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A thematic analysis of local people's views in relation to service provision within Sunderland tPCT

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SECTION 1 -BACKGROUND

Sunderland is looking to develop an integrated wellness model which will provide a holistic approach in addressing multiple issues and facilitate easy access and support into services for priority groups. The aim is to provide accessible, seamless services responsive to those in greatest need - a population approach that feels personal to the user.

An integrated approach could result in wellness services being embedded in a wide range of services. For clarity, services addressing the following issues will be within the scope of this development.

- Smoking
- Physical activity
- Nutrition
- Weight management
- Substance misuse
- Sexual health
- Emotional health and wellbeing
- Health checks.

In addition, given their impact on wellness outcomes, links to the following wider determinants of health will be considered: -

- Financial support – benefit and debt advice
- Support to employment
- Housing.

Part of the national vision for local government leadership of public health is about tailoring services to individual needs and basing service provision on a holistic approach. This development of wellness services focuses upon wellness services that address multiple needs and using new technologies to develop services.

A working group met for the first time in March 2012 to scope out the need for and first steps of the development of integrated wellness services in Sunderland. The group considered the initial scope of the services and the next steps. The aim of the working group is to develop the model which can then be passed to commissioners to develop specifications and procure the service. An integrated approach could result in wellness services being embedded in a wide range of services.

There is currently a range of services and pathways addressing these issues but with little recognition that services are often attempting to reach the same people. Moving between services is not straightforward and will often require people to have a range of visits to different service providers. Equally, however, there will be a limit to the degree to which services can be integrated. Some of the services listed above have an element which is clinical and/or highly specialised and so may be more difficult to integrate into other services. In these cases, the aim might be to improve signposting or outreach.

Critical in all cases is the way in which services engage with individuals, families and communities, building on the contributions made by existing organizations. Key to this approach will be the segmentation of the population and how this is addressed. The working group has defined the principles on which the system and individual services will operate. These are summarised below but will need to be developed in greater detail as the approach develops.

System	Providers
• Choice • Needs led • Targeted (Proportionate universalism) • Joined up • Shared information (with appropriate governance) • Aims and outcome focused • Life course	• Local/area/community of interest based approach • Cost effective • High quality • Shared goals for providers • Diversity leading to new ways of engaging • Transparent • Fluidity of movement between services/interventions

1.1 Structure of the report

A brief overview of the project aims and objectives follows: this outlines the process by which the secondary data was analysed. The findings from the analysis are presented in a summary section which reads as a synthesis of the key themes across the areas in which reports are held as detailed below;

- Drugs and alcohol
- Health checks
- Mental health
- Obesity
- Women's services
- Young people
- General population

The relationship between the data and the principles of the integrated wellness model are mapped out specifically focusing upon what people want

from services, and finally the issues for consideration are outlined in the concluding section. The appendices follow the conclusion, in which the findings from the thematic analysis of each document are outlined and summarised on a detailed report by report basis. The summaries provide background information with details of relevant themes and feedback highlighted in relation to why people are not accessing services.

1.2. Project aims and objectives

The primary aim of the project is to develop a clear analysis and report of the common themes of what local people want from services, especially groups such as hard to reach, men, young people, people living in disadvantaged areas, routine and manual workers, unemployed This will be completed via a thematic analysis of all the current information the Sunderland Public Health department holds from local people on services and programmes such as Stop Smoking Service, NHS Health Checks and social marketing report on stroke and cervical screening. This information will help us to shape services to meet local need and develop a model which can then be passed to commissioners to develop specifications and procure a service. This collation of information will be used to shape service specifications and the development of a model of wellness.

The project objectives are:

- To review all current information held by the Sunderland Public Health Department from local people in relation to existing services and programmes.
- To produce a final report detailing the key findings from the thematic analysis of secondary data.

1.3. Thematic analysis approach

The secondary reports will be analysed using a qualitative thematic approach. At the heart of qualitative data analysis is the task of discovering themes. The documents (and where possible raw data) will be read and re-read to identify common areas of what people want from local services. Thus, the analysis carried out will be a circular process of describing, classifying (1) and articulating the voices of those who have contributed to the existing documents to discover regularities, variations and singularities (2) in relation to the perceptions and attitudes that individuals hold towards service delivery. These themes will then be synthesised in relation to the concept of an integrated wellness model.

SECTION 2 -DATA SYNTHESIS

- **Drugs and alcohol services**

Service	**Barriers identified**	**Suggestions for improvement**
Smoking	No data about this	Increased partnership work Learning from others – best practice from other service providers Use social marketing methods Engage specific target groups such as pregnant women and men and BME Tailored service for different groups e.g. young people Improvements in targeting the service • Be able to contact service by phone • Variety of locations (GP's, community) • Advertise service – GP, TV and newspapers Provide 1 to 1 support
Drugs (female users)	Lack of awareness Service Family Access Perception and fears	Development of an integrated service Easier access Service improvements

- **Health checks**

Service	Barriers identified	Suggestions for improvement
CVD Services	Knowledge Accessibility Perceptions Culture Terminology	Be able to attend without appointment Range of locations for service delivery Improved communication Marketing that is direct concise and clear is preferred Tailored communication for different BME groups
NHS health check for CVD	None.	Check could include looking at other health issues – broadening the scope Improved communication
Workplace health check	Communication Practical barrier Support from line managers Concerns and attitudes	Improved communication – more sensitive approach to lifestyle changes suggested More wide-spread communication Encourage recruitment Prolonged support

- **Mental health**

Service	Barriers identified	Suggestions for improvement

Needs of LGBT in shaping services	Lack of awareness Perception of services Service provision Perceived problems with staff Availability of generic vs. specific services Lack of equality and diversity training and monitoring Lack of awareness of broader issues e.g. domestic violence Lack of recognition of different needs Lack of role models within services	Promotion of visibility of LGBT services and communities needs Development of more specialist services Tackling discrimination Building capacity to engage groups Partnership working and development of best practice Monitoring of service use tied to commissioning practices Targeting of young people Work on the needs of the transgender community
Needs assessment of BME communities	Gender Knowledge/awareness Lack of opportunities Support Language Staff attitudes	*Barriers need to be addressed* Increased accessibility of services Overcoming language barriers e.g. translated material and interpreters Monitoring Collaboration with BME communities Work on specific needs of asylum seekers/refugees Targeted promotion of mental health in the work-place
Needs assessment of South of Tyne and Wear, Gateshead, South Tyneside and Sunderland	No barriers identified but a range of areas of need identified such as Deprivation Social isolation Education	Development of social enterprises Availability of more group support Developing services that are appropriate

	Employment Housing Lack of physical activity Lack of healthy eating Alcohol misuse Substance use Sexual health Life expectancy Domestic violence Groups with different needs – BME, LGBT, Offenders and ex-prisoners, older people, young people	Working in partnership Communication campaigns Working within communities

- **Obesity**

Service	**Barriers identified**	**Suggestions for improvement**
Sunderland exercise referral and weight management programme	None	None – service has continued to evolve and develop.
Sunderland lifestyle, activity and food programme	Denial of a problem Accessibility	Support for maintenance Increased referrals via partnership working
Sunderland weight management programme	None	More wide-spread promotion Increased length of programme Changed location for easier access Change in service e.g. be allowed to repeat the programme, be able to include family members to increase support.

- **Women's services**

Service	Barriers identified	Suggestions for improvement
Cervical Screening	Levels of knowledge Experiences of screening Accessibility of screening	Raise awareness Changes to service opening hours, and a more friendly atmosphere Changes to staffing e.g. female practitioners
City Hospital maternity patients –patient experiences	None identified	Breastfeeding support Preparation for pregnancy and labour Preparation for discharge Improved care – maternity and post-natal Changes in health visitor provision More support for first time/young mothers
Sunderland maternity services liaison committee – patient experiences	Phone calls not returned by health visitors	Changes to appointments Increased support Increased continuity of care Better staffing

- **Young people**

Service	Barriers identified	Suggestions for improvement
Specialist community	Access and	Changed location,

child and adolescent mental health and learning disability service	appointments Out of hours support Staff Promotion of the service Use of language Stigma	single point of referral, reduction in waiting times One key worker per patient Publicise the service and use jargon free words/material
Sunderland risk and resilience consultation	None	Need increased support Needs increased marketing of services Need increased education in schools around emotional well-being Staff training – non-judgmental approach
Your health initiative	None	None
Tellus3 Local Authority Report	None	Need more information on healthy eating, alcohol and smoking, sex and relationships and bullying
Health behaviour survey	None	Children reported that they were more likely to talk to their family rather than services, therefore the need for parental education to help children could be explored in future work.
Your Health survey	None	Use internet to communicate information
Young people's health conference	Not aware of services in some areas and how to contact them Worried about confidentiality	Changes to services, out of hours, more local services, Extended provision e.g. of sexual health services Raise profile of services

- **General population**

Service	**Barriers identified**	**Suggestions for improvement**
Stroke Awareness	Awareness Cultural issues Language and terminology Attitudes and perceptions Appointments	Increased knowledge and awareness Individual targeting of services Changes to communication
Health Champion Evaluation Report	None.	None – health champions have been identified as effective in sign-posting to existing services.

SECTION 3 - OVERVIEW OF DATA IN RELATION TO INTEGRATED WELLNESS MODEL

In order to develop an Integrated Wellness model the key themes highlighted by this thematic analysis are now mapped against the principles of the approach already highlighted by the working group (see section 1).

Table 3.1 – Integrated Wellness Model as a system

System	**Mapped against thematic data**
Choice	The data analysed shows that service users in a range of areas would like greater choice. Service users suggested changing locations of services to increase accessibility and extending open hours to account for work and other (e.g. school) commitments. Having services delivered in community locations was also suggested.
Needs led	The thematic data shows that some groups feel that their needs are not being met. For example, the LGBT community felt that services do not meet their needs in some areas e.g. in relation to emotional support and domestic violence. The BME community highlighted issues in relation to language barriers and cultural barriers. Young people were often unaware of what services they could access, and thus were not having their needs met.
Targeted (Proportionate universalism)	The data included in this area demonstrates that there needs to be targeting of services to deal with specific health problems as well as specific communities. Needs assessments included in this analysis show a variety of determinants of health, as well as specific needs in relation to communities such as BME, LGBT and young people.

Joined up	The thematic analysis also showed that partnership working is required in several ways 1. To better provide services and reduce need to points of contact 2. To encourage learning from best practice in any area (local and indeed national)
Shared information (with appropriate governance)	The thematic analysis showed that service users have concerns about stigma, the perceptions of them held by staff and confidentiality. Staff training can help to deal with changing perceived stigma. In addition, information sharing needs to be handled sensitively. This links into developing effective partnerships for service delivery.
Aims and outcome focused	No data from the thematic analysis relates to this area. However routine monitoring and evaluation can be used to assess how service provision is related to the aims and outcomes of the integrated wellness model.
Life course	There are differential health needs across the life-course and the thematic analysis shows that service users are concerned that these are not always recognised. For example, young people's needs are different to those of older people. Women's needs also change in relation to their reproductive health. Young men are more likely to smoke etc. Thus, services (wherever possible) should be designed to account for changing health across the life-course. Effective needs analyses should feed into the process of tailoring services appropriately across the life-course.

Table 3.2 – Integrated Wellness Model provider roles

Provider role	**Mapped against the thematic data**
Local area/community of interest based approach	The thematic analysis demonstrated that service users were interested in

	having more community located services and in capacity building. For example, the LGBT community suggested capacity building to improve engagement. BME communities also suggested working in collaboration with service providers to improve existing provision**.** Some services may also need to be increased in terms of their availability e.g. weight management services need to work with their community of interest for longer.
Cost effective	The thematic analysis did not report findings related to cost effectiveness. However, increasing partnership working and reducing overlaps in service provision will be useful in increasing cost effectiveness. Some service provision could be broadened in scope to address more health needs. Regularly monitoring and evaluating service delivery will help to assess cost-effectiveness.
High quality	Identification of current barriers to the use of services can be used to inform quality developments. For example, in some areas the need for staff training and greater sensitivity to service user needs was identified (LGBT and young people). Engaging with communities and capacity building are also useful tools in achieving quality improvements. Change management strategies should also pay attention to staff motivation and attitudes as these are important in relation to quality.
Shared goals for providers	The need for partnership working was clearly identified by the thematic analysis. Such partnership working can be facilitated via the provision of shared goals for providers, as well as routine monitoring of the effectiveness of current partnership mechanisms.
Diversity leading to new ways of engaging	A key theme around communication has emerged from several data sets. Thus strategies for engaging and promoting services need to be

	explored and diversified. Social marketing was suggested as one mechanism to engage. Communication needs to be sensitive, and tailored to different groups as approaches for young people, BME and LGBT communities should be different. Using the internet as a communication mechanism was suggested by young people. Working within communities should be used as a strategy to engage.
Transparent	The thematic analysis did not report any findings labelled as transparent but the theme of communication was identified throughout. Transparency can be improved by changing communication methods and referral processes, identified via the thematic analysis. The suggested changes in communication and marketing of services identified by users are also important here in raising awareness of service availability, and thus increasing transparency. Changes made in relation to delivery related to rationing also need to be clearly communicated to users.
Fluidity of movement between services/interventions	Increased partnership working can contribute to improved fluidity of movement between services, with effective sign-posting also important as part of this process. However, this needs to be achieved in a way which does not breach service user trust. Changes in delivery and referral should also be considered. For example, some service users suggested a one stop shop of community based provision, whilst others suggested a single point of referral to facilitate easier access.

SECTION 4 - CONCLUSION AND ISSUES FOR CONSIDERATION

This report has presented the findings of a thematic analysis of several reports in order to help inform the development of an integrated wellness service within Sunderland. The thematic analysis particularly reported upon the barriers which prevent people from accessing services and the areas in which services could be improved. The development of an Integrated Wellness Service needs to consider

1. How to address existing barriers to service provision. Service users identified issues with locations, times of provision, accessibility, stigma and staffing.

2. How to improve the provision of services in relation to delivery that meets service user needs and expectations. Methods of communication and advertising should be revisited, and consideration should be given to the tailoring of services in appropriate areas.

