of commitment and motivation to start things and generally what we would expect people to say. Diet and losing weight were important to women. Wanting to start exercise or activity was a priority for many families for different reasons. Deeper conversation also suggests a variety of meanings to what exercise and activity actually are. It also highlighted the lack of awareness and knowledge as to what is enough? Is it making a difference?
STOP STARTING	Re: starting an unhealthy behaviour (such as smoking) that a family member had given up on was a common priority. Many examples shared of participants not wanting to start a behaviour that had an association of negative experiences they themselves had witnessed in their own childhood or within their family. This was particularly said by young parents who are very clear about behaviours they will not accept around their own children for example raised voices and violence or ensuring they do certain behaviours they never had for example wanting their children to always sit at a table for meal times.

TOPIC 2 – IMPACT OF THE WIDER SYSTEM

The importance of taking a whole system approach to change was increasingly advocated throughout this work. Behaviour change must move beyond the individual, to that of the wider system and how it can make it easier for the individual to 'do the right thing', rather than the wrong. This also includes how parts of the system are tackling important topics and issues, what this look like strategically and how it translates into practice at the frontline. Throughout interviews with both families and frontline workers there was clear evidence that for some behaviours we do not currently do this. The table below gives some examples

Regeneration/neighbourhood planning

"Its very hard if I'm honest. There is a Greggs and a chip shop opposite my house. So when I am late on the school run, because my meds makes me very sleepy. I don't get time to do them breakfast. We just pop into Greggs for a sausage roll. After school, I cant be bothered to cook, I cant pop in the chip shop and feed us all for under £5 as we can share the chips!"



Wellbeing

"Fast food outlets like MC-Ds and KFC as they provide opportunities for social interaction for the kids and this is really important to them, and me."

Availability of food

"I can get £20 of food for the week in Iceland, getting fruit alone would cost me about that"

"Eating take aways…. When I can feed the family at mc donalds for about £10 and only have to pop through the drive thru, don't even have to get kids out the car"

"Round here makes its so hard. Look today, I have got a lovely pie and chips for dinner with some ice cream for dessert. They cook that here for £1 so how can I say no."

Housing identified by some as having the biggest impact on their family – yet out of their control.

" I would love to be able to feed my child more healthy foods, but when your living in a hostel with no usable electrical equipment in the kitchen and no means of washing up, I don't have a choice, but to get take outs"

"Environmental health dealing with 'worms' in wall with private landlords, private landlords can get away with more"

Dads are kept apart from family due to housing situation

Work

"I work nights in the hospital and very rarely get time for a proper break, the only available for is from the vending machine outside the ward, which only sells crisps and chocolate bars"

Data sharing: Confidentiality where information cannot be passed- ie from social worker to probation officer. No one wants to know about the other person, very much dealing with own job.

CASE STUDY: "If it's not their job- they don't want to know".

Young mum feeling threatened and "pimped out" where she is living. The only staff member that she could tell because they all have specific roles could only be seen at 2.30-3.30 on certain days of the week. She therefore had to leave another appointment early, which was important as she felt she had to go to because she has to 'prove myself' but also had to deal with the issue where she was living with her children.

TOPIC 3 - ENGAGING WITH FAMILIES

Participants were asked to share their experiences of others engaging with their families, what worked well and what they didn't like. From these experiences researchers explored what families wanted in the future. The term "engagement" is considered a spectrum of things from a well-positioned leaflet to on-going support and advice to participation or regular attendance at a group of support service.

In terms of results we are sadly hearing the same kind of things being said about how people want to engage, how they would like to be treated and what they value. Common phrases such as '*don't judge me*' were a common reflection for many families. The examples from the interviews of missed opportunities at best are shocking, giving clear rationale as to why a systems thinking approach is the only option.

Families shared experiences where only the presenting symptoms were being considered making the conversation too specific and not looking at the wider case of the issue or problem. Many spoke about issues being wider than what they appear, wanting someone to help them think about how and why they got to where they are and what they could do- disappointed when offered tablets.

Results suggest a general lack of conversations on a range of topics and that information within waiting areas in Children's Centres or GP practices was the only engagement they had. Participants highlighted how sometimes stands, leaflets and display boards if well positioned and if the topic is on your radar could work well. However, these would only be helpful if the timing was right. For example following a conversation with a professional or a life event.

During the life course of children, parents spoke about lots of examples of engagement or contact when children are young and at primary school but then reflect that it then stops abruptly when children become older. Examples included contact with midwifes, health visitors and school.

WHAT DOES GOOD LOOK LIKE?

