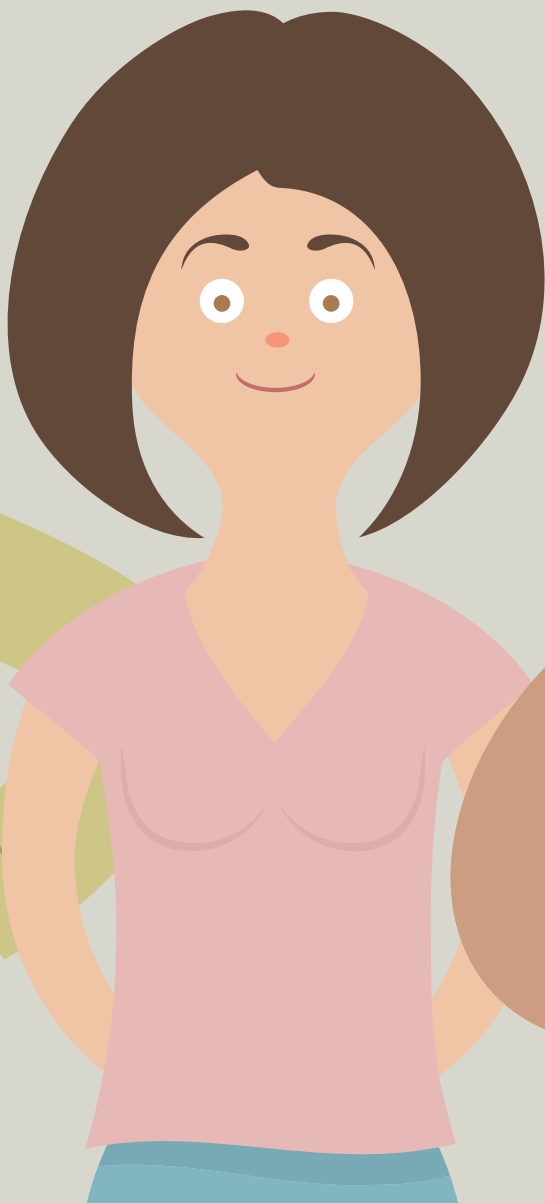
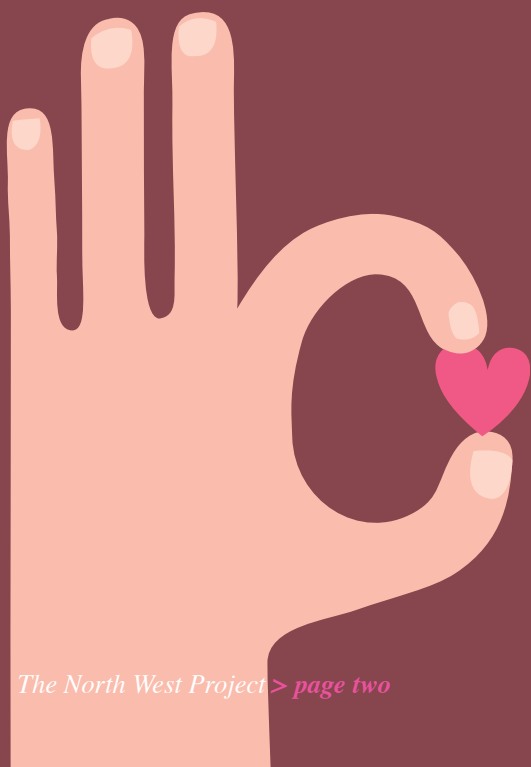

Reaching Out

Understanding the health attitudes of
harder to reach groups in the North West



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Foreword



01 >

The North West is a region of contrasts. Travelling from the north you will find the rural beauty of Cumbria, the mill towns of Lancashire and the conurbations of Greater Manchester and Merseyside. In all these areas, the region's hospitals and healthcare services manage an enormous range of issues. The post-industrial legacy of the region, however, means that amongst areas of prosperity there are still pockets of deprivation and inequality, where there is a higher likelihood of ill health and subsequently shorter life expectancies.

Against this background, NHS North West, Our Life and Pfizer have come together as a partnership to look at a sector of the population that does not routinely use the health care system in the North West, is economically deprived, and has existing health risk factors. For the purposes of this report, the research group is termed 'harder to reach'.

As equal partners in this project, we recognise the significant health challenges that face the population of the North West and we aim to suggest potential ways of bringing that population and the healthcare system closer together. We also share a determination to address those challenges by working in a spirit of collaboration. Our partnership, bringing together the public sector, health campaigners and the pharmaceutical industry, is an excellent example of how different organisations can join together and work across sectors to address issues and solve problems.

If we are to be successful in truly addressing health inequalities it is crucial that we gain an understanding of the attitudes and motivation of harder to reach population groups. This aim was central in commissioning our collaborative research and has informed all our work on the project.

By working together and reaching out to a group of citizens who do not traditionally have a relationship with health services in the region, NHS North West, Our Life and Pfizer hope to identify ways to improve and ultimately transform the health and wellbeing of an important part of the North West population.

We commend this research to colleagues and partners across the region.

Alison Giles, Chief Executive, Our Life

Richard Blackburn, Head of Primary Care, Country lead, Pfizer UK

Mike Farrar, CBE, Chief Executive, NHS Northwest

Executive summary



02 >

An ongoing review of health inequalities by Sir Michael Marmot aims to identify the health challenges facing England, post-2010, and determine the evidence most relevant to underpinning future policy and action¹.