3. How to diversify communication strategies to increase awareness of services available and to reach particular groups such as BME and LGBT communities. Language barriers, cultural differences and sensitivity to LGBT needs, all should be considered.

4. How to develop models of good practice and partnership working to support quality service provision in all areas. This approach needs to be implemented within a shared system that facilitates trust amongst service users.

5. How to develop a model that can effectively account for the social determinants of health. The aims of the wellness model refer to these, and needs assessments also demonstrate the importance of a range of social determinants within the area. Therefore, services should be broad and encompass provision which moves beyond a limited view of health.

6. How to work with commissioners in relation to service delivery. Service user needs should be communicated to commissioners via the development of a clear communication and feedback pathway.

7. How to work within communities. Service users identified specific needs within their own communities, as well as accessibility issues. An integrated wellness model should consider service provision within

communities. The role of health champions as a communication and sign-posting mechanism is a good starting point.

8. How to maintain services in relation to user needs. Whilst the financial landscape underpinning service provision is changing, the length of service provision should be considered. For example, in some areas such as those relating to long term conditions and obesity treatment, service provision needs to allow an adequate length of time to deal with the issue and maintain individual progress.

9. How to lead the required changes in implementing a new model of service delivery. Implementing new provision means that change management will be required in order to ensure that staff remain motivated and engaged in any changes to provision.

10. How to monitor progress. There needs to be routine monitoring and evaluation of the integrated wellness model to assess how the programme is meeting its intended aims and outcomes, as well as the needs of service users.

SECTION 5 - APPENDICES

5.1 DRUGS, ALCOHOL AND SMOKING

Access of NHS Stop smoking Services in 2009-2010- Sunderland results

This report presents the results from a Health equity audit of access to smoking services in SoTW, where significant inequities in health were reviewed with access to effective services and outcomes. Under-represented Population groups were identified.

Table 5.1 –Summary of access to services

Rate of accessing services	Rate of access by gender and age	Rate of access by broad ethnic group	Rate of access by Mosaic group	Rate of access by socio-economic group
In 2009-2010 there were more successful quitters per 100,000 population age 16+ in all three areas (South Tyneside, Sunderland and Gateshead) than the average for England South Tyneside had the highest rate of access per 1000 population Access to intermediate advisors	More women access Stop Smoking Services per 1000 smokers aged 16 + and over per year in each area Men are underrepresented among service users particularly in Sunderland Wider health inequalities due to cancer among the Sunderland population and among males make it more important to engage with these groups. There are low rates of access among young adult males aged 16-34.	Low access rates to intermediate and specialist advisors in Mixed, Asian or Asian British, Black or Black British and Chinese or Other. There were no Black or Black British smokers accessing specialist advisors in 2009-2010 – only intermediate advisors (14/1000 population to intermediate	Need to identify those Mosaic groups where there is low access and lots of smokers For example they identified that young well-educated city dwellers (3300 smokers) And old owner occupiers in older style housing in ex-industrial areas (7500 smokers) have high rates of	Rate of access is either equitable across all socioeconomic groups or slightly higher among disadvantaged groups The balance of service provision is particularly fair in Sunderland Looking at rate of access by residence in Sunderland there are below average rates of access in Hendon, Ryhope, Pallion and St Chads where there is a high

for smoking cessation advice was just under double that of access to specialist advisors in all three regions	• Specialist advisers are successfully engaging with young women but young men are under-represented. Young women seem to be the community of interest due to the high prevalence of smoking within this group Men are under-represented across all areas of South of Tyne and Wear, but particularly in Sunderland – of particular concern because of the recent rises in early mortality rates in cancer among men in Sunderland Early mortality rates due to cancer among men in Sunderland have been rising recently.	advisors) People from black and minority ethnic groups are under-represented among service users, but intermediate advisors have been more successful at engaging with these groups The shortfall is small as a proportion of all service users but high compared to current BME users Comparing service users from BME groups to expected service users if BME groups access services at the same rate as the White population, In Gateshead there are 20 service users from BME groups per year	smoking yet low access rates Suggested that they hold focus groups to understand these groups' attitudes towards services and find out if it is awareness, accessibility, availability or acceptability that is causing low uptake Promotion – work with marketing staff to design promotional material that speaks to these groups Send out the materials to addresses in those postcodes where the groups are concentrate d	prevalence of smokers These areas have a high health need but also means there will be a large potential customer base There are providers locally but it is suggested that they could be re-energised with refresher training Asks the question if there are any potential outlets in these areas that could deliver intermediate advice

		compared with 100 for expected services users if access was the same as the White population20 compared with 250 in South Tyneside 40 compared to 180 in Sunderland		

Main findings

Table 5.2 Information on how to improve stop-smoking service

Areas to develop	Suggestions
Groups to target	Only one quarter of pregnant women who smoke are engaged by the Stop Smoking Service- engage more pregnant smokers? Males' under-represented, particularly young males. Cancer mortality is higher and inequalities due to cancer are more significant among males BME groups are under-represented among service users. Need to attract 140 extra BME service users each year in Sunderland for fair representation Young people and people from more disadvantaged communities find it harder to quit- Can these groups be given a different offer? Rate of access is higher among more disadvantaged groups or equal depending on area and service type Need additional provision or re-

	energising or retraining providers in Ryhope, Pallion, St. Chads and Hendon in Sunderland Could marketing campaigns target the Mosaic groups where there are lots of smokers but low access
Learning from others	Sunderland Specialist Advisors achieve quit rates 10% above SoTW averages across all different socio-economic groups – what are they doing differently?
Using intermediate vs. specialist	Intermediate advisors lose more people to follow-up but resulting quit rates are not significantly different to those achieved by Specialist Advisors (except in Sunderland) BME population tends to go to an intermediate advisor Where quit rates are high what are local intermediate providers doing differently Specialist advisors are effective in engaging young women. Older women seem to prefer intermediate advisors. Neither are successful at engaging young males

Engaging females in drug services 2011

No methodology or background is detailed in this report. There were interviews/focus group conducted with 17 drug service users in Sunderland.

Table 5.3 - Reasons for not accessing treatment

Barrier	**Themes supporting (number of respondents)**
Lack of awareness (numbers of respondents)	Unaware of specific services (22)- greatest response
Service	Couldn't provide what they wanted at the time (7) Lack of communication from staff, e.g. ringing social services without communicating what they are doing causes distrust

	Reputation of Sunderland Drug service is not good according to some respondents
Family	Do not want partner/family to know (3) - Worried about what family may think if they find out they're on a methadone programme for example Partner won't let them attend (1)
Access	Employment, can't take time off work, be late for work or be seen standing outside a chemist (1) Where the service is e.g. Chemist being too far away for methadone for example - makes it easier just to buy them off the street (1) Service opening hours (1) Too young (1) Cost e.g. cost of rehab (11) Cost of transport (2) Homelessness- e.g. nurse cannot come out to them if they have no home (3) Too busy to "sit down for hours on end in those places" (drug service)
Perception and fears	Didn't want to be labelled (2) Fear of being registered as a drug addict as the police would "hunt you down" – fear of drawing attention to themselves Previous negative experience (3) Sexual orientation issues (2) May bump into old acquaintances (1) Lack of trust as they may ring social services

Table 5.4 summary of what the service needs

Area for improvement	Recommendations
Integrated service	To offer help with multiple issues- integrated service e.g. alcohol and drug use in same place, as well as housing and benefits - treat more holistically E.g. respondent couldn't get a "script" for methadone because they were an alcoholic
Easier access	Locations of service- e.g. chemists need to be more available and easier to access, more chemists need to give out methadone Accommodate for the homeless – barrier to accessing alcohol detox because they are homeless Need easier access to counselling and rehabilitation
Service improvements	More rehabilitation services Help partners together A gender specific service so partner wouldn't necessarily find out Service can ensure confidentiality More information on all the problems with different drugs A service that was more accessible for people who worked Need extended access to key workers – outside 9-5 hours If the service was anonymous – didn't have to give their name may encourage some to use it Specifically one mentioned they needed something to help with crack, much emphasis on methadone- cannot afford rehab A location they could go to for alcohol detox - allow gay couples to use this service

	Smaller waiting times on getting prescriptions (methadone) Better staff attitudes – not be patronised and be more understanding and offer more support

Survey of Smokers in the South Tyne and Wear area - Completed March 2012

A street survey was carried out in March 2012 to ask smokers to give their opinion about where and how they might consider engaging with stop smoking support services. A total of 271 surveys with smokers were included in the final analysis.

Summary of findings

Table 5.5 - Targeting of service provision

Area to improve	Suggestions for improvements
Contacting stop smoking service	Majority selected telephone as their preferred contact method (33.9%) Followed by email (16.9%) text (15.3%) Website (13. 1%) and Facebook (15.3%) were more popular in those under 36 followed by Twitter (5.5%).
Location of service	GP was the most popular selected by females and males (37% and 36% respectively - Slightly more females preferred GP to males Followed by community centre (21% females, 17% males) and leisure services (16% females, 15% males) More aged 36-65 selected GP (40%) than those under 36 (34%) Slightly more under 36 year olds selected community centre (22%) and leisure services (16%) than those aged 36 and over for community centre (17%) and leisure services (15%)

	'Other place' was the next most popular for males and females in both age categories (10-11%)
Advertisement of service	GP and TV were the most popular choices (12.2% and 12.4%) Over 36 gave papers a higher emphasis and under 36 gave TV a higher emphasis
Support for stopping smoking	1:1 support was the most popular for males and females (45% female, 42% male) Followed by group (slightly more females) (21% female, 20%males) 5% more females indicated an interest in a drop in session than males (11% females , 6% males) Facebook (more males) (10% females, 12% males)
Tools for quitting	38% said they would consider stop smoking service, GP, pharmacy or Health Trainer (based on the aggregate count) (GP – 16%, pharmacy -13%, Health Trainer – 9%) 66% of individuals would try to stop smoking through willpower, buying NRT or cutting down More males would do it through will power (most popular) (26.9% compared with 21.2% females), buy NRT (23.1% males compared with 18.8% females) More females would use a stop smoking service (12.9% compared with 9.6% males), slightly more would visit GP (5.9% females, 5.8% males). More males said they would use a Health Trainer (3.8% compared to 1.2% females) or a pharmacy (7.7% compared with 1.2% females) More females were not interested in stopping (15.3% compared with 3.8% males) but more would cut down than males (12.9% compared with 9.6% males).

5.2 HEALTH CHECKS

Cardiovascular Disease Pathway Phase One Research – produced for NHS South of Tyne and wear January 2009

11 focus groups were conducted across the three PCTs, Gateshead, South Shields and Sunderland including one BME group, one group of unemployed men, one male only and one female only group

32 face to face and telephone in depth interviews were conducted concurrently across the three PCTs with GP practices, Optometrists, Dentists, Pharmacists and representatives from community groups.

Table 5.2.1 - Potential Barriers to accessing services in relation to cardio-vascular disease

Barrier	Themes supporting the barrier
Knowledge and awareness of general public	• Knowledge and understanding of CVD was varied – the majority believed they had heard of it • Some respondents admitted being confused about healthy lifestyle advice, which was sometimes perceived to be contradictory e.g. 5 a day, salt intake • There was a general low awareness demonstrated by both the public and practitioners (except GPs) of lifestyle interventions beyond smoking and alcohol association and weight management • Lack of knowledge about the risks of CVD • People are not aware they can go to the pharmacy for checks rather than the GP surgery
Accessibility	Taking time off work – younger people are always working • Looking after children • Inconvenience of getting to a venue/distance from venue • Language difficulties • Perceived difficulty of getting a double appointment (to include a partner or interpreter) a lack of support from family or friends

	• Cost of getting there or of taking part in some of the recommended activities e.g. smoking cessation products and prescription costs
Perceptions	Fear of finding out something they don't want to know • Being scared of lifestyle changes – knowing they may drink too much or smoke too much • Embarrassment of attending such an assessment – exposing body • Motivation • Loss of faith in the ability of the health service to help – poor previous experiences • Denial that this could be relevant to them
Culture	• Taking on healthy lifestyle advice impacted by diets determined by culture e.g. Asian people eat certain types of spicy, greasy, fried food as their staple diet • In certain cultures it is not readily accepted for women to do a lot of exercise • Language barrier – some people from ethnic backgrounds can hardly read, need an interpreter
Terminology	• Split of opinion about the term 'vascular risk assessment' – some concerns across practitioners, BME community and the at-risk patients the word sounds too medical. Respondents preferred something simpler and less medical • 'Risk assessment' – liked for its clarity but also disliked for its connotations and harshness • Terms were seen as difficult to communicate with the BME community – there is no direct interpretation.

Suggestions for programme

- The CVD pathway was accepted as a good idea by everyone: focus group respondents, practitioners, stakeholders and community leaders:
- Talked about the benefits of a more holistic service with the referral system (instead of just giving advice)
- The benefits of prevention rather than cure were highlighted
- Wanted the target age group to be extended to those in 20's and older than 75 (people living longer)

Location

- One of the main advantages would be the ability to go without appointment, for example to drop in centres/community centres
- Want to be seen as quickly as possible
- Pharmacies- open later than GP- provide drop in service
- Mobile centre – if well-advertised so no where it is and when
- Open clinic at the library or leisure centre- possible concern with lack of privacy
- GP surgery (GP or practice nurse) was still the main preference (more faith in Doctor)
- BME communities might respond to a link person who would accompany them to the practitioner e.g. community/faith leader/interpreter

Which practitioners

- GPs, Practice Pharmacists, Practice Nurses, Health Care Assistants, Occupational Nurses were suggested
- In the BME community midwife was suggested to access women (majority have children) as women are usually difficult to access
- Respondents were less likely to relate to the role of a dentist or optometrist- there was some support for these practitioners to be able to refer them onto the GP

Prevention education

- Educating about CVD risk to young people at school- starting early

Information about CVD and risk factors

- Amount of information given to respondents when they had been monitored for different risk categories from varied health professionals varied from an information pack to a piece of paper telling them what to do to nothing.
- Sometimes they were given too much information, some received no information and would have appreciated more (written and verbal) in terms of what to do next and what test results mean- amount and content of information needs to be considered after CVD assessment.
- Information in doctors' surgery waiting rooms needs to be more organised and categorised

- Information needs to be available in more than one language as well as have leaflets in different languages – the main community languages
- Format- shocking images of peoples suffering still work for many
- Endorsement by a popular figure in entertainment (e.g. Jeremy Clarkson) or a locally known person, or someone whose circumstances were particularly relevant.
- Text could be used to 'shock people into action' similar to 80s campaigns suggesting you are missing out on something. Text used to identify the benefits of what changes could achieve- show how easy it is to change or make messages personal

Examples: "get yourself checked before it's too late", "Don't die of ignorance", "it's your body. You are getting the chance to fix it. Why not take that chance"

- Small minority wanted statistics of how many people have it etc.
- Lifestyle interventions should also be found 'in a central place' e.g. the British Heart Foundation website

Communication methods

- Traditional routes to market for motivational messages:

Leaflets and posters, available on display or at a variety of venues including a waiting room or location where public may congregate. Examples included:

Chemist, mail shot, supermarket, bus shelters, public transport, community centres, bingo halls, pubs/toilets, sports arenas

Media: newspapers (national/free/local), magazines (general and specific) television, radio, internet (BHF), introduce topic into soaps or advertising during.