- A local asset that people use regularly for a variety of reasons- they know you for you, you get to know them and you build up trust.
- A connection with the person- you get on with them especially if you are looking to build a longer term relationship.
- Person centred- asking what I want, rather than what is assumed I need.

WHAT DOES BAD LOOK LIKE?

- "*Passive aggressive*"- made to feel like a failure
- Lack of understanding on real life situations- give '*advic*e *without knowing if this would work in my life'*
- Let down- all too often told will help but nothing happens
- FEAR
- To be nagged- everyone has something different for you to do?

WHAT COULD WORK

As we would expect responses to this question were very much dependant on wider behavioural determinants and where individuals were in their behaviour change journey. Although responses were very much an individual thing, 'who' they felt should be offering support fell into three categories.

1. **Professionals:** *'GP- is obvious and if you trust him is the best but you don't often see your GP and how could this a preventative measure?'*
2. **Social Network:** *'Family- and only family. They will understand, keep it within, especially "tightknit"'*
3. **Wider Community:** *'Everyone and anyone- friends, school, mum even the pub'*

This segmentation can be further validated and explained by the Personas in Appendix 4.

There were also some general observations and messages supported by all the families, which need to be observed across the range of engagement methods used. **The most Critical of this is that both the message and messenger must be appropriate and what a family would expect.**

'A teacher shouldn't give advice on obesity, my GP doesn't teach me sums'

How conversations should be handled differs depending on the topic or specific behaviour. With conversations about topics such as smoking, drugs and alcohol participants felt that the message if often clearer often with simple and regular messages being heard in many ways and experiences shared suggest professionals are sensitive about the topics. However with other behaviours such as obesity and activity participants felt '*judged*' and seen as '*lazy*'.

Insights from conversations with a small number of front line workers about their role and challenges in engaging on health behaviours documented within this report supports the comments made by families.

TOPIC 4 – MISSED OPPORTUNITIES

The most apparent missed opportunity identified across this cohort was around the contact and 'engagement' families and individuals were having with frontline staff, interventions or services. Although there were plenty of opportunities where contact is made, in many of the examples given by the families this privileged time was not used to its full potential. Support was often just around the expertise of the worker, or only about the issue they were dealing with, with very little additional conversation to understand better the wider situation for the family and why things may have changed for them.

CASE STUDY

I am a 21 year old young mum with 3 children, aged 5, 2, and 1. I have lived in my 2 bed flat for the last year, which isn't very nice. I have always had problems with damp and bed bugs, but no one has helped me to move. We are on the council waiting list for overcrowding and I bid all the time, but I don't get anything!

Last August out of the blue I got an eviction notice, I had no idea what to do! The letting agent told me that the landlord wants to refurbish and re let for more money. I can't read very well, and I don't like speaking to people, because they judge me, so I continued my life as normal and pretending it wasn't happening. I would take my eldest to school every morning; the school knew about the living conditions, as my son had bed bug bites, I had to tell them about it. I would attend my young mums group on a weekly basis at the local children's centre, where I had been going for the last 4 yrs. I would talk to the other young mums within the group about what was going on,

and I did speak with the leader, who told me to take the eviction notice to the council. I did this with a friend, but nothing happened.

As the months went on, I then got the bailiffs letter telling me I would be removed from my property after Christmas! I was going to be homeless. I have no family or support, all the local council told me to do was keep bidding and wait for the eviction date then go to the council on that day.

In December, I didn't go to my group, my brother, who also goes called me to say that the housing lady was coming to speak to the group and I should come, but I was told I couldn't because the children were with their dad that day!
The week before the eviction, the support worker from the school came to visit at the flat, she could see the conditions and I told her of the eviction, but they didn't do anything. The same week I went to my group very upset, as I was at the end of my tether! My leader got someone from the children centre to speak with me, she rang Porchlight, but the advice was to sit and wait for the eviction date. I had 3 small children and don't know where we are going to live next week and all I can do is wait!

There were also a small number of examples where the standard of this contact had a negative impact on behaviour of families.

"I had a panic attack and the paramedic said it would be too stressful to stop [smoking] as I was pregnant so I continued to smoke" Mother who had serious complications with previous pregnancy.

TOPIC 5 - THE ONE THING

During the planning phase of this work it was suggested by stakeholders that it would be helpful to include the following question;

'What is the one thing that could make a difference to you and your family now?' (health, wellbeing and happiness'

This question was asked to all families at the very end of the conversation, it was a useful way to reflect on discussions, summarise and end the interview.