The North West has the highest death rates in the UK from heart disease and stroke and the highest rates of long-term mental health problems and hospitalisation from violent injuries². Improving the health and wellbeing of this population and reducing health inequalities across the UK is one of the overarching ambitions of the NHS described in the NHS Operating Framework².

The 2010/2011 Framework, which sets out the ambitions, priorities, policies and purpose for the NHS, marks a pivotal year for healthcare services across the UK².

On one hand, all Trusts are facing major challenges to reduce overheads and management costs. On the other, the NHS still needs to maintain a focus on quality, drive innovation, increase productivity and efficiency, and drive towards a more preventative and people-centred service.

NHS organisations therefore need to develop robust and comprehensive strategies to which they will be held to account through their Operating Delivery Plans and the World Class Commissioning Assurance process².

In order to better understand the challenges facing the North West region and its healthcare services, and in recognition of the aims of the Marmot review, three health stakeholders in the North West – NHS North West, Our Life and Pfizer – have come together to provide this research. Over a four week period, Adelphi Research interviewed 258 volunteers within Cumbria, Lancashire, Merseyside, Greater Manchester and Cheshire³.

The results of this study demonstrate the clear views of some of those living in the North West about who is responsible for their health and when they choose to access the NHS. Around two thirds (64%) of those questioned believe it is their responsibility alone to take care of their health³. They do not see the NHS as a primary means for supporting them with lifestyle issues such as smoking, drinking or obesity and their priority lies with their families over their personal health.

All those chosen to be surveyed had not visited a doctor within the last one to three years³, were economically deprived and were at risk of lifestyle-induced, long-term illness³. There were 187 smokers who took part in the survey along with 67 people who had been classified as obese³. For the purposes of this report, the surveyed group is termed 'harder to reach'.

This research clearly highlights a number of recommendations that, if implemented, may support the transformation of the health and wellbeing of individuals and communities across the North West:

01> Refining the content and delivery of communications and messaging about healthy lifestyles and preventive services – Effectively targeting PCT communications to encourage disengaged individuals to take responsibility for their own health and to raise awareness of available lifestyle support services.

02> Increasing motivation of disengaged individuals through financial incentives.

03> Re-shaping services to better meet the needs of disengaged individuals and communities – Using insight to commission and deliver services appropriate to the target users in terms of place, time and style.

04> A skilled workforce – Regional workforce programmes need to ensure that the public sector workforce is fully aware of the attitudes and preferences of harder to reach population groups and are sufficiently skilled in responding to them.

This research is timely and supportive for NHS organisations, and highlights that individuals do not recognise the need to improve their own health and lifestyles or see the health system as a source of health and lifestyle support and intervention.

In response, the NHS must formulate better ways of reaching out and engaging with this audience. Managing the issues highlighted by this research will require a range of stakeholders using very specific communications channels to reach these communities and ensure appropriate provision of preventive services. Inactivity on behalf of the NHS will result in patients being condemned to ongoing poor health, matching the worst statistics anywhere in the UK.

Introduction



03 >

The full effect of the diversity that exists within the NHS North West region is apparent to anyone driving through the M6 corridor. From the rural beauty of Cumbria to the conurbations of Greater Manchester and Merseyside, our region's hospitals and PCTs manage an enormous range of health issues. The historic legacy of the region, however, means there are still some areas of deprivation where there is a higher likelihood of ill health and subsequently shorter life expectancies.

The region has the highest death rates in the UK from heart disease and stroke and the highest rates of long-term mental health problems and hospitalisation from violent injuries². NHS North West and other stakeholders, including Our Life, have been working to address these unacceptable inequalities and a comprehensive strategic plan is in place to improve health and life expectancy, especially within those communities most affected by poor outcomes.

A review of health inequalities by Sir Michael Marmot aims to identify the health challenges facing England and determine the evidence most relevant to underpinning future policy and action. Part of the Marmot review is to understand how this evidence could be translated into practice in specific demographics.

This current study aims to develop a deeper understanding of those individuals who are less likely to engage with the healthcare system in the North West and to suggest interventions that can address the determinants of health inequalities.

In order to better understand these attitudes, three health stakeholders in the North West – NHS North West, Our Life and Pfizer – have come together to provide this research. Over a four week period, Adelphi Research interviewed 258 volunteers within Cumbria, Lancashire, Merseyside, Greater Manchester and Cheshire³.

All those surveyed had not visited a doctor within the last one to three years, were perceived to be socially deprived and were at risk of lifestyle-induced, long-term illness. There were 187 smokers who took part in the survey along with 67 people who had been classified as obese³.

Objectives and methodology

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This research was designed to provide an insight into the attitudes around the health and lifestyles of this under-served sector of the population in the North West. The results from this study aim to inform the strategy for how best to encourage this group to improve their own health and to identify how the NHS could provide preventive services, with specific emphasis on key areas of smoking and obesity.

Each interviewee fitted into each of the following three criteria³:

01> Non-routine user of primary care

- 18-34 yr olds not seen a GP in the last three years
- 35-54 yr olds not seen a GP in the last two years
- 55+ yr olds not seen a GP in the last year

02> Economically deprived

- Respondents must be in receipt of benefits
- Household income of less than £11,000 per year, excluding benefits

03> At risk

- Having a health risk factor such as smoking, drinking, obesity, chronic condition, family risk factor

Working in conjunction with Adelphi Research UK, the research was developed in two distinct phases – a qualitative development stage and a quantitative stage.

Stage One: Qualitative development stage

A pilot day, consisting of five 45-minute in-depth interviews with candidates from the target demographic, was designed to canvass individual views on their perception of health issues relating to them and their families³.