- Less traditional methods:
- Proactively reach into the community through the church, faith groups, mobile vans, the workplace and the classroom, leisure centres, ESAL classes, supermarket car par, shopping centre, council tax bill, off licenses, Asian shops and restaurants.
- Text messages, carrier bags and till receipts, face to face (e.g. BME), as part of an event e.g. in restaurant and products that encourage personal trial e.g. heart rate monitor

Overview

Feedback analysis suggested that there were three main communication tasks: awareness raising; motivation; the provision of information. How this is managed is dependent on the segment they are trying to reach

Three main target audiences- 'The Proactives', 'The Denials' and 'The Rejectors'.

Table 5.2.2 - Communication strategies for main target audiences

Segment to communicate to	Communication strategy
The Proactives	Good awareness of CVD, if know about pathway patients will use it Likely to be receptive to an invitation for a 'healthy heart check' by their local GP
The Denials	Good awareness of CVD- focus on educating about risk factors. Need to inform them about pathway and relevance Need motivations to accept relevance- Communication of risk factors is most important, e.g. mail shots, newspaper articles, getting them to accept that they may be at risk Ensure texting is accessible and they know when and where CVD check is available i.e. may be better in a community setting
The Rejectors	Low awareness of CVD- needs developing to recognise own risk Inform about pathway and relevance - unlikely to be accessible in a healthcare environment Need to shock into action. Think more about traditional media e.g. advertising, PR, radio and newspapers, TV And less traditional – workplaces, pubs, back of toilet doors, shopping centres A combination of both needed Assessment needs to be accessible- easy as possible for people to get involved

Overall messages for communication in include

Communication messages

- Need to be positive and focus on prevention rather than the cure or wellness rather than illness

- Educate people to give them more informed choice
- The Rejectors may respond to shock tactics especially (e.g. on level of drink driving campaigns)

Terminology

- The name of the assessment needs to be universally recognised. Preferences for name of CVD assessment:
- There was a lot of support for the word 'heart' e.g. Heart Health Check
- 'Cardiovascular risk assessment'– patients understand 'cardio' more easily
- 'MOT'
- 'Lifestyle assessment'
- 'Danger'
- Some terms 'vascular assessment' and 'cardiovascular disease' were seen as difficult to communicate with the BME community in particular, as there was often no direct interpretation

Who should be involved in the pathway?

- There needs to be partnership approach between practitioners delivering in primary care services i.e. GP and community care services e.g. workplace, places of worship, pharmacies, shopping centres etc.
- Procedures, systems, referrals, forms and assessments need standardising so that relevant information can be shared and so everyone is working to the same guidelines.
- Practitioners and stakeholders need time – either built into their existing schedule or additional budgeted time to do it.
- There needs to be across the board training for those involved in delivery on how to broach a sensitive subject, how to deliver the message and how to assess for risk.

Health Check Campaign Pre-test September 2009

In 2008 Explain conducted CVD Social Marketing Research with insight to help NHS SOTW develop a CVD pathway including service development and supporting a marketing campaign. They pre-tested to gather insight on the campaign for a Free NHS Health Check asking the general public for motivations, perceptions, barriers and practitioners for perceptions and likelihood of using it. Focus Groups were carried out - 1 in Gateshead age 40-55, 2 in Sunderland aged 40-55 and 56-74, 1 in South Tyneside, aged 56-74, and interviews with representatives of BME communities.

Table 5.2.3 –Overview of findings in relation to CVD marketing

Area of research	Evidence
Invitation	Everyone was happy to receive a letter in the post to be invited to the Health Check Non English speaking BMEs would show letter to friends/family/relative etc. to translate Accepted NHS or GP letter - NHS logo endorses letter but needs to be larger or if letter from GP practice – comfort in GP letterhead. Could merge the two characteristics “Free NHS Health Check” should be highlighted in communication materials
Accessibility	The age barrier of 74 can be alienating The length of time for the test at 20-30 minutes could be too long
Examples of marketing	Waiting room posters “Get Your Free Health Check Here” preferred for its directness Preference for a direct approach – needs to be straightforward, clear and concise Current posters gained mixed reviews: • They need to be made applicable to differing cultures and languages- for example in the Bangladeshi community – catchphrases don’t work. • Concern that by targeting specific disease e.g. by saying “can you spot the diabetic in the room?” on the poster makes you think it’s only about diabetes • Some preference for something shorter and more direct in posters e.g. “book now for your free health check now”

	• Could display posters in both pharmacy and surgery Public Transport Poster e.g. “Does the person sitting opposite you have a blood clot?” • There was agreement that the message would work better if it was aimed directly at the reader • Many preferred one straightforward message – the more messages the more ambiguous it becomes and confusion about what they are trying to tell you • There needs to be more emphasis on you rather than other people e.g. “Do you have a blood clot?” • Interviews with BME reps revealed Bangladeshi, Pakistani and Indian tend not to use public transport because of abuse Washroom posters e.g. “Is the girl in the next loo diabetic?” • Concerns were raised over the suitability of washroom posters- questions about taste and could be perceived offensive to some communities • Also people usually associate posters in toilets with STIs
Press Advertising	Potentially too many headlines on posters influenced by the indirect approach • E.g. “Is your striker at risk of a stroke? • “Has your boss got high blood pressure?” • “Does your estate agent have a blood clot?” • Some recognised the idea that it was trying to make you think anybody could have a problem • Some fears that people could not relate to these people and wouldn’t care about their boss or estate agent

	• In the Jewish community – they don't want scaremongering and need to stress the good health aspects of the check i.e. prevention • Example of striker would isolate potentially women who wouldn't know what a striker was and perhaps it is too gimmicky • Could misunderstand the theme i.e. would you actually ask the person sitting next to them if they have such and such
Areas for consideration	Letters and posters need to be consistent in who they are targeting i.e. poster says 'over 40' and letter says aged between 40 and 74 And length of time the check takes needs to be consistent on all materials Use of messages on beer mats may be seen to contradict alcohol awareness promotion by NHS Media consumption reported by participants included: Newspapers- Metro News, Sunderland Echo especially (Chronicle, journal Sunday Sun) Magazines- women's and household Radio- smooth especially, Galaxy, Sun FM, Magic, Metro • BME Bangladeshi – Bangladeshi/Bengali TV Indian - Metro FM, Metro News, Echo, Council newsletter, Asian channels Chinese TV- Phoenix Pakistani- no community radio or TV read council newsletter Jewish – BBC and Labruit newsletter

BME Communication Differences

Table 5.2.4 highlights the communication differences across a range of BME groups

BME Group	Communication issues
Bangladeshi	Small proportion of over 40s speak English Respect NHS logo Tend not to use public transport Posters, newsletters, leaflets at: restaurants, places where gather e.g. Apna Ghar and mosques Work long hours at restaurants- watch late night Bangladeshi TV
Black African-	Those that don't speak English bring letter to refugee centre for translation NHS logo important Posters at all locations including Refugee Service Offices Need to include photos of people from different ethnic backgrounds so it is all inclusive Options needed for Health Check venue -should be community venues
Chinese	Surgeries can provide translators Visit GPs as a couple Campaign in simple English (or translated) at church, pharmacy, GP, public transport, Chinese supermarket or English supermarkets Option to have check at Church
Indian	Family friend or member will translate letter- NHS logo important Option to have checks at Sikh temple Few use public transport

	Read Metro, Echo, Council Newsletter, 'Wise' They were the most supportive of the theme of all BME reps
Jewish	Posters at Labruit Healthy Living Centre, weekly newsletter Where possible same gender doing checks, separate times and places
Pakistani	First and second generation often don't speak English Make sure translation service always available at GP Information at mosque, community centre, newsletter, grocery shop Do not use public transport Perceived lip service and tokenism when catering for ethnic minorities in Sunderland

NHS Health Check Programme: Secondary Data Analysis July 2011

Part of an extensive research project to evaluate the commissioning model being used by NHS South of Tyne and Wear to deliver the NHS Health Check programme. The pilot began in May 2010 and evaluation of this is on-going. A total of 3617 health checks were recorded as having been completed by the practices involved in the POCT pilot and data from 1820 feedback forms was sent to Explain for analysis in July 2011- an estimated 50% response rate.

Table 5.2.5 summary of key findings from NHS Health Check Programme

Theme	**Evidence of theme**
Awareness	Overall 75% of patients indicated a level of awareness of the NHS Health Check programme through practice staff including their doctor. Analysis of literal comments revealed that those who stated 'other' had most commonly found out about the programme via invitation letter/leaflet in the post from their practice
Motivation	The largest motivation to male and female respondents was "I take care of my health and this was an

	opportunity to have it checked out" (54%). More male respondents were motivated because they felt it was convenient for them. When analysed by age group, those aged 66-74 reported less than younger age groups that the staff here had told them about it when they came in
Staff	Rating a series of statements, overall the majority of patients indicated that they felt • Staff were friendly and explained things clearly • They were given enough time to ask questions after the check • They felt informed about their health and motivated to make lifestyle changes.
Outcomes	The majority of respondents planned to make changes to improve their diet (56%, 17% of which specifically in relation to losing weight) and to exercise more (47%) 6% indicated no change was needed informed either by the outcomes of their NHS Health Check or by the perception of already having a healthy lifestyle.
Procedure	Rating a series of statements overall the majority of patients indicated that they felt the test was simple and less worrying than having bloods taken from the arm The process was over quickly, was convenient and preferred it to having bloods from the arm.

Positive feedback

• 97% of patients indicated they would recommend others have an NHS Health Check

• 79% of additional comments given indicated patients had experienced the health check positively focussing on individual members of staff being helpful and friendly

• Positive feedback included being given ‘peace of mind’ having the health check, prevention being better than the cure and how quick and simple the experience was

Negative feedback

20% of additional comments given indicted patients had experienced the health check negatively, focusing mainly on perceived need to widen the scope of the health check to include for example a diabetes check and finding the focus on cholesterol as a limitation to the programme.

Communication

The concept of a health Check needs to be more clearly explained as some patients believed other aspects of their health would be medically assessed – it was not clear the programme focussed on prevention of CVD

Other comments

• Finger prick machines were not always working effectively to take blood sample

• There was a feeling that health checks should be given more regularly to patients than currently offered

• Should be given a copy of results to take home as an important improvement

Summary of An evaluation of a targeted workplace Health check and Intervention Programme: The workforce health and wellbeing project

The workforce health and wellbeing project was a research project that aimed to test the effectiveness of the workplace as a setting in which to deliver screening and intervention programmes aimed to improve the health and wellbeing of employees at Sunderland and Gateshead councils (from April to November 2010).This was targeted at over 40s working in low paid positions and predominantly living in more deprived areas of Sunderland and Gateshead. It involved a baseline health check followed by advice on lifestyle and an appropriate lifestyle intervention and then a second health check approximately one year after the first. The evaluation involved 4 focus groups with 43 participants, 2 interviewees with non-attendees and 13 semi structured interviews with board members and project team.

Table 5.2.6 summarises barriers to access for the work-force and well-being programme

Barrier	**Themes supporting barriers to services**
Communication about the programme	The take up of the initial health check was less than anticipated (initial aim to provide checks for 1000

	employees) relating to communication with employees about the project and its potential benefits. Some non-participants did not hear about the programme, others did not understand its aims. Not all participants received letters of invitation to participate in the project Referral opportunities such as subsidised/free gym passes and swimming memberships needed to be advertised in the recruitment drive – increased uptake Suspicion about the objectives – thought information recorded might go on their sickness record
Practical barriers	Lack of opportunity to take time away from work Lack of support from line managers for employees to take time away from their jobs Time limitations and transport barriers and child care responsibilities affecting up take of referrals to interventions, particularly for women in terms of child-care duties
Support from Line managers	Managers lack of knowledge about the programme influenced uptake and support Managers of male manual workers were more supportive of programme and allowed release of staff compared to managers of women – due to finding shift cover in certain jobs. Women more likely to work in customer facing roles – making cover an issue
Concerns and attitudes	Women and those with a higher BMI at the initial health check were less likely to return for the second assessment. Those with higher BMI more embarrassed and anxious about returning for the second check especially if they had not taken up lifestyle advice or intervention opportunities - staff communication and attitudes.

	Worries about own absence from work to do programme and ramifications. Resistance to engage with health professionals related to own attitudes to health Lack of motivation and willingness to participate in the interventions recognised as important factors associated with drop out and non-participation

Summary of what people want from services

Setting

- Workplace was deemed an appropriate and convenient setting for the checks for reasons of convenience and practicality. No need to make an appointment, take time off work or make travel arrangements to attend the check

- Most preferred idea of doing check there rather than at GP surgery –as is often associated with illness rather than wellness-This has great potential for future schemes. Feeling of not wanting to 'bother' GP with something perceived to be less than urgent

- More equalised power dynamic of a nurse led health check rather than GP for example

Format of health Checks

- Health checks constructed as a "reality check" or a health related MOT prompted reflection and the impetus to make behavioural changes.