Response to this question fell into two very distinct camps. One group felt there was nothing they needed or wanted that was significant to improving the health, wellbeing or happiness of their family. They felt they had what they needed, had the right support around them and had the skills and resources necessary if the situation would change.

In stark contrast to this, those in the other group gave examples of '*one thing'* that would significantly impact on their children's health, wellbeing and happiness. These examples were not '*out there'* but simply where a person's basic need is not being met, the situations of these families were very much examples of Maslows Hierarchy of Need.

TOPIC 6 – PROACTIVE CARE – VIEWS AND PERCEPTIONS

The concept of pro-active care was introduced to families towards the end of the conversations. Families defined pro-active as ***'a trusted professional, a family member or a friend raising a concern with you because they were worried about an aspect of your health or your children's health now or in the future*".** They agreed in principle to this, and as previously mentioned all families interviewed felt there was an obligation for the professional to talk about a health issue if

they were concerned. This concept became more complicated when exploring the roles of friends and families, including how the individual might do this and acceptability of the conversation.

The role as a friend or family member

Undertaking a pro-active conversation with someone was deemed acceptable adult to adult, for example if you were concerned about your friend, sister or neighbour. Although those interviewed felt that it would be more important to do this if your concern was about a child, it was felt the realty of doing it was not likely. The biggest reason for this was not wanting the individual to think there were judging them.

"I'd like to think I would because of the guilt if I didn't….. but it's like I'd be saying you are a bad mum, its really hard"

Acceptability of the conversation

Whilst it was agreed it was easier to have conversations about a concern for an adults health, there were topics that were deemed unacceptable or '*off limits*'. In line with national research talking about someone's mental health was felt too difficult, however using language and topics such as stress and anxiety would make this conversation '*more normal*'. Behaviours that were linked to an addiction such as alcohol or smoking were both easier to have the conversation, and acceptable to hear as it was felt the person would be more emotive to the situation.

There was a unanimous agreement that talking about someone weight or the food they ate was off limits.

"If I said to the wife you're getting fat, well I just wouldn't my life wouldn't be worth living'

"It would open up a whole can of worms what if she got an eating disorder'

Trusted professionals

To reiterate, there was strong agreement and expectation from all families that a professionals should tell them if they were concerned and there were no topics that were off limits.

CASE STUDY

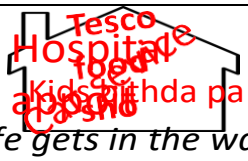
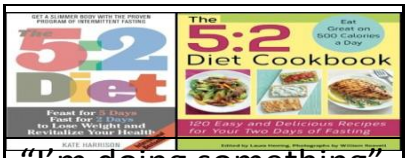
"It was not that long ago that I had issues with alcohol. I'd like to think it just came out of the blue overnight but looking back it didn't. My friend, who I worked with was my rock. I told her that I was having problems and it was affecting my work, I decided to leave. She was so supportive but very worried that I was now at home all day and could drink. She was very honest and told me straight that I was not taking care of things that were my responsibility, like looking after my dogs.

This hit home and I got the support from rehab I needed. When I got better and back home, my friend came round and she could see I was struggling to get do things because I had put on so much weight. She tried to tell me that I needed to get help for this, but I thought she was being horrible! I know I'm fat and need help, but I don't need someone else to tell me! I don't think it's any of her business, it doesn't affect her"

7. WHO ARE OUR FAMILIES? - INTRODUCING THE PERSONAS

The following personas have been created to demonstrate some of the key themes identified during the work, they are therefore not fully representative of the cluster. The personas aim to portray the very real contrast of people and families that we met, and the need for person centered design and delivery of services and interventions.

The table gives an **overview of the personas**, more detail such who they trust pressures and barriers | motivations | engagement what would work | and missed opportunities can be found in appendices.

‘Readiness’ to change	What do we know?
 In denial	This group does not believe their body will fail them ‘it wont be me’, often guided by social media or the news.
 *“Life is crap”*	Chaotic life, rarely trust the system. Often having to fire fight situations, other things will take priority.
 *“Life gets in the way”*	Recognise the need to tackle some health behaviors, often at the 11th hour something else will take priority.
 *“You think you know me”*	Expectation that family will have awareness, often due to having previous children, where they live, age or profession. This group are often making poor choices due to time and stress.
 “I’m doing something”	Doing something, but is it enough? lack commitment even though they are aware of the issues they are living with.
 *“Not sure what I’m doing is right”*	This group very quickly change behaviour, but often want reassurance about what they are doing, and seek perfection which if not achieved will put them off.
 “Don’t want to die, I’m doing something now.”	Very quickly make a change due to an event, eg heart attack. Often the ones ’in denial’ previously.