The questionnaire was subsequently tested and refined before it was rolled out in the quantitative stage.

Stage Two: Quantitative – trends and analysis

For the second stage of research, recruiting from the same demographic, 258 people from Cumbria, Lancashire, Merseyside, Greater Manchester and Cheshire were interviewed for 30 minutes each³.

The resulting data were analysed to reveal key trends and relationships within the target demographic to gain an insight into their attitudes and perceptions of healthcare.

Region	Total	Sex		Age Band (yrs)					Ethnicity		Smokers	Obese BMI >30	No Qualifications	Income
		Male	Female	18-24	25-34	35-44	45-54	55-56	White	Non White				
Greater Manchester	21%	43%	57%	22%	24%	19%	22%	13%	52%	48%	74%	43%	52%	46%
Cumbria	14%	57%	43%	22%	16%	22%	30%	11%	97%	3%	81%	3%	35%	27%
Lancashire	17%	50%	50%	18%	20%	32%	9%	20%	91%	9%	80%	18%	50%	57%
Cheshire	21%	25%	75%	26%	15%	23%	23%	13%	100%	0%	62%	38%	62%	30%
Merseyside	27%	44%	56%	11%	19%	37%	14%	19%	99%	1%	70%	21%	70%	49%

The North West

05

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The North West at a glance

**210,500 Staff
Employed by NHS**

**64 NHS
Organisations**

Cumbria

Lancashire

Greater Manchester

Merseyside

Cheshire

**7 Million
Population**


**24 Primary
Care Trusts**

**39 NHS
Hospital
Trusts**

The North West



'Struggling Families' are low-income families, living on traditional low-rise estates



'Blue-Collar Roots' are communities in which most employment is in traditional blue-collar occupations

A snapshot of healthcare in the North West

NHS North West is the second largest of England's 10 Strategic Health Authorities (SHA)³. There are 64 NHS organisations including 24 Primary Care Trusts and 39 NHS Hospital Trusts in this region with 210,500 staff currently in NHS employment³.

The North West has the country's highest rates of deaths from heart disease or stroke, a high percentage of long-term mental health problems and an increasing number of hospital admissions for alcohol and drug-related conditions³. It also has a high level of hospital admissions for depression, anxiety disorders and schizophrenia, as well as an increase in violent injury incidences serious enough to require a hospital stay³.

The North West has a population of some seven million – higher than the national Strategic Health Authority (SHA) average population of over five million⁴ – and includes areas of great ethnic diversity.

The area suffers from significant health problems and severe social inequality – more than 50% of the North West population is considered to be deprived, and this region is the second most deprived SHA in the country³. This deprivation closely follows the density of the population, with more urban areas such as Liverpool and Manchester experiencing higher levels of social inequality⁴. The more deprived the area and the lower the annual income levels, the higher the health needs⁵. This supports the theory that the more deprived a population, the more likely it is to have current or future health issues.

The majority of the individuals studied in this report would be classified as socially deprived according to ACORN³ (a geodemographic classification system of residential neighbourhoods which classifies the UK into five categories, 17 groups and 56 types)².

Using the ACORN classification system to analyse respondents, better methods to reach these demographic types can be identified. Models already exist for reaching out to the ACORN types identified in this report – these will provide valuable insights when developing future communication strategies.

77% of the survey respondents were grouped under the following: Struggling Families, Blue-Collar Roots and Burdened Singles⁶.

‘Struggling Families’ are low-income families, living on traditional low-rise estates. This group has generally low incomes, a relatively high level of unemployment and high incidences of long-term sick leave. Additionally there is low educational attainment amongst this group⁶.

‘Blue-Collar Roots’ are communities in which most employment is in traditional blue-collar occupations. This group also has low levels of educational qualifications; incomes range from moderate to low and unemployment is higher than the national average, as is occurrence of long-term illnesses⁶.

‘Burdened Singles’ are urban groups, characterised by single adults. These include single pensioners, young singles and lone parents. Members of this group again have low incomes, higher than average unemployment and a high incidence of long-term illnesses⁶.

There are frequently cited disadvantages highlighted in each of the ACORN classified types described, including low income, high levels of unemployment and low educational attainment⁶. These disadvantages, combined with other lifestyle choices and low presentation to the NHS, could be determining factors in the higher than average occurrence of long-term illnesses in those surveyed. This highlights the need for a better understanding of this group in order for the NHS and other stakeholders to develop effective strategies to communicate about services on offer, with the audience studied in this research.

Key findings

06

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16%

of those questioned who did visit their GP within the last year, the majority of appointments were mainly for benefit purposes³

Perceptions of the NHS and responsibility for healthcare

The data suggest that the majority of the respondents questioned are registered with a GP (89%), but that they do not regularly visit their local surgery or medical centre³. One of the key objectives of this research is to understand why these individuals do not use the preventive services provided by the NHS³.

The doctor remains an influential figure for respondents. The research suggests that patients neither mistrust nor are afraid of visiting their doctor – 63% say they would trust their GP or family doctor to deal with conditions such as weight loss, smoking or alcohol use³. And 70% would not be embarrassed to discuss their problem with their GP³. In addition, 43% of those questioned said that professional sources are the ones they most trust, with only 17% valuing opinions of family and friends first³.

However, when it comes to lifestyle issues such as obesity or smoking, this group does not see the NHS as a primary source of help. Instead, 64% believe that it is their responsibility to look after their own health if they do get ill³.