Staff attitudes and communication

- Need for positive staff- the enthusiasm and professionalism of the occupational health nurses delivering the health checks was seen to be of paramount importance in the success of the project

- Effective risk communication- Small number of participants perceived the format and delivery of advice to be judgemental and uncomfortable preventing return for second health check. Efforts are required to boost risk communication skills

- Needs to be a more nuanced and sensitive approach to suggestions for lifestyle behavioural changes. Exercise referrals to the gym are not appropriate for everyone-, can present an intimidating environment. Need to think of alternative ways to exercise

- Those that had not made changes were less likely to return – communication of intervention staff needs to be addressed so participants are not intimidated to return

Factors to encourage uptake

- Communication about the project needs to be effective and more wide spread- ensure all employees receive invitation materials and can hear about the project face to face relating to benefits of programme and interventions
- Uptake of second health check - Factor that encouraged participants to return for the second checks was the perception that the process was straightforward and “painless” and the nurses delivering the checks were professional and efficient
- Board members need to ensure managerial “buy-in” to the programme so staff can be released to partake.
- Recruitment methods- oral recruitment methods were favoured to written methods which were perceived to be long worded and difficult to read - although they should be used in conjunction
- Make briefing sessions available to all potential participants rather than on an ad-hoc basis –Highlight referral opportunities to increase uptake–

Line manager support

- Involvement of more line managers would increase recruitment

On-going support

- Concerns about the short term nature of the project - would want continuing lifestyle support with regular checks to encourage motivation and adherence
- Consider ways to build in long-term support for participants, including regular health checks

5.3 MENTAL HEALTH SERVICES

Mental and Emotional Health needs Assessment of the LGBT populations of NHS South of Tyne and Wear, Gateshead, South Tyneside and Sunderland – March and September 2010

It is often assumed that LGBT people's health and wellbeing needs are the same as their heterosexual counterparts, except for specific needs relating to sexual health. However, this group experience discrimination on a wide range of levels, being treated differently by professionals and are often subject to violence, verbal abuse and bullying in society. This can lead to a range of health problems such as alcohol, drug abuse, depression, suicide and self-harm, as well as problems around housing and employment (3). Many LGBT people also experience "dual discrimination" – being part of an ethnic minority group and having a disability.

There are no local figures available for the size of the transgender population.

Consultation took place between March and September 2010, with a range of public sector workers including those from Local Authorities, education establishments and from different parts of the NHS, voluntary sector workers and volunteers and service users were invited to consultation about shaping the LGBT Mental and Emotional Health and Well-being Needs Assessment. Data was collected from 130 people of whom 107 completed Equality and Diversity Monitoring Forms.

Table 5.3.1 Barriers to accessing services for the LGBT community

Barrier	Themes supporting the barrier
Lack of awareness	Of what services there were - either LGBT focused or generic services welcoming to LGBT. Examples of the services that were used by contributors included: South Tyneside LGBT Youth Group, LGBT Youth Forum- Gateshead Council Gateshead Psychology Department at Sunderland Gender Identity Clinic Tea with Dorothy, Plus Group, Stag Group and Outpost LGBT people struggle to find information about LGBT specific services as information is limited to the promotion of gay nightclubs, events and bars
Perception of services	Felt stereotypical assumptions were

	made of their needs and believed their needs were denied or ignored Many generic services seem incapable of reaching out to the needs of the LGBT populations, perceived as “straight” services and unwelcoming to the LGBT community LGBT people feel so accustomed to services being inadequate in providing help, advice and support, they do not seek it. May spend many years self-medicating with alcohol, recreational and pharmaceutical drugs and become more isolated which can exacerbate the problems. There is little in the way of services coming together such as LGBT and ethnicity, disability or faith
Service provision	There are few services or groups that come close to meeting the needs of LGBT people. Limited services- across SoTW there are few specific services with good examples of real community engagement, despite the lack of resources and capacity- others struggle through lack of support/experience reflected in the service they provide There is lack of continuity with services- the few projects that have been developed are not getting long term funding. There are many services with a remit to address mental health issues alcoholism, addiction and relationship issues but the perception is that they are for heterosexuals Felt services do not target LGBT people and are therefore less able to work with them on health priorities, such as physical activity, healthy eating, alcohol and substance misuse, mental health issues etc. Participants felt there were only groups for LGBT that were based on social activities and did not address

	health needs- e.g. no support to help with emotional and mental health issues. Felt services do address the health needs of the general population and their social and emotional needs but they do not reach out or make themselves accessible or welcoming to LGBT people. The perception is that they are for heterosexuals - LGBT feel excluded, have concerns and their needs are not being met Some felt that services, groups and activities that claim to cater for the LGBT population predominantly cater for gay and/or bisexual men. Lesbian sexual and general health needs are ignored and generic services give poor or inappropriate advice.
Perceived problems with staff	Lack of awareness can result in well-meaning heterosexual workers being insensitive to LGBT issues. A person's sexuality appears to raise fears within workers, which leads to a lack of engagement and a lack of awareness of the issues LGBT face. Sexual orientation may be bypassed or seen as irrelevant or an over emphasis placed on LGBT identity. Labelling people LGBT can appear that such labels are used in a non-person centred way which services to put people in a box resulting in problems of not being diagnosed properly. Felt that far too much emphasis is placed on sexual orientation rather than the mental health, housing or education issues. LGBT label starts to be pathologised and treated rather than dealing with the issue the person may actually be seeking help for. Staff are resistant or hesitant to ask questions about sexual orientation There is a lack of empathy within the medical profession

	There is a fear of 'coming out' within institutions, if influential professionals feel they have to hide their sexual orientation they will be unable to provide effective role models.
Generic vs. specific	Options to attend either a generic or an LGBT specific service should be available. Felt there was no reason why generic organisations could not support or deal with LGBT people • Some participants were opposed to segregated services because it could further ghettoise LGBT people and does not address the lack of inclusivity. There is a lack of trust with generic services and they feel vulnerable • They were fully supportive of a one stop shop LGBT centre to deal with issues including counselling, confidence building, creative pursuits, housing, legal matters, joblessness and provide training to organisations • There were concerns that fully accessible LGBT specific services could mean that non specialist services lose their accountability. • If services are set up this must be done in consultation with LGBT people and the workers to come from the LGBT community (acknowledged this may be difficult as their views are difficult to collect due to many LGBT people being invisible or isolated). • Services need to recognise that LGBT people are not a homogenous group. Workers need to be clear that sexual orientation is important • These services need to work in partnership with other organisations – it is not enough to say 'we are working with LGBT people- if few actually use the service • If there is an organisation that caters for gay/bisexual men's health, there ought to be one for lesbians and bi sexual women

	• Transgender issues regarding mental health and emotional support need to be higher on the agenda- there is only one group for people working out options, awaiting or going through surgery. • Specific advice sessions and groups are needed to support people in their 'coming out' process or for legal advice, housing, mentoring and buddying • Gay participants with mental health issues stated they want to be with other gay men to talk about their issues and not in the heterosexual arena.
Equality and Diversity training and monitoring	• At present services are not monitored for sexual orientation- so data on how many LGBT people are using services are not being collected. No mechanism for accurate recording was identified as there is with other minority groups • If NHS staff are not asking about sexual orientation, LGBT people will continue to be hard to reach and invisible within mainstream services. • If they don't have the stats, monitoring data or outcomes about generic services and any LGBT specific work – the need cannot be demonstrated to justify the argument for more tailored or LGBT specific services.
Recognition of issues e.g. domestic violence	It is now more widely recognised that domestic violence is more common within LGBT relationships, although there have been improvements, services and organisations have been slow to address same-sex domestic violence. • Felt domestic violence provision has been set up from a heterosexual mind-set, including the use of posters and leaflets showing women or violent men. • There is little in the way of

	psychological support for LGBT people experiencing it. • Lack of promotion – there is little in the way of psychological support for LGBT people experiencing domestic violence. • There have been no regional or sub regional campaigns which are needed to create more awareness of same sex domestic violence LGBT people can find support difficult or impossible to access. • There are few services in the North east to signpost onto, only MESMAC and Victim Support do provide some support and help. • Housing departments and the probation service are not equipped to deal with LGBT domestic violence • Workers can seem to lack confidence, saying that a person is LGBT can become a stumbling block with workers saying that they aren't an expert even if their daily job involves working with domestic violence.
Lack of recognition of different needs	E.g. young LGB groups have different needs to older people.
Need role models within services	Reported self-esteem can come from having good role models within organisations and institutions. It can be very positive for LGBT to work with self-identified LGBT workers – feel more empowered.

In summary there were clear reports of experiences that involved LGB individuals being treated like 'hot potatoes' being passed from 'pillar to post' and thus there is a need to improve services.

Table 5.3.2 - Recommendations for service improvements for LGBT community

In an ideal world separate services would not be required for the LGBT population. Where this is not possible, the aim of commissioners and providers is to ensure that mainstream services are sensitive to the needs of all users from whatever background. Table 2.6 below outlines

recommendations to improve existing services for individuals from the LGBT community.

Area for improvement	**Recommendation**
Promoting visibility	Mainstream services need to be aware of the LGBT population and be sensitive to their needs Training in LGBT issues needs to be developed and promoted across all mainstream services especially around attitudes Services should ensure equal access to those services for the LGBT population Appropriate signposting supported by a directory of local services Appropriate images of LGBT people should be included in all literature produced by services, e.g. including pictures of same sex couples
Generic vs. specialist services	There are a limited number of specialist services for the LGBT population and most LGBT people are expected to attend generic services- rarely sensitive to the needs of the LGBT population Can result in users being sent to inappropriate specialist services There are many more specialist services for gay men than lesbians Some targeted specialist services should be developed and promoted particularly around mental health and well-being Some specialist services should be targeted to lesbian and bi sexual women
Tackling discrimination	ARCH (hate crime reporting system) should be promoted across SoTW and responses reviewed on a regular e.g. quarterly basis to inform action Training around discrimination should be part of any equality training and it

	is not adequate to do this as an online exercise
Capacity building	Community development is an ideal approach to engaging groups with no access to mainstream services Should be funded to promote LGBT work e.g. self-help groups, drop-ins and phone-ins Public health services need to be aware of particular needs when developing programmes such as smoking cessation, weight reduction etc.
Partnership working	Should involve a wide range of key stakeholders across the statutory and non-statutory sectors Use best practice from around the country for new local developments
Monitoring	Services should be monitoring the use by LGBT identifying gaps in provision and taking action to remedy this
Commissioning	Current findings need to be disseminated widely to commissioners Commissioners should be collecting and reviewing monitoring figures from services to ensure LGBT people receive the appropriate services
Young people	Findings about the recognised difficulties many young LGBT people suffer from bullying at school, relationship problems at home and feeling unsafe on the streets should be disseminated to the commissioners and providers of current services, particularly the CAMHS
Double discrimination	People suffering from two types of discrimination e.g. LGBT and being disabled or minority ethnic background need extra support, both

	mainstream and specialist
Transgender	The consultation suggested that more transgender people suffer more discrimination that LGB people – service provision needs to ensure inclusivity. It is recognised that there is a lack of services both in the statutory and voluntary sector- there is a clear need for more work to be done in this area

Mental Health Needs Assessment of the Black and Minority Ethnic communities: NHS South of Tyne and Wear; Gateshead South Tyneside and Sunderland October 2009

A number of studies were carried out for the purpose of the Mental Health Needs Assessment by the DRE Community Development Workers. In Gateshead, there were discussions held by the GVOC BME workers with a number of ethnic minority organisations, questionnaires and focus groups were used. Participants were more from asylum-seeker/refugee groups than the longer-standing BME communities but one of the focus groups involved young people who were university students and unemployed (GVOC, 2009b).

Table 5.3.3 Barriers to accessing mental health services amongst BME communities in Gateshead

Barriers	**Themes supporting barriers**
Gender	Greater for women than for men, with language, childcare problems, transport and culture all creating problems
Knowledge	Knowledge of mental health support services was typically limited to primary care services Little or no knowledge of secondary or tertiary services Lack of basic understanding of mental illness
Lack of opportunities	Lack of opportunity to have access to culturally sensitive recreational and support services
Support	First point of contact was generally family, friends, religious leaders or the GP Asylum seekers experienced more serious and prolonged mental illness

	due to the uncertainty of their immigration status Lack of support for access to clinical services Smaller communities found religious leaders more helpful than more established communities who feared stigma
Language	Anecdotally a Tyneside Women's Health Community Development worker reports that mental health issues are not raised by women for some time due to language reasons and need to develop trust over time.

South Tyneside

A Survey of the Wellbeing And Health of BME groups in South Tyneside was carried out in March 2009 in order to investigate the BME community's view of health and wellbeing. Questionnaires distributed to 460 people at a variety of events. Asked what can services do to help? The top answer was to be more visible and culturally appropriate.

Table 5.3.4 – Barriers to services for BME in South Tyneside

Barrier	**Evidence**
Awareness	Awareness of therapies and medication available on the NHS was not very high. Asylum seekers in particular reported limited knowledge of health services, beliefs may differ from that of service providers, services planned for majority are not always appropriate.
Language	Two thirds of BME group had found themselves interpreting for a family member or friend in contact with the health services- suggest interpretation services are unavailable or unsuitable. Asylum seekers in particular reported poor English and experiences of difficulty in gaining access to care even with the support of an

	interpreter.

Sunderland BME groups

In June 2006, Sangini a BME-led women's voluntary sector health organisation produced the Sunderland BME Health Needs Assessment (HNA) Report. This HNA was carried out to identify the health needs and priorities within BME communities and involved consultations with 237 BME residents via focus groups, questionnaires and activity sessions and discussion groups and put forward recommendations within the report.