8. INSIGHTS FROM FRONT LINE WORKERS

During the course of the study an additional small range of front line workers (housing, Children Centres, healthy living and community centres, health professionals) were invited to take part in a short interview. (15 interviews in total) The interview aimed to gather workers views and experiences on their role in relation to supporting families in improving their health and wellbeing, what they believe works well and the challenges they face. Key themes from these interviews are as follows:

TOPIC 1 – YOUR ROLE

- To deliver what they are commissioned to do as targets to get rather what the people want.
- Some believe that it is their role to talk to families about health and wellbeing, but they are worried that they don't have the knowledge or correct information.
- Some just don't believe it is their role and it is someone else's job.

TOPIC 2 – WHAT WORKS WELL?

- Systems working together and where possible all under one roof
- Dedicated group displays providing information about health and wellbeing.
- Bringing someone else in to talk to families.

TOPIC 3 – CHALLENGES

- Funding.
- Perceptions and prejudice can lead to assumptions and judgments being made that can lead to missed opportunities.
- Some topics are more emotive or unacceptable to discuss and others have very clear messages, which enable easier conversations

- Pigeon hole people so much that they can't deal with it until the right time
- Lack of understanding from the top level, of what is happening locally
- Mixed message confusion
- Continuity of care and challenges of information sharing
- Pressured workload, paperwork and data collection is becoming the priority

QUOTES FROM FRONT LINE WORKERS:

" I don't mind telling them the shouldn't smoke or drink, but telling someone they are overweight is so much more difficult. I don't want to upset or offend them"

"We should be having conversations with mums about eating healthy during pregnancy, but the information changes all the time, and we get no extra training, so I worry about given the wrong information"

"I assume she knows about healthy eating, and if she is slimmer than me I feel like a hypocrite!"

"We do sign post a lot. WE work closely with SSS, and the exercise referral team. We can also get a lot of mental health issues, but we are not a counselling service, so we just refer back to GP, or KMPT."

"Its easy to talk about a topic your passionate about, but when it comes to one that you don't necessarily relate to, I tend to brush over it!"

"It easier to have conversations around smoking or drinking because everyone knows that smoking is bad for you, so you shouldn't do it, but when it comes to healthy weight, you have to really know your stuff. Should you cut out sugar or fat? should you eat so many calories or exercise more?"

"The amount of paperwork we receive is too much. Before we have even spoken to the client, we need to get them to Sign a consent assessment, Risk assessment, Clients charter-rights and responsibilities, then their goals achievement. The mental wellbeing scores need doing. Then on leaving an exit form"

"How can I start speaking to my clients about giving up smoking when their mental health is fragile? I would rather turn a blind eye to that, so I can focus on their wellbeing"

"We are doing smoking as a topic in the next few weeks, we can discuss it when that comes up"

9. CONCLUSIONS AND RECOMMENDATIONS

This summary report provides the key findings from the recent interviews conducted with families in Kent. We offer the following conclusions and recommendations for discussion rather than final commentary. This project originally to provide a user /stakeholder voice within the JSNA process has had a long and interesting journey over the past 18 months and this section of the report should be reflective of the final objectives for the support and study. Draft conclusions to be considered through discussion both at the KCC Public Health DMT meeting in May. This section of the report is therefore in grey.

DRAFT CONCLUSIONS FOR DISCUSSION – ALONGSIDE OBJECTIVES FOR INSIGHT STUDY:

- **OBJECTIVE: Family views on the health and wellbeing of their family and what impacts on this.**

  Health and wellbeing is important to families

  Families were not incentivised for their involvement in the work. Not only were families willing to share their experiences they **welcomed the opportunity** to talk about their family in a way they have never done before. The conversation was like a brief family coaching intervention with all recognising that it had been a positive conversation, that their self-awareness was improved and some also reporting that they felt motivated to consider making a change within their family as a result.

  Wider determinants are severely impacting on some families (in this cohort) ability to change their behaviour.

  Most of those interviewed were at the 'contemplative' stage of change (Trans theoretical Behaviour Model), meaning whilst they realised and had awareness they were still ambivalent about change. In the case of our families, living within the targeted areas with high deprivation, the cost/benefit to them of doing behaviour vs not had not yet been made. At it's most severe basic needs are not being met for some of the families and yet the bigger formal system continues to try and change some behaviours without addressing these basic needs.