Of the 16% of those questioned who did visit their GP within the last year, the majority of appointments were mainly for benefit purposes (allowing the individual to claim benefits based on ongoing illness certification from their GP) or for their children, rather than being prompted by their personal health needs³. In addition, 77% of those questioned believe that they have to be ill in order to see their GP³.

So, while respondents understand the role of the NHS in dealing with specific health problems and issues, like diagnosing illnesses and dispensing medicines, there is a lack of awareness of the role that the NHS can play in helping to tackle various lifestyle health issues at an early stage.

64%

believe that it is their responsibility to look after their own health if they do get ill³

63%

say they would trust their GP or family doctor to deal with conditions such as weight loss, smoking or alcohol use³

Understanding social foundations and perceptions of health

07

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Parts of the North West region have a high proportion of social deprivation, with 50% of the population said to be deprived³. In order to acquire a deeper understanding of this group's attitudes to health, the research also probed favoured social activities, what is important to them and the information sources they currently value.

Across almost all areas investigated, respondents thought they were significantly healthier than they were. Of those questioned, 26% were clinically obese (with a BMI of over 30) yet only 7% of those recognised they are overweight³. Additionally, as few as 6% thought they were binge drinkers, whereas the reality is 40%³.

There is also a level of misunderstanding as to what constitutes a healthy diet – 72% of respondents eat an unbalanced diet yet only 59% think they do³. In addition, for over half of those questioned (52%), health awareness was only triggered at point of diagnosis³. This low health-awareness and the extent of potential problems could be just one reason for not using preventive health services.

Family values

Family comes first for those surveyed. When asked what was important to them, the value of family was significantly ranked above health in order of importance³.

Access to information

This study indicates a largely sedentary lifestyle, with 81% of those questioned saying that watching TV is their most common social activity³. In contrast, just 33% go to the park regularly and only 7% play a sport or use the gym³.

While only 36% use the internet³ and 37% read national newspapers³, the majority of respondents (55%) read local newspapers³.

81%

of those questioned said that watching TV is their most common social activity³

Across almost all areas investigated, respondents thought they were significantly healthier than they were

Key barriers to health and maintaining a healthy lifestyle

08

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40%

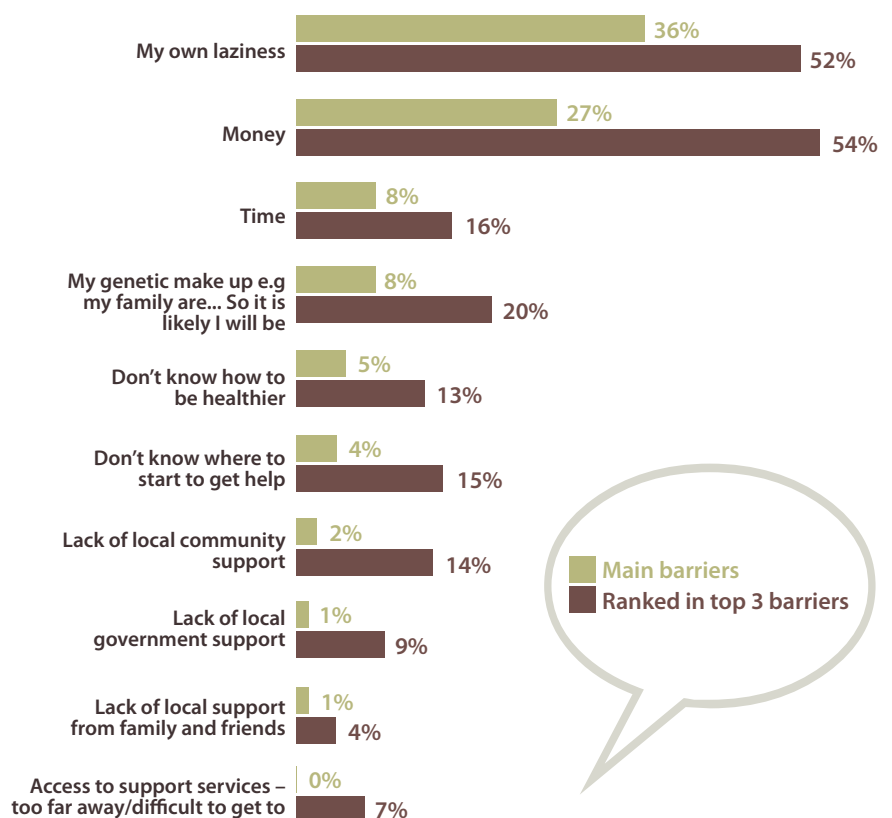
of respondents who smoke heavily do not worry about their health at the present time³

In addition to a reluctance to visit their GP, those questioned also cited barriers to being healthy in general. We have already demonstrated the misconceptions that exist between what is perceived as healthy and what actually is healthy among those questioned. Although they understand and see the link between their 'health' and 'living a healthy lifestyle', perceptions of what this entails vary enormously.

To better understand the poor health of those surveyed, it is important to understand what they believe are their key barriers to maintaining a healthy lifestyle. Lack of money (54%), laziness (52%), and genetics (20%) were most frequently cited as the top three barriers to having a healthy lifestyle³.

The research reveals that 40% of respondents who smoke heavily do not worry about their health at the present time³, and 46% of clinically obese patients are not currently trying to lose weight³. However, 40% of respondents would like to live longer than they actually expect to live³.

Health is recognised by this group as a key driver to living longer. Of those questioned, 17% realise that they need to be healthier and 21% know they need to eat more healthily in order to live to the age that they aspire to³. However, 84% of those questioned say that they do not really worry about their health at the moment³ but 64% state that they are likely to worry about the impact their health will have on their life in the future³.