Table 5.3.5 –Barriers to services for BME in Sunderland

Barrier	Evidence to support theme
Staff attitudes	General lack of cultural competence and awareness form frontline staff and health professionals when dealing with people with ethnic backgrounds Been experiences of racism and its effects on mental health – perception that professionals did not always acknowledge and address issues around racism Fear of rejection because of individuals' ethnicity
Awareness	Lack of awareness of services available within the Health service, especially support services within mental health services Lack of awareness within the BME community of the term 'mental health' and the mental health services. Terminology and stigma appear to have major associations with an individual's concept of mental health and their confidence and ability to access services
Language	People felt unease at using family members as interpreters Lack of adequate interpretation, using family gives no privacy or confidentiality

Professionals Views

Health needs raised of Asylum Seekers were raised in the North East, Asylum Seeker, refugee and other Migrants Health Study 2007 (Horton 2007), which collected information on what PCTS knew about the health needs of these groups:

- There is incidence of Post-Traumatic Stress Disorder, trauma and isolation
- Position of women in society here is different from that of home country – can cause conflict within the family, prevent integration and access to services
- Sexual difficulties, rape and unwanted pregnancies: low self-esteem and shame prevent them from telling families or seeking help
- Anxiety and depression exacerbated by poor healthcare, civil unrest and abuse in country of origin and alienation in the host country

Priority issues

Priority issues for all groups were considered to be:

- Primary care access - Get GPs to register new arrivals, not turn them away
- Secondary care access- services need to be able to respond to the needs of asylum seekers and refugees dynamic needs
- Educating GPs – understand the needs of this client group, need to ask for interpreters

PCT staff views

- Access to education not offered to adults
- Lack of translated materials and access to interpreters
- Letters sent out in English for hospital appointments – cause high failure to attend rates
- Using family members to interpret is poor practice and dangerous
- Perception of services as “unhelpful”
- Transport and gender issues
- Robust data collection processes nationally and locally need to be improved

Hearn (2007) pointed out majority of mental health services in South Tyneside had no recorded information about the needs of BME communities, also took the view the majority of professionals had little/ no understanding of mental health issues and did not recognise indicators like stress, anxiety or depression, more likely to recognise severe clinical mental health issues. More generally Hearn (2007) found:

- A lack of service provision for men and women forced into marriage and male victims of domestic violence
- Lack of service provision aimed at BME men’s health
- Difficulties in supporting ‘hard to reach’ BME communities who did not attend existing mainstream/BME services with mental health provision

- Representatives from services often only approached community leaders and established organisations and info not always disseminated
- Services could be indirectly accessible e.g. if located in a Church might think for Christians only
- Lack of sustained work with BME communities – one off events only for reasons such as finance, resources, lack of cultural understanding or awareness

Conclusions drawn together from this report and other documents to prepare it demonstrate the need for development in the following areas.

Increase accessibility

- Mental health services should be made more accessible particularly within GP practices, IAPT and secondary mental health services

Training and awareness

- There needs to be development of cultural competence in all general services, alongside specific services providing individualised care
- This includes understanding of the pressures on people (including young people) in tight-knit and often isolated BME communities
- Comprehensive training in Race Equality and Cultural awareness- ensure everyone working in mental health has appropriate values and skills to work with diverse patients
- Priority should be given to IAPT work for the BME community, through provision of more talking therapies sensitive to traditional and cultural values, whether delivered through mainstream services or more specialised groups- training for therapists
- Recognise that people from the BME community do not turn to members of their community for advice/signposting because of the stigma with mental health
- Training in mental health awareness should be offered to BME community leaders including religious leaders with guidance provided on advice and referral.
- On-going awareness – raising education programmes should be developed in BME communities in collaboration with community members and in single sex groups where appropriate.

Overcoming language barriers

- Needs to be improved free access to interpreting services, promote their availability and ensure they are resourced effectively for equity of access.
- Female interpreters should be provided for female patients
- A need for more translated material

Research and monitoring

- More robust data collection and regular monitoring is needed with work at senior management level to ensure shortcomings in data are overcome and monitoring of the progress of work in built into future action plan

- Further research needed on issues such as forced marriage, domestic violence experienced by males, substance and alcohol misuse, post-natal depression, self-harm and suicide

Using community resources – collaboration with BME communities

- Use staff resources in the community such as health visitors who have direct contact with pregnant women to help post natal depression in BME community

- Community health Workers can provide information and advice to elderly BME people

- A programme of positive promotion of mental health is needed with the use of role models who have links to the BME communities

- Support and resources should be offered to community based groups and organisations for engagement with BME communities

- Develop strategies to engage particularly with young people in the BME community, involve them in the development of services

- Suggestions for new projects include development of one stop health drop in localities, with a significant mental health component

- Funding of posts of advocates from the BME communities and/or speaking BME languages

- Targeted early intervention services to increase social inclusion and reduce isolation should be provided to BME communities, through drop-in provision, a range of personal support including advocacy and signposting, emphasis on promoting trusting and positive relationships

Workplace

- Promotion of mental well-being within the workplace should be increased through targeted partnership work and awareness raising with employees

Asylum seekers – complex needs

- Develop more specialist mental health support for those who have experienced torture

- Access to psychological therapies (including CBT) should be easily available for asylum seekers

- Create more asylum focused support groups to be funded through mainstream budgets or have managed service level agreements with PCTs

- A programme of education for GPS so that they are willing to register new arrivals and are sensitive to their needs

Table 5.3.6 – overview of needs assessment findings

Area of need	Indicators
Deprivation	On most indicators of deprivation, SoTW measures poorly against the rest of the country • However there are positive factors also – traditions of 'neighbourliness' on which strategies can be built • Across NHS South of Tyne and Wear, there are very high levels of disadvantage- there are greater overall levels of deprivation in South Tyneside • There are more extremes of poverty in Gateshead and Sunderland (percentages of people living in England's worst 10%). Sunderland (27% and Gateshead 27.2%) • South Tyneside has more people living in the worst 25% (61.5% of the population) (4)
Social isolation	A clear relationship between social support and the risk of mortality and morbidity has been identified (5). • Despite the fact that people living in SoTW have the highest levels of social networks and neighbourliness, they have the highest rates of mental illness in the North East than anywhere else in the country.
Education	The North East has a lower percentage of young people gaining qualifications than the average for England, although there has been a greater improvement than the average over the three years prior to 2007 (England 1.8% compared to North East 6.7% improvement) (5) • Tyne and Wear has a particularly high rate of people with no

	qualifications when compared to England as a whole.
Employment	Unemployment is still high within the North East as a whole, although there has been a considerable decrease over the last decade • Unemployment is higher overall within SoTW, and in South Tyneside it is almost twice the national average. • There are high proportions of people claiming benefits due to mental or behavioural problems when compared to England as a whole
Housing	There is a lower rate of owner-occupied accommodation in SoTW than the average for England, and a comparative high rate of local authority and housing association rented property. This situation has been shown to have a negative association with mental wellbeing. • Access to good housing and environment can improve the mental health and well-being of residents and should be taken into account in developing services.
Physical Activity	Participation in sport and active recreation of moderate intensity averaging 5 or more times per week is around 11.6% of adults across England (5) while around 21% of adults across England take 30 minutes of moderate activity 3 times a week • In SoTW 20% of adults in South Tyneside and Sunderland do and only 18% in Gateshead • There is considerable potential for improving mental wellbeing through participation in physical activity.
Healthy Eating	Levels of obesity in South of Tyne and Wear are high compared to England as a whole, with nearly a quarter of people being obese; these areas suffer the added health burden

	associated with this condition.
Alcohol	The North East has the second highest level of harmful alcohol consumption in the English regions (6).
Substance Use	The population of people in contact with structured drug treatment in the North East is higher than in England as a whole (over 600 per 10,000 in 2005/6 compared with 550/10,000 population (5). • According to MIND dual diagnosis is a common problem for both metal health services and drug and alcohol treatment services- suggested that 30-50% of people with mental health problems also have a drug/alcohol issues (7) • No local figures on this issue
Sexual health	In SoTW the rates of teenage pregnancy has been reducing over the long term but latest figures suggest an increase (figure not yet available)
People at particular life stages	*Ante and Post natal women* • Breast feeding figures appear to be low in NHS South of Tyne and Wear (based on info collected on hospital discharge) • There are no figures on rates of ante/post natal depression locally *Older people* • In 2008 all three localities had a higher proportion of people aged over 65 than England as a whole. This causes a shift in the dependency ratio. At present there is a corresponding higher rate of older people living alone in Gateshead, Sunderland and South Tyneside compared to the rest of the country this has implications for the provision of support to this group.
Life Expectancy	Life expectancy across SoTW is lower than in the North East as a whole or England. In Gateshead the

	disparity between the best and worst wards is 9.9 years for males and about 11 years for females (8). The main cause of death due to mental health problems directly is suicide. The major contributors to poor life expectancy in SoTW are circulatory diseases and cancer.
Other vulnerable groups	A quarter of the population in SoTW suffer from a chronic disease. Figures of all three localities are significantly higher with regard to coronary heart disease and COPD. Also high for cancers in Gateshead and South Tyneside.
People experiencing mental illness	The North East is estimated to have the highest rates of mental illness (17.5% compared to 13.2% in England) based on the proportion of adults scoring four or more on the GHQ indicating possible psychiatric disorders (5). • The rates of people claiming benefits or allowances due to mental health/behavioural issues – all three areas have greater numbers than across England (9). • Rates of prescribing anti-depressants are higher in North East local authorities than national rates- Gateshead has the highest rates out of the 3 areas • The North East has the highest age-standardised mortality rate directly due to suicide and injury undetermined among people of all ages (2004-2006), of all English regions However of the three localities, only the mortality rate in Sunderland is higher than the NE regional average and is higher than the England rate.
BME groups and mental illness	Have a different experience of mental health than the indigenous population due to discrimination that they may suffer which impacts on self-esteem, ability to cope and can lead to people feeling isolated, intimidated and fearful

	• Poor outcomes for mental health problems can be down to lack of access to appropriate services • A number of reports (NIMHE 2003, SCMH 2002) have shown that with regard to mental health issues, BME groups are more likely to experience: • Problems in accessing services • Lower satisfaction with services • Cultural and language barriers • Lower GP involvement in care • Inadequate community-based crisis care etc.
LGBT experiences of	It is being increasingly recognised that people experience health inequalities as a result of their sexuality (10). • It is now accepted that being LGBT does not in or itself cause mental health problems (10), however this group may experience a range of issues which can contribute to mental health difficulties • Hostility and/or rejection • Bullying or harassment • Danger/violence • Difficulties in accepting their sexuality • Low self esteem This has been described as 'minority stress' (11) in which the process of coping with the discrimination increases the risk and prevalence of mental disorders – they are more at risk of substance misuse, self-harm and suicide (12 & 13).
Offenders and ex-prisoners	The North East Public Health Observatory (14) found high levels of mental illness among prisoners in the North East- for men on remand, 78% had personality disorders, 10% had functional psychosis in the past year and 59% had neurotic disorders in the past week.

Domestic violence	Is more prevalent in the North East than in the rest of England. Sunderland has a higher rate of Domestic Violence than Gateshead and South Tyneside.

Felt and expressed needs

A consultation was funded by SoTW Public health to establish an understanding of views on mental wellbeing in three localities. The first phase was door to door survey of members of the public to explore the views of a small sample of 30 people from each locality. The second phase was a consultation with participants who had experience of using mental health services and those with experience of delivering mental health services.

Positive and negative factors that influenced mental wellbeing

Inclusion and belonging

- Being involved and belonging to a community as well as spending time with family and friends.
- Ability to make links with friends and other people
- Companionship of a pet was highlighted
- Issues with young people, anti-social behaviour and crime were problems in relation to inclusion, exclusion and community harmony
- The opportunity to gain access to services and to spend time with people and 'belong within a community' was important
- Services to provide opportunity for people to feel safe, develop friendships and build positive relationships with other people

Being active and having a structure

- Structured activities were identified as being important, including access to employment, education and training
- Volunteering, hobbies and sporting activities – beneficial to mental wellbeing
- Having access to courses where new skills could be developed
- Linked to social aspects of wellbeing – participate with friends/family, meet new people

Personal time and a balanced life

- The need for relaxation and time for enjoyment through a 'balanced life'
- It was felt that this should be a human resource issue within many organisations, should be joint responsibility between the employer and employee. There needs to be a 'culture shift' in terms of developing a clear understanding the importance of work-life balance
- A stepped approach for those returning to work with a mental illness

- More training for professionals to help support with mental health problems returning to work

Other factors that would help foster improved mental health included:

- Voluntary work, identity from employment, structure to days, family and friends, hobbies and interests and adequate housing. Not feeling isolated particularly for older people. Transport easily accessible.

The promotion of mental wellbeing

Consultation with professionals from the NHS and local government was undertaken by consultants and SoTW staff- involved 6 focus groups between August and November 2008 – they were asked to comment on some of the themes explored by service users and workers from voluntary organisations- ideas of where the promotion of wellbeing could be focused and in what form.

Professionals' views

Message and the approach

- From the focus groups it was felt that there was sometimes inconsistency in the use of the terms mental illness and mental wellbeing and this needed to be addressed.

- Initiatives need to be sustained, creative and eye-catching and include elements that are 'fun'

- The messages on mental health should not be too prescriptive, should emphasise options open to the public

- There should be no separation of physical health and mental health; wellbeing as a whole should be addressed

Communication methods

- Important to use other forms of media other than TV, newspapers and radio was stressed to engage young people.

- Media use by young people such as the internet (YouTube) and texting should be exploited

- Ways to promote messages relating to mental health to young people, without them having to actually look for them should be explored

- The local free magazine The Crack was a suggested potential source

- Opportunities for social workers to meet young people in schools to discuss their mental wellbeing should also be considered

Education and training

- An on-going educational programme is needed to challenge stigma as a barrier

- There were felt to be training opportunities to work with staff in a number of organisations, including local authorities, particularly frontline staff

Partnership working

- Use potential key partners to support work in promoting mental wellbeing including local authorities, local retail outlets and schools

Services and opportunities

• Tailor services to meet the needs of the individual – was felt that such personalisation would have an impact upon the provision of services and lead to the development of more creative ways to meet the needs of individuals.

• The role of professionals might become more focused on “helping people to come up with their own solutions”

• Early intervention and services focused on prevention – prevention should be emphasised.