- **OBJECTIVE: Family perceptions of what is healthy.**

  Perceptions of smoking and the importance of stopping smoking were very clear (and perhaps offer learning to other topics such as obesity and healthy weight)

Perceptions of what is healthy on other topics such as healthy eating, weight and activity very confused and unclear for majority of family segments (personas). There is little understanding of how these behaviours impact on long term health.

- **OBJECTIVE: How families could improve their overall health, wellbeing and happiness**

Early health prevention work with a family focus is key to changing long-term health.
Ideally, a focus would be early in the life course and would be about stopping children from ever starting unhealthy behaviours that they will later need to stop or change as an adult. However, this piece of work has highlighted the need to take a family focused approach given the high impact behavioural determinants such as attitudes, beliefs and social norms have had. We cannot change the behaviour of our children, if we do not work with the wider families also.

Engagement with our families must be meaningful, at the right time and by the right person.
There are so many privileged opportunities the system has to make its contact count when engaging with families. Current experiences of engagement are often failing due to: professional silos, providing critical information too late, leaving families to reach crisis point or not picking opportunities up at all. Poor engagement (as shared by some interviewees in this study) at best impacted on the levels of trust for the individuals but at worst had the opposite effect often pushing individuals to do the wrong thing or make wrong choices.

The way forward must include a Whole Systems approach
By putting the person at the centre and valuing the contribution all parts of the system (from Tier 4 Specialist through to Tier 1 – Universal) can make to improve and impact on health. The current system at times does not support us to make the right choices. It is only by taking a whole system approach we can work with parts of the system to make it easier to do the behaviours we want. Further exploration and analysis is needed to understand where the system currently works together, and we perceive it to be 'joined up' but is actually working against families. This applies in particular with families living with multiple issues including housing; the system sometimes does not support them to address these and instead focusses on a single issue only that they are involved with which can lead to a family having to make hard choices. In the earlier case study of the family due to be evicted and told to present at the Council at 9.00 am, the family had the additional issue of ensuring that the children were at school that day or risk them being reported for absence. In this case, the school were aware of the living conditions of the family and of the up and coming eviction.

- **OBJECTIVE: Families priorities and what changes they might like to make in the future.**

Mental health and wellbeing were a re current issue for families.

However these areas were only recognised across other behavioural topics such as alcohol, sleep, weight rather than when discussing wellbeing directly. Family 'happiness, friendships and relationships' and in particular for children are a top priority.

Families are clear on their priorities when offered the time to reflect and improve their self-awareness and open to help and support.

RECOMMENDATIONS (ACTIVMOB RECOMMENDATIONS ONLY WHICH NEED TO BE DISCUSSED AND DEVELOPED AGAINST PRIORITIES FOR DMT AND STP ETC)

1. **To <u>support behaviour change</u> in this cohort of families using the insights we have which offer more clarity around who the 'audience' or community is, what motivates them and what is the offer that could be tested.**

    - Identify a focus / priority. (ie area / behaviour / cohort)
    - Work with families to help them **raise self-awareness**, similar to Activmob Awards for All - Lottery Funded- 'Family Coaching Pilot'.
    - Consider what will support families to move from contemplative to planning to take action, targeting interventions to make a shift.
    - Use 'personas' to test out how different people and families would perceive and respond to different approaches.

2. **To <u>develop training</u> and support for trusted assets- frontline staff**

    - Training to support staff in having motivational based conversations to raise families ability to become more **self aware of current position**, understand what drives their perceptions of health and wellbeing, how to help families set goals etc.
    - To be able to recognise and identify where they are on the cycle of change, and how they can move them further along – using **personas from this study**.
    - A clear message, that support families in the same way

3. **To share <u>insights and personas with key stakeholders</u> across the whole system.**
    - STP Prevention Group / DMT

- Commissioning of services and support for families - explore how mental health and wellbeing services such as Live Well Kent can support and work with other topics such as healthy weight, activity and relationships.
- Encourage discussion on RECOMMENDATIONS and next steps
- Consider and understand how these insights for this cohort sit alongside other insights and programmes such as One You.

4. **Whilst there was no significant difference in insight across the 3 areas, further validation of key findings and themes may be needed if this was to be used wider.**

10. FINAL THANKS

Our final and special thanks go to all the families who gave their time freely to share their experiences and insight.

11. LIST OF APPENDICES

Appendix 1 – Briefing Sheet – used for families
Appendix 2 – Topic Guide – used for family interviews
Appendix 3 – Activmob Family Health Wheel – adapted from Activmob master and used during interviews with families.
Appendix 4– Personas
Appendix 5 – Activmob Family Health Wheel – Fact sheet