Routes to improved healthcare

09

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Taking responsibility

As mentioned earlier in this report, the majority of respondents (64%) recognise it is their responsibility to take care of their own health³, but would not approach the NHS for help or guidance – instead, 54% turn to family to look after them when they are ill³. In comparison, only 9% would visit their GP or family doctor and only 1% would go to their local hospital³.

There is a clear understanding of the need to improve lifestyles in order to enjoy a better quality of life and gain a longer life expectancy. There is recognition of wanting to improve their lifestyles for the sake of their future – over two-thirds (64%) admit they worry about the impact of their lifestyle on their future health and how it could affect them in the future³.

Community and environment

When comparing personal health against the perceived health of the community, 56% of smokers believe their health is about the same as others in the local area³, while 57% of those with a BMI of more than 30 also see themselves being as healthy as others in their community³.

It would appear that community and lifestyle references play a significant role in shaping self-perception. Those questioned make observations relating to their own health based on the people and lifestyles around them.

Methods to reach the target audience

While 40% of those questioned did not recognise any previous health campaigns³, there were a number of Government campaigns that did resonate; including the F.A.S.T stroke campaign, which 28% of those questioned recognised spontaneously and the 'it's 30 for a reason' speeding campaign, which was recognised by 17% of the survey sample³.

We have already revealed that the most common social activity for those questioned was watching the television – with 81% stating that this was their top social activity undertaken in leisure time³. The research revealed that 80% of those questioned believed that television would be the best way to make individuals aware of services that are available to them locally and 33% say that materials through the door would be the best method³.

The research also reveals that the majority of respondents (55%) read local newspapers³ and 37% read national newspapers³, highlighting an alternative potential route for intervention.

Opportunities for intervention

When asked, 46% of those questioned said they were not aware of any solutions that could help improve their health and lifestyles. However, when all respondents were prompted with some potential solutions, many were enthusiastic about using them.

Introducing financial incentives as a means towards a healthier lifestyle was very well received. For example, offering individuals vouchers to redeem against certain healthy foods such as fruit and vegetables was the most popular idea for intervention – eight in ten (81%) confirmed they would be likely to use this service³. Additionally, free or subsidised services such as weight-loss, fitness and swimming classes were also a popular option. This option was particularly favoured by those with a BMI of more than 30, of whom, 50% said they would be very likely to take advantage of this service³.



54%
turn to family to
look after them
when they are ill

Discussion and recommendations

10

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15%

of the population in the North West are classified by ACORN as 'Struggling Families', who engage with their GPs primarily for benefit reasons

Communicating health messages and information about services

Harder to reach populations are by their very nature hard to help.

The real challenge is to identify effective methods to encourage and motivate disengaged individuals to improve their health and to raise awareness of the support that is available. This could be their GP, local pharmacist or other community health services. The task ahead is to develop communications and services appropriate to the target users.

This report provides a timely and geographically relevant precursor to the publication of the Cabinet Office Social Exclusion Task Force's work with the Department of Health examining primary healthcare for socially excluded groups. Their study is looking at how well the primary healthcare needs of the socially excluded are being met and will identify recommendations and tools for improvements⁷.

As well as contributing new analysis about specific groups, their project will consider how to improve access to, and quality of, primary healthcare for the most vulnerable in our society. It also aims to provide greater clarity about the contribution that primary healthcare services can make to social inclusion, and expose innovative ways of delivering NHS-funded care to those at risk. The report is due to be published in early 2010.

Children and family-related messages

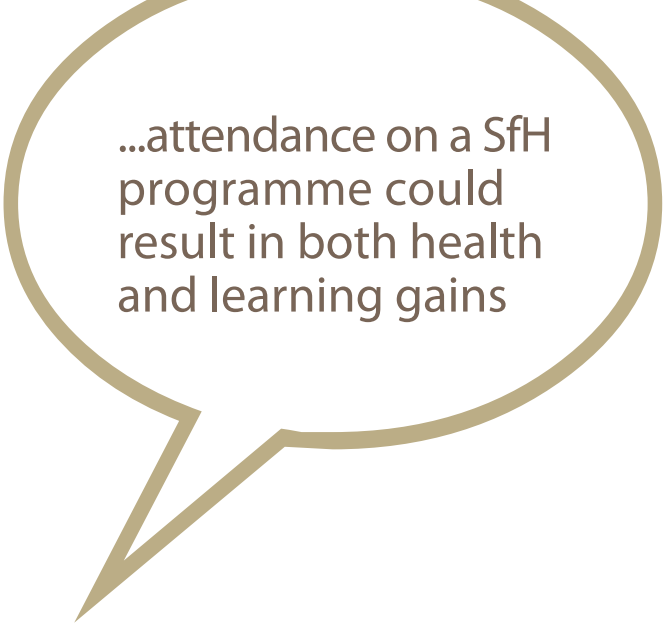
Given that 15% of the population in the North West are classified by ACORN as 'Struggling Families', who engage with their GPs primarily for benefit reasons, this group is likely to have a high exposure to child health services⁶.

This provides an opportunity to engage with these individuals using children and family-related messages which may have a stronger impact.

The Family Nurse Partnership Programme is a targeted intervention programme aimed at the most vulnerable pregnant teenagers. It is being piloted nationally and there are eight pilot sites in the North West⁸.