• Was mentioned that there was too much emphasis on voluntary and third sector organisations which did not have the appropriate skills to work with individuals within a preventative context. Suggested resources need to be switched towards “upstream working”

• Suggested there could be a gap between a person’s isolation and links into available services- this needs to be bridged

Gaps in services that could be developed

1. Social enterprises-

Opportunities to develop social enterprises including working with animals and training employers about MindFul Employer –a scheme which aims to increase awareness of mental health at work. Support for businesses in recruiting and retaining staff

2. Group support –

Opportunities for services to deliver more support within a group environment, e.g. group support - share coping strategies

3. Substance misuse-

Services need to focus on alcohol misuse as well as opiate users which they have mainly focused on – was recognised that this was being dealt with

4. Supportive services-

A focus on supportive services as opposed to care e.g. a mentoring project for older people into physical activities

5. Developing appropriate services-

Services should constantly elevate their provisions and ensure that they remain relevant to the needs of the people accessing them, particularly in relation to age and gender. Services need to provide evidence of outcomes

6. Developing new partnerships and new ways of working with people-

- Create opportunities within volunteering to make use of a person’s existing skills and support people to ‘get out more’. Much of this intervention would be focused on contact with others and doing things with increased investment in lifestyle interventions, including exercise referrals.

- Link with a range of other services and agencies e.g. links with culture services within local authorities, e.g. provision of leisure passes, community centres

- Teams combatting anti-social behaviour

- Employment support in helping people get back into work
- Supporting teams to develop floating support systems for housing

Health Visitors Focus groups

Two meetings with 10 and 5 health visitors respectively in November 2008. The main concerns of problems with depression were due to issues with housing and also financial and debt problems in the South Shields area. Anti-social behaviour and crime were other issues.

Barriers to help

• It could be difficult to get through to the police, and callers have to wait one or two hours before anyone contacted them.

• The breaking down of courses and groups in community centres- removed opportunities for engagement activities, frustrating for health visitors as they had worked hard in setting them up and could no longer continue them.

• Services were seen as very stretched with cause for concerns around vulnerable families and others. The effect on young children was particularly mentioned.

Staff emails from Council and PCT

A number of staff contributed to the consultation by e-mail.

How advice and guidance should be promoted on the sort of things people can do to improve their wellbeing

• Need a very individualist model of mental health

• There is still a stigma associated with the words relating to a poor sense of wellbeing (e.g. mental health and mental illness) – the good step of emphasising a 'sense of wellbeing' is a leap forward in itself, positive psychology- basic guides for different groups

Promotion/communication

• Awareness raising campaigns, marketing with simple and straightforward messages

• Advertising campaigns – links with World Mental Health Day and physical activity. Message needs to be woven into service delivery across the board e.g. with obesity, smoking cessation, housing, benefits etc.

• Incorporate into TV, cinema, pub and retail life- depends on age and gender and class

• Through services that the most vulnerable access e.g. supermarkets, post office, housing office, pharmacy, schools, local paper (Older people in Sunderland read the Northern Echo.

Use Health Trainers and health champions

• There is a role for promoting champions but these need not be the usual suspects. Champions might be people at work who understand the issues and can help for example: using word of mouth

- Use of third sector organisations e.g. Age Concern

Community groups/services

- Make more community activities available

- There is need to identify how we get to people who would not join a group – they are trying to cope on their own and we need to be clear that we should have a structure to capture these people (with brief interventions or more at the first opportunity)

Where should we advertise and promote to local people

- Young people/families – schools, colleges, youth settings, young offending, health visitors (all front line staff). Advertising through YouTube

- Needs to be more research to see what works for young people

- Adults – pubs, clubs, libraries, workplace settings, GP surgeries, local free paper. Council News (delivered to all homes), via healthy schools networks, via business networks, in supermarkets, job centres, children centres, libraries, leisure centres, CAB

- Need to think about how to reach 'white van man' – places where they lunch/target as sports watchers/radio etc.

5.4 OBESITY SERVICES

Sunderland Exercise Referral and Weight management programme annual report (April 2010 to March 2011)

This report provides information based on the period of delivery from April 2010 to March 2011 of the Sunderland Exercise Referral and Weight Management Programme. Post programme feedback showed that the programme was well received by GPs, healthcare professionals and participants. Positive comments included

- Staff were very helpful
- Lost weight through physical activity
- Programme helped with rehabilitation
- Gains in confidence and self-esteem were frequently reported.

The report did not identify areas related to why people are not accessing services and this is of limited value in the context of this report. However, the programme has continued to develop and change in a number of areas such as those listed below;

1. Further development of links through the referral continuum

2. Lifestyle Activity and Food team will continue to work alongside the Exercise Referral team to promote both programmes to referring agents and the general public

3. The Wellness Exercise Referral team were to include NHS Health Checks into the programme from Sep 2011

4. GP practices targeted to ensure that all referring agents understand fully the eligibility criteria of the programme and benefits it offers to their patients

5. A further targeted piece of work will take place working with GP practices that have a greater percentage of patients from the BME community

6. Further training for Exercise referral Consultants and Lifestyle Officers to ensure staff meet the needs of the developing programme

7. Exercise and Mood programmes were to be piloted in collaboration with Northumberland, Tyne and Wear NHS Foundation Trust in Sep 2011- to raise awareness of the positive effects of exercise for those who suffer from stress, depression and anxiety.

8. Delivery of cooking sessions by Sainsbury's staff to demonstrate how to make quick and easy low costs healthy meals

9. Delivery of supermarket tours and cooking sessions as an individual intervention to those who complete the 8 week weight management component

10. Development of a self-referral option to the weight management component so that individuals can access the programme without visiting their GP in the first instance.

Conclusion

The programme continued to develop and established itself as a successful, quality support intervention programme for individuals with health risks or established health conditions.

Report of the Sport, Wellness and Partnership Manager August 2011 on the Sunderland Lifestyle, Activity and Food Programme Annual Report (April 2010-March 2011)

Introduction

Sunderland LAF – Lifestyle Activity and Food programme is commissioned by Sunderland tPCT and delivered in partnership between City Hospitals Sunderland NHS Foundation Trust and Sunderland City council's Wellness Services. The programme is available to any child aged 5-15 years who is above the 91st centile on the UK 1990 BMI chart.

Outcomes from feedback across the programmes

- In total 26 families attended the 4 programmes
- The majority (97%) of the 26 families felt that the session day and time suited them
- The majority (92%) agreed that the recipes were suitable and could easily use them at home again
- The majority (92%) said the LAF programme had made a positive impact on helping them and their family to make healthier lifestyle choices
- All 26 parents said they would recommend the course to others

Post programme questionnaire feedback

Feedback in general was positive with all of the parents enjoying the learning and making new recipes that they could use with their children at home. More specific feedback showed that

Accessibility

- The majority (97%) of the families agreed the venues and meeting places were excellent
- The majority (99%) of families found it easy to book onto the LAF programme
- 95% felt the venue was appropriate

Content and materials

- Were given information to make the right choices for their children
- Majority (90%) of families said they were happy with the content of the LAF programme
- Majority (96%) of parents felt the activities were delivered at the appropriate level for their child

- Some (10%) suggested other activities they would like to be included

Staff

- Generally found staff to be really friendly and helpful, professional yet down to earth, they didn't them what to do just helped them to understand

Impacts

- Most children who have attended the LAF programme increased their fruit and vegetable intake and physical activity levels
- 96% reported they felt fitter and healthier than they did before attending the LAF programme

Other comments

- Some stated mealtimes were a lot easier following the programme, children now understand more - raised awareness in children about calories, foods
- Now make belter choices and make time to exercise
- Social capital gained from meeting new people on the programme
- Take more caution over shopping now

Lessons learned during 2010-11 relate to potential barriers to the accessing of services.

Table 5.4.1 – overview of barriers to tackling obesity

Barrier	Explanation
Denial of a problem	Often parents do not accept that their child is overweight or believe that their child's weight is either normal or "puppy fat"
Accessibility	Families often only visit the GP when there is reason to do so- therefore GPs are not always in a position to refer into the programme- for this reason a self-referral process was to be implemented in September 2011 to assist in the removal of this barrier.

What is needed to improve service provision?

Support for maintenance

- Post intervention support is needed in several forms- include celebration events and follow ups at 3, 6, and 12 months after completion as well as a physical activity exit programme to encourage and promote physical activity
- Experiences of the past 12 months has reinforced the belief that a family centres approach is necessary to ensure the key messages from the programme are adopted

- Support of school nurses is required to engage more families in the programme
- Continuous communication with schools, GP practices and other healthcare professionals is needed to ensure they continue to support and refer onto the LAF programme.

Further development

Each member of the LAF team has been allocated an area of the city to concentrate on improving working relationships with partners to increase referrals

- Development of promotional materials- e.g. a DVD to promote LAF programmes
- A pilot programme for young people aged 12-15 was initiated in May 2011.
- Continue to develop the 2-4 years programmes within Children's Centres
- Develop and implement a self-referral process as an additional method of referral into the programme

Sunderland Weight management Programme Follow-up Survey Report

Patients who have a BMI of greater than 28kg/m² may be referred onto the programme by a health care professional (Commonly GP). The programme consists of one hour session per week over 8 weeks and aims to guide and support patients to improve their health and lose weight with nutritional education. Patients are weighed weekly and set a 5% weight loss target to achieve over the 8 weeks.

A survey was undertaken of patients who attended the Sunderland Weight management Programme in 2011. 300 questionnaires were distributed to patients randomly selected from those who had completed the programme in the last year.

- 100 to those who finished 3 months ago,
- 100 to those who completed 6 months ago
- and 100 to those who finished 12 months ago

Suggestions made to improve the programme

Most were happy with the programme and felt it did not need improving but a few specific suggestions were made for slight alterations

Promotion

- More widespread promotion of programme

Structure and content

- Length of programme was too short – needs to be longer and possibly to lengthen the sessions themselves (some felt they were rushed and went over the hour)

- Prefer smaller classes
- Use more examples and demonstrations of healthy meals for example, combating slip ups/ coping strategies
- More help with dealing with emotional/comfort eating

Accessibility

- More central location for people who have to travel by public transport

Support

- Could partners or families attend together to support each other?
- On-going support after completed e.g. maintenance group after
- Would like the opportunity to do the programme again as some reverted to bad habits after finishing the programme

Feedback

- Generally positive
- Most people found the programme helpful and useful, would recommend it and it made a difference to their understanding around nutrition and health, as well as improving confidence and self esteem
- Praised the teachers for their encouragement and support

5.5 WOMEN'S SERVICES

Cervical Screening Collaborative project

In January 2008 Sunderland TPCT commissioned the Bridge Centre in Washington to recruit volunteers to assist in increasing the uptake of cervical screening. Achieved through raising awareness of cervical screening in the community and understanding reasons why women were not accessing the services – the approach was to focus on two areas of Sunderland where uptake is low – Pennywell and Thorney Close. A questionnaire was developed and administered to explore barriers to screening.

Table 5.5.1 – Barriers to the uptake of screening provision

Barrier	Detail
Levels of knowledge	Results suggested that women did not fully understand what cervical screening does detect. • When asked why it is important, only 29% reported detection of cancer and only 23% early detection of cancer specifically • Some described the test benefits general health, with non-specific knowledge on the purpose of screening. • Some thought it would detect infection or a wider range of cancers so in this case, they would be falsely reassured by a negative result and may ignore symptomatic disease. • Many of the women who identified themselves as belonging to ethnic groups other than white and/or British gave a more general response to the question- this could be due to language difficulties
Experiences of screening	About 1 in 5 women had failed to attend at some time- increased to 1 in 3 for women aged 26-35. Main reasons included: • uncomfortable/painful (most popular) • Due to appointment or waiting times • Forgot their appointment

	• Feeling awkward or embarrassed • Don't like smears • Fear/ scared
Accessibility of screening	Majority of women would prefer to attend in the mornings followed by the afternoons (approx. 80%) • 38 (21%) women said evenings and weekends

What would encourage women to be screened?

The most popular factors were:

•Having a female practitioner

- Nurse being friendly
- Improved experience

less uncomfortable,

more control over how it was done

more informal atmosphere

- Information/advertising

Other factors:

- Appointment time/convenience
- Drop in clinic at certain times just for smears
- Extended opening hours (after 5pm)
- Interpreter
- Childcare
- GP recommendation
- Faster results

Recommendations

- Should be an increase in general awareness raising so that women can make informed choices
- All sample takers should be aware of these findings so they can improve women's understanding and experience of the cervical screening process

City hospitals NHS Trust Maternity Patient Experience Survey 2010: Summary of key findings from Questionnaires and Comments

The Maternity Patient Experience Survey is a locally produced questionnaire satisfaction survey produced by Sunderland PCT and Hospitals NHS trust. The April 2010 survey was given as a follow up questionnaire to all new mothers giving birth at City hospitals within one year of November 2009. 277 questionnaires were given out by midwifery staff, 56 responded giving a rate of 20%- 29 were first time mothers.

Table 5.5.2 – Needs identified within maternity services

Need from service	Evidence
Breastfeeding support	24 women had stopped breastfeeding (14 first time mums). Some women had given up breast feeding early in hospital – here additional support was necessary from midwives. More information needs to be given to women in hospital – better education on common problems and solutions e.g. it takes time for milk to come through, to prevent giving up prematurely.
Changes in Health Visitor provision	First time mothers may need to be able to access health visiting support more often in order to feel they are more supported Having a health professional they can speak to over the phone for advice and guidance is important to them Health checks were also seen as important in providing reassurance that all is well.
Preparation for pregnancy and for labour	First time mothers and younger aged mothers especially felt they needed more support with issues such as feeding, accessing the midwife, more information about labour and recovery. More information on parenting classes, ante natal classes and more check ups Some wanted better medical care during labour First time mothers especially wanted

	better and clearer communication from midwifery staff- such as when to go into hospital during labour
Preparation for discharge	More support for those with difficult births and first time mothers, e.g. nappy changing, bathing the baby. Better communication by health professionals- ensuring health visitors return calls
Improved general maternity care	Want improved levels of hygiene in hospital, staff being more attentive to their needs e.g. food and drink, staff attitudes occasionally. Maternity care needs to be personalised and needs-based rather than a one size fits all type approach First time mothers and those experiencing difficult births need more pro-active and additional levels of support
Improved postnatal care	23 women had negative experiences with their care, they needed better information, communication and support (not being left alone) Want their partners to be with them longer Want midwifes to be able to answer their questions Want to be reassured they were doing the right thing Want to be listened to Health staff need to keep their appointments and there needs to be more appointments available. Don't want to have to chase up health visitors

Recommendations

High number of women reported health care as excellent or good overall however comments uncovered some themes which suggest improvements can be made in existing maternity and health visiting provision.

- Some women felt they needed mores support/input from health professionals than others in the sample :- there is a need for more personalised care and support across maternity and health visiting - needs based approach which is more systematic and not ad hoc.

- First time mothers and younger age mothers (under 25) and those experiencing difficult births need additional levels of support by health professionals e.g. to be shown skills such as nappy changing, baby bathing etc.

- First time mums did not like being left alone for long periods with a new baby unsure of what to do

- Improved breast feeding support in hospital and on discharge – want info on common problems and how to overcome them

- A small number of women said that some staff had not followed up or returned their calls

- Mothers generally appreciated having a key health professional they could contact when they needed to at their convenience, both ante-natally and post-natally available for advice and guidance (by telephone/in person).

Sunderland Maternity Services Liaison Committee Maternity Patient Experience Survey: Summary of key findings from Questionnaires and comments –November 2010

This report is the result of a locally produced survey to capture patient experiences of maternity services provided in antenatal and postnatal care across Sunderland. 273 questionnaires were sent out via post. 23 women responded giving a response rate of 8%.

Emergent Themes related to what women want from midwives and health visitors

Although midwives were praised for their support, guidance and reassurance to women and support with breastfeeding, some areas for improvement were expressed as detailed in the table below.

Table 5.5.3 – Areas for improvement of maternity services

Theme	Evidence
Appointments with midwives	Need to arrive on time for appointments Appointments are too early in morning Visits were often too short- so not enough time to discuss issues

	Should be given option of more home visits rather than having to go to local centres
Support	Need to be more supportive to women who have decided breast feeding isn't for them More information needs to be given about keeping wounds clean/infection and checking wounds more regularly Want more support with weaning Better service provision during summer holidays
Continuity of care	Women did not tend to have the same Health visitor for each visit – would like more continuity so they can build a relationship with their health visitor. In general there was different staff for different visits.

Barriers

- Phone calls not returned by health visitors

Confidence to approach services

- 62% of women felt confident to access the midwife service, 18% did not really feel confident
- 56% of women felt confident in approaching the Health visitor service and 14% not really confident
- 86% felt confident to approach their GP surgeries, 4% not really confident

More confident accessing GP – this could be due to the services being new to them being first time mothers

- Doing well on provision of local services including easy access to baby clinic and children's centre groups, support for weaning and breastfeeding

Improvements to all services

- Listen to the needs of women more and listen to complaints
- Staff need to consider the way they talk to expectant mothers
- Waiting times in antenatal clinics created an issue
- Offering support if mothers choose to bottle feed – some felt pressured to breast feed but also offer more support with breastfeeding in hospital
- Want more support with weaning and foods

- Some mentioned would like their partners to stay longer with them in hospital
- Women wanted continuous information during labour around what is happening and more information following birth about breastfeeding, weaning, caring for baby and weight management for mother
- Better staffing levels on antenatal and postnatal wards.

5.6 YOUNG PEOPLE'S SERVICES

The pre-provision of Specialist Community Child and Adolescent mental Health and Learning Disability Service in Gateshead, South Tyneside and Sunderland 2011

NHS South of Tyne and Wear consulted on a new way of delivering a joined up Specialist community Child and Adolescent Mental health Service (CAMHS) and Learning Disability (LD) service. The consultation ran between August and November 2010 to give children, young people, parents, carers, staff, local people, interested organisations and key partners their say on the way in which the new service will be delivered across their area. Views expressed were gathered from a formal consultation document, a children's and young people's survey, a parents and carers survey and through focus groups, public meetings and one to one interviews. Stakeholder views were also included in the consultation.

Table 5.6.1 - the key themes in relation to what young people want from such services

Area of service	What is required
Access and appointments	Needs to be a single point of referral for the new service linked to the common referral pathways and young people. The new service should be delivered nearer to where young people live Appointments need to be available after school – flexible opening hours Use of local venues and a contact at the stage of discharge/disengagement Provide appropriate venues for therapies provided Ensure appointments are 'young person friendly' Adopt an outreach programme to engage families Reduction in waiting times and delays
Out of hours support	Need for immediate easy access to information and support, such as a 24 hour call out service in case of emergency and a 24 hour helpline with access to professionals to support parents and carers waiting for

	initial appointments or change of circumstances between appointments
Staff	Would prefer to have access to one key worker throughout their experience of the service – so don't have to explain their situation several times to a number of staff and/or agencies
Service design	Clearer transition arrangements into adult mental health services from the new CAMH and LD service to Adult mental Health Services (AMHS) – encourage joint working between these services Promote a single point of referral for CAMHS- seamless transition between the tiers to remove unnecessary waits Provide services for under 5s Provide a multi-disciplinary approach to the assessment of specific disorders e.g. Autistic Spectrum Disorder and clear links with speech and language therapy services Provide local community based services with integrated working with other services for children with a "one stop shop" approach Need for a holistic approach to ensure all children's workforces have an awareness of emotional and mental health issues and GPs have a greater supporting and information giving role Ensure equality of access for children with learning difficulties Increase the availability of advocacy services
Promotion of the service	Leaflets and materials must be jargon free, provide information about mental health and explain how the service and support services will work Materials should be available at a wide range of venues including schools, GP surgeries and online.

	Publicise the service and referral pathways Engagement activities with children and young people
Use of language	The use of positive language is preferred, particularly when describing the CAMHS and staff job titles – a dislike for the service name 'mental health'

A further survey was made available to children and young people through key leads working in various clinical settings of the existing CAMH and LD services. The survey was completed by 108 children and young people aged 12-18. Investing in Children (IIC) also carried out 2 agenda days for children and young people (YP) who had contact with CAMHS for under 11s and over 11s. They also conducted engagement work and focus groups.

Table 5.6.2 Young people's recommendations for CAMH and LD services

Area	Barriers	What is needed
Appointments and access	Young people had experienced delays in accessing services following an initial assessment and lack of provision to respond to a change in circumstances or crisis management Stigma attached to mental health issues	More information at GPs about their first appointment and support while they wait for a service from CAMHS with 'follow up appointments to provide a listening ear' To be treated holistically- with 'problem free talking' and listening to the 'whole story' and not just looking at the 'problem' To address stigma of mental health – more group sessions to discuss emotional and mental health issues in schools and youth settings Want workers to explain what is meant by confidentiality and the

		limitations of it A 24 hour telephone help line to be provided for immediate access to support Direct access to people and support groups Accessible service with up-to-date information An appropriate length of time to wait for an appointment would be 1 week Choice and flexibility over appointment times and dates and use of reminders by text for example the day before the appointment
Out of hours support	Times that services are available	Children and YP said they would talk to someone they already know if they have a crisis e.g. family, friend or worker Would use online media for answers and used on-line advisors Out of hours Freephone number to speak to an expert if needed and 24 hour drop in centres 24 hour call out service for emergencies Best time to access service would be after school
Staff	Concern to the young people was a lack of general support around emotional and mental health issues Negative experiences reported when trying to access services through their GP-	Other professionals should be able to refer them to CAMHS without having to go through GP first Would prefer to talk with someone that they already knew e.g. family or friend, teacher or

	workers/Doctors need to look at the whole person – talk about normal things and people need to get to know them	learning mentor- just to be there to listen not for specialised advice Workers need to be able to provide basic advice on emotional and mental health issues More access to emotional/mental health training to support them before things became a 'big' problem e.g. group discussions to tackle depression and mental health Want Doctors/workers to dress casually, be more informal, be friendly and approachable, trustworthy, respectful and show understanding, easy to get on with. The most important qualities mentioned were to be friendly and understanding Important to have the same key worker, would like to be able to access them directly i.e. have a direct number Be kept up to date.
Service design	Needs to be more user friendly	Range of venues was suggested e.g. community centres, youth clubs, schools and coffee shops Want venues to be familiar to them, central, easy to get to and easy to find and affordable by public transport. Do not want services based in hospitals Explore how appointments can be

		held in different locations Many would prefer to be visited at home or near to where they lived The waiting room environment is important being their first experience. Friendly welcoming reception. Modern waiting area- not like a Doctors surgery, things to do, leaflets to read, calm and laid back area Want to be told how long their appointment will take and what will happen. Recommended that appointment lead times and delays are reviewed. Do not want their name announcing and the name of who they are going to see and their title e.g. psychologist – this would indicate to others the nature of their appointment Want photos of workers so they can recognise workers
Promoting services	Did not think CAMHS was promoted to them and were unaware of it	Provide plenty of information about CAMHS, service expectations, how to access help using leaflets, posters, websites, open days, and events and introducing a 24 hour telephone helpline Accessible, easy to read information explaining different types of mental health issues and includes lots

		of Q and As such as when something becomes a problem Produce information in partnership with children and young people Increasing the promotion of parents and carers support groups, developing group sessions to discuss issues such as dealing with stigma and prejudice True accounts of YP with mental health problems and how they received help should be promoted
Use of language	Needs to be more user friendly	The YP did not like the use of the words 'mental health' on signage in buildings nor some of the language in job titles e.g. "I didn't want to see a psychologist because I'm not a 'psycho" Alternative service names to CAMHS as it is a confusing acronym and not used by all services across Gateshead, South Tyneside and Sunderland. Suggestions for alternatives included 'Happy heads and Happy Brains' and 'Speak'

Parental views

These were similar to those shared by children and young people.

- They felt that GPS and schools or colleges were the preferred referral method

- Introduction of a helpline with access to professional support was important for families at all stages of the service
- Access to information and advice in a wide range of ways including health visitors was helpful
- Felt the service should be delivered within the home
- Very important to have access to one key contact throughout the whole experience to develop rapport and for reassurance
- Would welcome a drop-in service in addition to a telephone service

The findings from the consultation for the redesign of the CAMH and LD services across Tyne and Wear are similar to 'keeping Children and Young People in Mind': the Government's full response to the independent review of what CAMHS means for children, young people and families (2010).

Sunderland risk and Resilience Consultation Event

The Sunderland's Risk and Resilience strategy was implemented in January 2009 until 31st March 2012. Sunderland Children's trust sought to develop a strategy that will help the Young People of Sunderland to cope effectively with the healthy risk taking that is an essential part of growing up and building resilience to the adverse consequences of unhealthy risk. A wider consultation with stakeholders took place during 2008 attended by 38 young people and 36 professionals from a wide variety of agencies including:

- The Youth Offending Service
- Bumps to Babies
- YDAP
- City of Sunderland College
- SVYSF
- Sunderland City Hospitals

Table 5.6.3 presents the themes related to risk and resilience

Theme	**Supporting information**
Support	Parent support in dealing with teenager behaviour and setting realistic and consistent boundaries e.g. mediation support Want a range of holistic young people's reproductive services across localities and based in young people's settings. More support for service users and parents. Address the emotional needs of

	young people through a ‘stress test’ before any other services were offered. Young people are different and need a diversity of services from which to choose in clinical, educational and community settings Support for teenage parents- group welcomed the Holistic Services for young parents and their babies Felt there should be emphasis on mediation between teenage parents and their parents and more support with housing
Education	School is an important place to lean about risk taking - PSHE teachers need to be retrained to deliver risk training at school- an important setting, they should be supported by peer educators and outside agencies. Schools block internet usage which can create a barrier. Group believed PSHE should be taught in an age appropriate way from the age of 4, use a variety of facilitators from the community and should involve visits to services in school time. Should incorporate teaching on the link between emotional well-being and other areas of PSHE e.g. drug and alcohol use and sexual health More emphasis should be placed on the emotional aspects of sex and relationships
Promotion and awareness	More publicising and marketing of services for young people in school and community settings. Professionals need to be aware of services that are available and support young people in accessing them Sexual health services should develop a strong brand across the city

	More emphasis needs to be placed on the marketing of services at the local level- suggest a post appointed to market all the services included in the Risk And Resilience offer Information needs to be available in a variety of formats and continuously updated
Staff	Attitudes of staff very important- need to be non- judgemental, have a mutual understanding about confidentiality and it's limits and a real sense of empathy Have workers who have enough knowledge to make appropriate and quick referrals into specialist services when they are needed.

The young people also hoped to see contraceptive and sexual health services for young parents delivered in projects such as B2B+.

'Your Health' Initiative background

A 3 year communications strategy has been developed by the Special Initiatives Manager working in Children's services on behalf of children's trust. The strategy aims to improve universal health messages to young people and their parents and carers; raise awareness of local services and increase accessibility; raise the profile of services and local health professionals; reduce barriers to accessing services; encourage better health communications with better materials and key venues.

Progress to date

'Your Health' 3 year communications programme

- Focuses on 11-18 year olds (secondary and college aged)
- 'Your Health' brand identity was established and a communications strategy developed – starting with sexual health pages
- Consultation exercise took place July 2009 – data on young people's consultation
- Launch in secondary schools was planned for January 2010
- Website developed
- Young person's health card for all 14-19 year olds was in development

2.College Initiative

Launch planned for October 2010

Brand identity established and young people in publicity

Sunderland seen to be leading field in this area with interest from other councils

Literature and Your Health Info Points (electronic interactive health dispensers) implemented in every college site

3.Also implemented Baby and Teen LifeCheck

Tellus3 Local Authority Report (September 2008)

Tellus3 survey asked young people about their local area and questions surrounding the Every Child Matters outcomes. The survey was representative of the population of year 6, 8 and 10 children.

Themes

- Young people wanted better information on eating healthy food, alcohol, smoking, sex and relationships and 'their body'
- Almost half of those surveyed have been bullied - wanted better support with bullying saying school did not deal with bullying well.

Health behaviour related Behaviour Survey (September 2008) Y6, 8, 10

The survey asked pupils in years -6, 8 and 10 a wide range of health and wellbeing and lifestyle questions.

- Of those surveyed in Primary schools – 24% worried about health problems
- 72% children would share a health problem with their mum, dad, carer first
- Those in secondary schools said they would seek help from family and friends first on numerous issues such as health, feeling sad, sex and relationships, drugs, being bullied, healthy eating, followed by Doctors, nurses and health workers.