The intervention works with the mother to explore her aspirations and future hopes, and her readiness to adopt a healthy lifestyle. It encourages the teenage pregnant woman to consider the importance of being engaged in training or employment – an important element in prevention of ill health in families. Support is offered to those ready to make lifestyle changes. Whilst the overall emphasis is on ensuring maximum health of the child, the programme looks to encourage the mother to become the parent she would like her child to have.

Discussion and recommendations



...attendance on a SfH programme could result in both health and learning gains

Direct to consumer campaigns

Given that the surveyed group is largely home-based, due to high levels of part-time employment, unemployment and long-term sickness, communications delivered direct to their home may be a good route to reach this audience⁶. Respondents identified television and local newspapers as good routes to engaging individuals. This study found low educational attainment amongst this group and so information should be succinct and easy to understand.

Skilled for Health (SfH) is a national programme focused on engaging low-skilled people in learning in order to improve their health and skills for life. By embedding Skills for Life learning into health improvement topics it can address both the low literacy and health inequalities prevalent within traditionally disadvantaged communities⁹.

The North West piloted the SfH programme through community settings. National evaluation, across all settings, shows clear evidence of the success of the programme¹⁰. A second phase of the programme is being rolled out in more community sites in the region, as well as linking SfH to NHS North West's self-care programme and to the Offender Health Programme.¹⁰

Other communication mechanisms

- 01>** PCTs should take action to identify those individuals who are not registered with a GP and seek ways of encouraging full registration.
- 02>** PCTs should describe the prevention services on offer in each area tailored to individuals at different stages of their lives.

The NHS in the North West should consider developing a core guide for this purpose that is given out with every new GP registration, every new medical card issued, at the first appointment as an expectant parent, and generally available from PCTs and other local NHS websites.
- 03>** Health professionals should use every patient contact as an opportunity to ask about lifestyle, directing them to appropriate prevention services if necessary.

Increasing motivation

Lifestyle change in response to financial incentives is another key route to reach some of the disengaged audiences. As mentioned previously in this report, 'Burdened Singles' have very low incomes and are less likely to interact regularly with healthcare services unless they have a serious problem⁶. This means that services may need to be provided in a social or community-based setting, using a clear quantitative financial reinforcement. The Points4Life initiative, highlighted as a case study in this report, is adopting this type of approach.

Commissioning and delivering appropriate services

As this research has shown, many people in the North West do not avail themselves of health and wellbeing services³ because they do not recognise the NHS as a source of support.

The findings of this report highlight that people's aspirations for better health for themselves, their family and community may not be high. The most effective solutions will involve individuals and communities themselves in service development and in some cases delivery.


Commissioners, with public health colleagues, need to ensure they are collecting data on the population segments identified in this study, and are using the data effectively to inform the Joint Strategic Needs Assessment and the provision of appropriate services. As understanding grows of what it takes to be well, it is important that services build on the assets of local communities.

Commissioners should adopt a more collaborative approach to designing health improvement programmes, working with the end-users and the media as well as public health and communications colleagues. This co-production with the end-user will inspire the belief and drive for behaviour change to happen. The very act of involvement creates a value statement which is important at all levels.

As the findings of the report and the case-studies testify, there is no one solution but the focus should always be on the service user. To this end, commissioners need to prioritise the development of joined-up and holistic services, with more social involvement by primary care. With this comes a need to take an integrated approach, and to move away from individual organisations delivering similar or overlapping services with the commensurate risk that some population groups or types of services are not catered for at all.

A skilled workforce

Regional workforce programmes need to ensure that the public sector workforce is fully aware of the needs of harder to reach population groups and be sufficiently skilled in responding to them. The findings of this report provide valuable insights into some of the barriers and motivations that may be at play, and some of the potential solutions that a skilled workforce might employ in supporting healthier lifestyles.

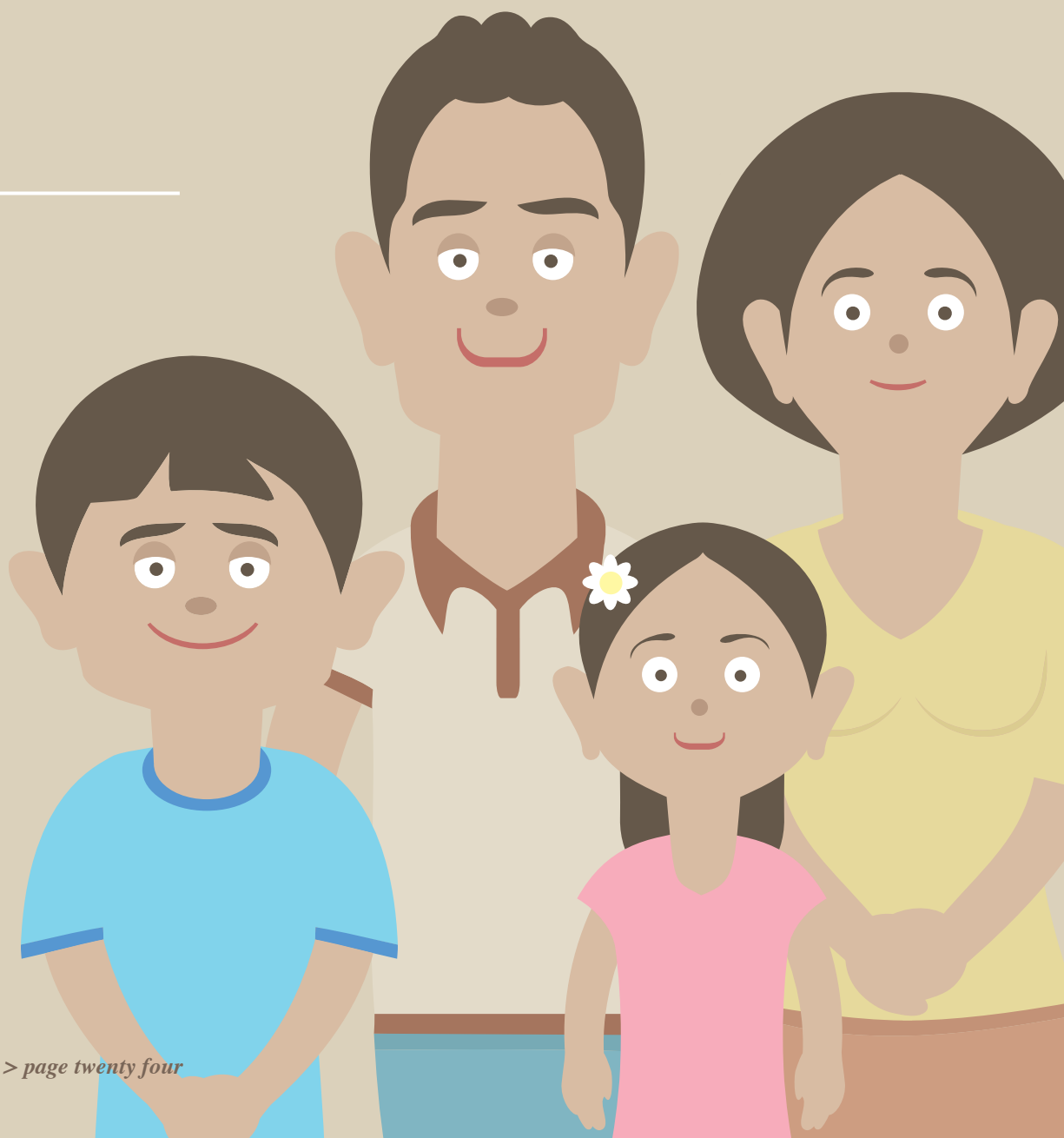


The findings of this report highlight that people's aspirations for better health for themselves, their family and community may not be high

Case Studies

11

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A £6million

programme of activities and support has been implemented across Blackburn which has resulted in a 71% increase in uptake of beeZ cards (Blackburn with Darwen Borough Council's leisure discount card)

Steps have already been taken to improve the lifestyles of those living in the North West

CASE STUDY ONE

Using financial incentives – Points4Life in Manchester

Problem

Many people, especially among the most economically disadvantaged, do not understand what constitutes a healthy diet or an appropriate level of physical exercise. And anyway, it is hard to resist temptation when faced with frequent choices between immediate gratification and more distant health benefits.

Background

Points4Life, developed by NHS Manchester and Manchester City Council, is the world's first citywide wellness incentive programme, rewarding people for making healthy and active choices. Points4Life brings together a range of partner organisations to help people measure their diet and activity levels, and create incentives to change behaviour.

Solution

Points4Life will launch in Manchester in the summer of 2010. Members earn Points4Life when they buy healthy food through partner retailers and by participating in physical activity with a range of partner organisations. The rewards depend on the number of Points4Life earned, with a range of rewards such as leisure and entertainment experiences, gadgets and money-off vouchers, as well as chances to win money-can't-buy prizes. Members who reach their Points4Life goals – representing achievable steps towards a healthier lifestyle – qualify for bigger rewards.

CASE STUDY TWO

Improving health and wellbeing in Lancashire¹².

Problem

Lack of physical activity in Blackburn with Darwen.

Background

The Re:refresh scheme was developed as a result of the Active People Survey, published in December 2006, which revealed that Blackburn with Darwen has:

- The lowest adult participation rates in the North West for any physical activity
- The 3rd lowest adult participation rates in the country
- 92% of the population do not do enough physical activity
- 58% of the population does no physical activity at all.

Through the Re:refresh scheme local communities are encouraged to increase activity levels with the incentive of free leisure facilities, health advice, dietary advice and more.

Solution

A £6 million programme of activities and support has been implemented across the borough which has resulted in a 71% increase in uptake of beeZ cards (Blackburn with Darwen Borough Council's leisure discount card). There has also been a 62% increase in attendance at leisure facilities in the borough resulting in many more people now leading healthier lifestyles.

CASE STUDY THREE

Taking heart disease prevention into the heart of the community in Merseyside¹².

Problem

Knowsley is one of the most deprived boroughs in the county and has very significant health inequalities to address, with rates of heart disease and stroke far higher than the national average.

Background

The latest health statistics (2008) show that although significant improvements have been made in recent years, the rates of heart disease and stroke remain much higher in Knowsley than the national average. It is estimated that more than 13,000 residents in Knowsley alone are at risk of heart disease. In 2008, 'Knowsley at Heart' was launched – a huge cardiovascular programme targeting high-risk groups with free health checks carried out in a community setting.

Solution

From October 2008 to the end of March 2009, over 1,300 Knowsley residents received a free general health check.

Case studies

CASE STUDY FOUR

Reducing obesity in Greater Manchester¹²

Problem

In Wigan borough, 57% of the population is overweight or obese. Wigan is now recognised as the most overweight borough in the North West.

Background

The Lose Weight, Feel Great programme was developed to help people of all weight ranges (overweight, obese and morbidly obese) access the help and support they need to lose weight. Public access to the care pathway is via a local free-phone number manned by NHS Direct staff where patients can be directed and enrolled into the most appropriate service or intervention.