Your Health Survey (July 2009)

This locally conducted survey sought young person's views (aged 12-19) on important health topics and how and where they would like to access future health information

Communication themes

- Best methods of communication – by MSN, text and Facebook – not twitter
- They wanted to receive information over the internet, 71% of young people wanted a dedicated website with games, forums and videos on it. They liked less text bright colours, easy navigation, graphical movement, short quiz sections and "nothing to look like the council"
- Through asking friends

• Locations - did not want information through the library , wanted it from school mainly and shopping or leisure centres

• They wanted more information on alcohol, smoking, bullying, drugs, pregnancy, sexual health and healthy eating

• Less than half knew how to direct a friend to information and advice should they need support with health issues

• Brand identity - liked iPhone apps images, wanted bright simple multi-coloured images, liked the existing iPhone imagery, silhouette figures and iPhone apps style buttons

Young People's Health Conference - 2005

Health Services in Sunderland: A report on the needs and wants of young people

Introduction

In March 2005 a consultation conference was planned and delivered by the Youth Educators: Advisors on Health (YEAH) for young people in Sunderland to identify barriers to access and explore how these barriers can be addressed. YEAH is a group of young people who are employed by the Health Development Unit, Sunderland PCT to participate in and facilitate the development of 'young people friendly' services in Sunderland. 67 young people attended the conference from 10 secondary schools and youth organisations. Workshops covered four major health issues: smoking, drugs/alcohol, sexual health and obesity/healthy eating.

Table 5.6.4 what young people want from services

Service	**What young people wanted**
Smoking	*Preferred location for service delivery.* - School was the most preferred location because they are a well-known environment - Participants did not want clinics during lesson times - Doctors were a popular choice because of professional knowledge and seen to be a safe environment but confidentiality was an issue. *Who should deliver the service?* - Preferred choice was ex-smoker as they can 'tell the story' will feel more relaxed with them. - Followed by Doctor- need for

	confidentiality stressed, see it as a safe environment - Need out of school hours • 43% of young people were unaware of smoking cessation services available to young people in Sunderland • Staff need to be friendly • They want advice, patches and the option to attend group sessions or 1:1
Sexual health and teenage pregnancy	There are not enough services and not enough sex advisors Want assurances of confidentiality , fear of being judged and that people they know may see them Services could be better advertised
Drugs and Alcohol	The majority of participants said they would go to FRANK for help with drugs and alcohol (28.5%) followed by Answers (19.5%) Reasons for suggesting FRANK included: - Well-advertised so more awareness; - Confidential and anonymous - Easy access- anyone can go and you can email them. *Reasons for not wanting to use a service:* - Unfamiliar telephone number, little awareness about it, not advertised well enough - Potential to be seen by people they know - if it is face to face - It goes on your record - you can't go on your own - If the service is not specialised - It is not clearly located - Unfriendly staff

	- Can't understand the language • The majority said they would not use a service if it was only a phone line and they didn't know the number • Although most young people said that they would prefer to go to parents or friends for advice- they would not trust the info to be accurate • Confidentiality was a major issue- they need to trust the services will maintain it and did not believe any of the services they mentioned would do
Obesity and healthy eating	*Barriers to access need to be addressed* • Worried about confidentiality • Long waiting lists are a barrier • Not enough groups like YEAH • Need to be different forms of help • Not enough home and school visits • Don't know what services there are *Suggestions for services* • The service should be local e.g. near a school and should be open after school and at weekends • Facilities should include a gym, pool and both indoor and outdoor facilities • The service should include a healthy eating café • It should be run by consultants with a specialist youth service • It should be funded by the government with cheap rates for young people • Confidentiality was not as important an issue as with other topics
GP practice questionnaire	The choice of who to talk to about a health problem depended on a trustworthy relationship. Young people rated that they would feel

	most comfortable talking to parents and friends about a health problem rather than a health professional • Lack of privacy and embarrassment were cited as main areas of concern Choice of doctors were gender-congruent • Confidentiality was a major issue- the risk of breaking was perceived rather than actual. • Fear of being seen by a family member or friend was a major concern • • The physical environment within the surgery promoted most negative comments • They would prefer a specialist service for young people in GP practices

Summary

Awareness of services

Needs to be more promotion of what services are available

1. 79% of respondents do not know what a health service is
2. 43% are unaware of stop smoking services for YP in Sunderland
3. 62% are aware of sexual health services for YP
4. 80% said there should be more awareness of sexual health services
5. 50% not heard of Answers (local service to Sunderland)
6. 83% not aware of 5 a day

Issues around confidentiality

- Location of services is important (concerns about being seen)
- Most young people would choose parents or friends to talk about a personal problem
- Lack of trust in health professionals is a barrier to access
- Breach of confidentiality is perceived rather than actual – but creates a sufficient barrier
- Trust in confidentiality equates with good service

- Lack of personal relationship with doctor will lead to concerns about breach of confidentiality
- There is a lack of confidence in the discretion of school nurses, more important with issues such as drugs/alcohol
- Need for a high level of trust in confidentiality from sexual health services

Delivery of services

- Need to be delivered after school or weekends
- Locations need to be easy to find (City centre), local and familiar e.g. schools
- Staff need to have experience of the issue, friendly attitude, professional training, easy to understand (Both terminology and accent)
- They would want help in emergencies
- Waiting times need to be looked at
- Environment needs to be more friendly, not stuffy and old
- Need help lines/free phone- appealing and well known- need to be backed up by service delivery

Ways to address barriers

- Raise profile of services
- Raise awareness of services through YP magazines e.g. Street
- Implement a 24 hour help line connected to local services
- Expanded delivery of services at local community sites e.g. school based health centres
- Explicit confidentiality policies in YP friendly format
- Camouflage service entrance and reception areas e.g. café or youth centre
- Non-clinical environment for service delivery
- YP only service and/or specialist drop-ins within general practices
- Increase delivery services from Answers One Stop Shop
- Provide services for YP in a one stop shop to address issues

5.7 GENERAL POPULATION ACCESSING SERVICES

Stroke/TIA Awareness Raising Research Draft report

NHS South of Tyne and Wear, April 2009

Introduction

NHS South of Tyne and Wear commissioned a social marketing exercise to understand the barriers for people accessing appropriate care in a timely manner and to understand how best to raise awareness of the care pathway with relevant professionals. Explain was commissioned to use the Mosaic marketing group to conduct this market research. They conducted consultation with residents of SoTW who had already suffered a TIA/stroke or the carers of them and consultation with the general population i.e. potential users of services. They also conducted a consultation with professionals to establish information and support required.

- 7 Focus groups and 10 in depth interviews with general SoTW population
- 60 in depth interviews with professionals and residents who had suffered a stroke/TIA in the last 2 years and carers

Barriers to accessing help/services

Table 5.7.1 – barriers to accessing services in relation to stroke patients

Barriers	Themes supporting the barrier
Awareness and attitudes to health	The biggest barrier was lack of knowledge or information about strokes or TIA, common across all sectors of the public including each BME community spoken to • Respondents agreed that people suffering from the symptoms of a TIA were less likely to get immediate help, than those suffering from a stroke – because symptoms may be less severe or confused with symptoms of another less severe problem or problems such as cerebral palsy, diabetes, drunk, ordinary headaches. • If there was uncertainty of the symptoms- some respondents said they would be tempted to do nothing first, depending on age and how well

	they knew them and then go to GP/NHS Direct/walk in centre- not realising the severity
Cultural issues	BME respondents varied in their attitude to stroke symptoms: For example the Indian and Bangladeshi communities tend to be more laid back which would affect the likelihood of seeking emergency services - would expect the symptoms to go and are therefore unlikely to do anything about it - Chinese have a perception that medical treatment in the UK is different to that in China and this may prevent them from dialling 999. - The Jewish people preferring not to bother people may be more likely to phone their own emergency services • Some BME communities have a general lack of knowledge of the NHS system and what it provides Females may not go to the GP on their own – especially common to the Bangladeshi community. • Treatment disparities between cultures e.g. Chinese very different to Western • Faith issues- worried they may not be able to pray whilst in hospital or may receive wrong foods, particularly for Muslim community Fear • Fear was a common barrier – fear of wasting time , finding out that was actually wrong, fear of never coming out of hospital
Language and terminology	• Especially with older people, perceived hassle of using interpretation services. Unable and frightened to call 999- communication barrier Some professionals talked about the

	use of language or terminology -'TIA', 'minor' stroke not conveying the importance of accessing immediate medical help • Not everyone – public or professionals knew what a TIA was. Public latches on to words.
Attitudes and perceptions	• Misconception that you are not at risk unless you are old • Embarrassment, pride and denial characteristics linked to all ages and all backgrounds • Common to the older generation – dislike of having to answer too many questions (need for privacy but also speed) and a wish not to cause a fuss • Perception of hospital – mistrust of the hospital environment influenced by their own or others experiences- evident across different sub groups • Inconvenience of going to aftercare appointments • The shame some survivors feel for needing any sort of care • The embarrassment and lack of confidence that precludes many from attending stroke clubs (Explain attempted to recruit survivors to a stroke club and found that many wouldn't join for often three years after their stroke)
Appointments	• Appointments/waiting times in hospitals – puts people off. Difficulty with getting an appointment with a GP • 999 Call operators- ask too many questions instead of taking your address and sending out an ambulance straight away • Dislike of doctors/hospitals – previous experiences of being let down by staff, not giving efficient treatment/care • Accessibility – if they don't call out an ambulance and don't drive- transport issues

What they wanted from services

Improve knowledge via awareness raising and information provision

- Low awareness of causes and risk of strokes - greatest perceived barrier to seeking help in a timely manner
- Misconception of strokes only affecting older people-use examples of younger survivors to raise awareness
-

Education and Information for the community

- There were several gaps in information that survivors and carers felt were important to fill
- From GP, In hospital and after care (and to be on-going)
- For survivor, carer and family and for general public
- Information to help recognise symptoms and access right help- respondents wanted shocking, relevant imagery (much like FAST)
- Wanted information on the causes and risks and how to prevent these
- Clarity about the difference between a stroke and a mini-stroke (preferred not to use the term TIA)
- Types of messages to be considered- prevention vs. cure
- Want to know what the age of a person is who can be affected by stroke
- Information throughout the hospital experience
- What all the tests were for
- What would happen next
- How to aid recovery and where to find support and aftercare
- Want to know about effects and consequences to the sufferer and family and friends
- Needs to be given at appropriate times so can be understood
- Use of appropriate language and explain terminology

BME communities

- Individual targeting of each community Is essential
- Messages to go through community leaders- traditional communication will not always be effective.
- Education is essential – could use ‘show and tell’ session with survivors giving their story
- Look at service availability within communities
- It was more likely BME communities were to respond if they could see a reason (and in the case of the Jewish community- it was endorsed by

Rabbinic authority- messages are more validated if you have a Rabbi's endorsement)

- There is a need to communicate the relevance of the NHS and healthcare system to the BME community and how it is in the best position to help all communities
- The Jewish community needs more information because they have other priorities, but they may be wary of being patronised
- For the Chinese community – information that would overcome the perceptions that hospital treatment is better in China
- Issue for the younger Bangladeshi community is to get them interested first – link information to something interesting to them e.g. football
- Educate the Indian community on the consequences of a stroke

Communication methods

- Ways of communicating the message recommended by the public:
- Consider who communicates: GP, Optometrist, employer, friends etc.
- Leaflets and posters- GP surgery waiting areas, community centre, chemist, library, post office, sports centre etc.
- Public Transport (buses and metros)
- Internet- NHS website and Facebook
- Media (television, radio, newspapers, magazines, cinema) – advertisements and soap storylines
- Education at school, in the workplace and in the community – use survivors to inform and inspire
- Word of mouth - children passing onto adults (pester power), discussion groups
- Miscellaneous (pub, supermarkets, stadia, motorway services)
- Age appropriate - Older generation may prefer to listen to radio rather than watch TV

BME community

- Important to understand the culture of the community before communicating any message for example if an effective way is to go into the community and proactively spread the message and allow word of mouth to echo it.

Examples:

- Indian community – use talks, presentations in mosques and temples
- Asian channels on TV, survivors passing on messages
- Bangladeshi community – community centre, hand out one leaflet in simple English or a DVD
- Bengali channels on TV, education in school

• Chinese community – Delivered in Cantonese for older community , Mandarin and Cantonese for young, use Chinese TV channels, leaflets in Chinese supermarkets, China Town

• Jewish community – Prayer, learning institutions, Labruit- a healthy living centre newsletter, leaflet drop endorsed by the Rabbonic authority, on the notice board.

Tackling barrier of fear, embarrassment, pride and trust

• Education of process, service provision, access for high-risk people, family etc.

Training

- Was felt that there was a need for more public facing staff e.g. receptionist at a hospital or GP surgery to be made more aware of the symptoms and what to do in the event of someone presenting with those symptoms

- Particularly information and training in the use of FAST

Health Champion report – April 2012

Leeds Metropolitan University conducted an independent evaluation of the Sunderland health champion programme, a programme which aimed to improve health and address inequalities in the Sunderland area via the piloting of a workforce development scheme. 22 interviews in total were conducted. Focus groups were also conducted with health champions. 4 focus groups were conducted with 33 champions taking part. Quantitative data collected includes the analysis of monitoring data from the tPCT database, as well as survey data. All 144 consenting health champions were sent a survey, 58 surveys were returned: 52 online and 6 by paper within the workshops (40% response rate).

Evaluation findings

The evaluation did not focus specifically upon exploring what people wanted from services but did explore the level of sign-posting that was done by health champions;

Number of times Health Champions reported signposting contacts to services in the last two weeks

• 25 (47%) signposted colleagues to other services in the last 2 weeks, 4 people signposted more than 10 times

• 37 (67%) signposted clients, customers or service users to other services in the last two weeks- 8 people signposted more than ten times

• 26 people (49%) had signposted friends to other services in the last 2 weeks, 2 people signposted more than 10 times, 23 people (43%) signposted

family to other service in the previous two weeks, with 4 signposting more than 10 times

- 22 people (41%) had signposted people in the wider community to other services in the last 2 weeks, 6 signposted more than 10 times

46 (79%) stated that they were in contact with people who are disadvantaged in health or social terms, 6 people (10.5%) thought they were not in contact with disadvantaged people and 6 (10.5%) were not sure.

These levels of signposting show that knowledge of services can be improved via communication strategies such as those employed by health champions.

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