Solution

The extensive social marketing programme for Lose Weight, Feel Great was rolled out in the first part of 2009 and inspired 2,500 adults to change their behaviour towards weight management either with an improved diet and/or an exercise routine specifically tailored to their needs.

CASE STUDY FIVE

Helping those in Cheshire live longer healthier lives¹¹

Problem

There is a need for a fundamentally different approach to tackling the source of sickness and ill health in Cheshire. People need to be given more opportunities to take responsibility for their own health.

Background

The YourHealthCoach service is part of the Staying Healthy for Longer project and is designed to provide extra support to patients with long-term conditions, above what would normally be provided by their GP.

Solution

The YourHealthCoach programme is a free telephone-based, nurse-led service that offers health advice and information. People can call a health coach to discuss their personal health concerns, or a health coach may call an individual to introduce them to the service, following a referral from their GP. On a monthly basis, health coaches will focus on different health campaigns and contact those individuals who have been identified as potentially requiring support (e.g. smokers or the overweight).

Half of the GP practices in Cheshire are participating in the YourHealthCoach initiative and the feedback from patients has been extremely positive.

CASE STUDY SIX

Reducing alcohol harm in Cheshire and Merseyside – a social marketing pilot in partnership with the pub industry

Problem

Most areas in Cheshire and Merseyside are well below the England average for alcohol harm but there are still high levels of people drinking to hazardous and harmful levels putting great pressure on health care services.

Background

In autumn 2008 the Cheshire and Mersey Public Health Network (ChaMPs) alcohol leads group commissioned the North West Public Health Observatory to undertake research to segment hazardous and harmful drinkers of alcohol in Cheshire and Merseyside. The aim of the research was to identify how a sub-regional response to preventing alcohol harm could be developed and targeted; identify areas for further research; and identify how drinking behaviour could be positively influenced and changed.

Following this report, ChaMPs Social Marketing team commissioned in-depth qualitative research to inform their alcohol segmentation pilot with a key Mosaic segment of male drinkers in Cheshire and Merseyside, 'Ties of Community'. There are high numbers of this group across Cheshire and Merseyside and they are predominantly in manual semi-skilled occupations and regularly drinking to hazardous or harmful levels. They do not access health services generally and may have underlying health problems as a result of excessive drinking.

The qualitative research showed that this group are not contemplating a change in their drinking habits at present



Within the last nine months 71% of clients have achieved a goal they set within their Personal Health Plan

and awareness needed to be raised to communicate the benefits to them of drinking less and encourage them to set their own behavioural goals to reduce their drinking levels.

Solution

The decision was taken to work with the pub industry to take the social marketing intervention to the pub itself rather than asking the men to access traditional NHS services. After extensive talks with the drinks industry, Robinsons brewery agreed to work in partnership with ChaMPs and trial a social marketing intervention in one of their pubs in November 2009 in the Central and Eastern Cheshire area. The main aim was to help men become more health aware and realise the effect that alcohol may be having on their physical and emotional wellbeing.

ChaMPs Public Health Network in partnership with Central and Eastern Cheshire PCT made free, confidential health checks available in the pub to males aged between 35 and 55, which incorporated advice on reducing alcohol consumption, along with other interventions and promotions. The health checks have proved popular in the trial pub and many pub drinkers had not visited their GP in years.

The University of Chester is currently writing their evaluation report on the trial to see how it has worked and the programme was rolled out at the end of January 2010 across other pubs in the Cheshire and Merseyside area. The full evaluation report for Phase 1 of the alcohol social marketing programme will be available in June 2010.

CASE STUDY SEVEN

Health trainers in Greater Manchester

Problem

Health inequalities persist in our most deprived areas as well as specific population groups. We all know that making health-related lifestyle change can be thwarted by circumstances unique to each individual. These include bereavement, illness, debt, social isolation, violence, poor education, housing, self esteem and so on.

Health and social care professionals are often compromised by their perceived authority in their interactions with people around lifestyle-choices. Interlinked are issues of self efficacy, wellbeing, and perceived general health, which are key to being able to identify goals and achieve them.

Background

Information campaigns around lifestyle choices have not resulted in reducing health inequalities. Research reviews show that people who are least likely to make and maintain a lifestyle change need extra support from someone who thinks like them – a peer to peer approach.

Health Trainers are recruited from local communities and engage in community settings as well as building relations with key professionals and community leaders. This is a national initiative with four main outcomes:

- Reaching the hard to reach
- Making sustained behavioural change
- More timely and appropriate use of services
- Building the public health workforce.

The Health Trainer role is unique in bringing both community engagement and behaviour change competencies into one qualification and applied in practice.

With a network of support across the country, more than 80% of PCTs in the North West have set up a Health Trainer service.

Solution

Tameside and Glossop, in Greater Manchester, established a Health Trainer service for people who want to make a lifestyle change.

This team has worked with people in geographically deprived areas, in community venues, the acute trust's occupational health unit, post-stage 4 cardiac rehab, probation approved premises, schools, SureStart and multi agency one-stop shops. The team has also worked with people who have low-level mental health concerns, people at risk of coronary heart disease, and anyone else over age of 16.

Reaching the hard to reach is at the heart of their work. For example, on one day in January 2010 in Glossop, Health Trainers knocked on 126 doors, spoke to 50 people and generated nine clients who wanted to make a lifestyle change but need support to do so.

At present, the largest proportion of referrals are coming from General Practice (33%) and the next highest is self referral – testimony to the credibility and reputation of the service within the community. Within the last nine months 71% of clients have achieved a goal they set within their Personal Health Plan.

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