healthwatch
Nottingham & Nottinghamshire



Public Health Commissioning Intentions 2020
Wellbeing Focus Groups report

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Executive Summary

From June to July 2018 Healthwatch Nottingham and Nottinghamshire carried out focus group discussions and semi structured interviews in Nottinghamshire. This was with people who would benefit from the Nottinghamshire County Council wellbeing service but were not current users. The aim of these discussions was to provide insight for the Public Health Team who are looking to inform the recommissioning of the wellbeing service in 2020.

Members of the public across the County were asked about any barriers they may have, and potential solutions to accessing wellbeing services for stop smoking and tobacco control, low level alcohol use, weight management and low level mental wellbeing. Further questions included whether an integrated or separate wellbeing service would be preferable and whether services should be provided for all ages or separated between adults, and children and young people.

Participants outlined their barriers and solutions which were then grouped into particular themes i.e. institutional, psychological, financial, geographical and environmental. Barriers included such matters as not knowing where to go, delays once referred, how mental health issues had led to unhealthy behaviours, cost of healthy foods, distance to services and treatments that did not suit them.

Our focus groups and semi structured interviews indicated that the majority of consultees were in favour of an integrated wellbeing service. The preference is that it is based in their local areas and starts with addressing their mental wellbeing - described as the underlying factor leading to unhealthy behaviours.

In contrast, opinion was split as to whether a family or separate service for adults and children and young people would be most appropriate.

From these findings Healthwatch recommends that Nottinghamshire County Council looks to commission an integrated wellbeing service in local areas which has mental wellbeing at its core. This service needs to be easily identifiable, have flexible access options and responds to individual needs in a timely manner.

Introduction

On 30th March 2020 the current Nottinghamshire County Council (NCC) Public Health commissioned wellbeing services contracts will be coming to an end. In preparation for this, NCC are in the process of considering the procurement options available, the scope of the services and the outcomes that can be expected from the newly commissioned services. As part of this, a public consultation is being undertaken to understand the needs of current and potential users.

In June 2018 Healthwatch Nottingham and Nottinghamshire (HWNN) were commissioned by the NCC Public Health Team to undertake 9 focus group discussions as part of the consultation. The aim of these sessions was to consult on:

- Stop smoking and tobacco control
- Low level alcohol use
- Weight management
- Low level mental wellbeing

These focus group discussions were held with members of the public who would benefit from wellbeing services but were currently not using the service.

The NCC Public Health Commissioning Intentions Engagement Sub-Group identified who the target audiences would be and the questions. These were then developed in conjunction with HWNN. The questions were designed to identify what are the barriers to accessing services, what changes might overcome these barriers, whether people would rather access services as a family or an individual and whether separate or integrated services were preferred. These questions can be found in Appendix 1.

Our approach

An orientation workshop was held on 21st June attended by seven Healthwatch staff. The aims were to fully understand the rationale for the project, refresh staff knowledge of how to carry out a focus group discussion and familiarise themselves with the materials and resources to be used to collect the information. In addition, staff were briefed by the Senior Public Health and Commissioning Manager on the current and future wellbeing service and the terminology used in the briefing papers.

HWNN carried out a mapping exercise to identify groups across the County to ensure a demographic and geographical spread of responses - see Appendix 2. The NCC Public Health team supplied maps showing areas where smokers, alcohol users, people with low level mental wellbeing and weight management issues were living in order to support the mapping process. See Appendix 3 for this map.

HWNN approached 68 diverse community and self-help groups which represented a wide range of members of the population including, but not limited to, the following individuals:

- Working aged smokers and drinkers
- People with low level mental wellbeing
- People aged 65+
- Individuals who are homeless or at risk of homelessness
- Carers
- Young people
- Members of the LGBT community
- Job seekers and people in receipt of benefits

In total 8 focus groups and 10 semi-structured interviews were conducted involving a total of 66 people.

At the focus group discussions the project was explained, consent forms were signed, the discussion was recorded and demographics collected.

The recordings were then sent to an external transcription company where they were typed up verbatim. On their return, the narratives were coded into themes and then analysed by the Evidence and Insight team. The findings are summarised in this report with conclusions and recommendations to inform NCC how to improve access to the Wellbeing service for those who might otherwise not use it.

Data analysis and reporting

In total 8 focus groups and 10 semi-structured interviews were conducted involving a total of 66 people as per the NCC brief. These were distributed across the County as follows, Ashfield 7.6% (n=5), Bassetlaw 28.8% (n=19), Broxtowe 4.6% (n=3), Gedling 18.2% (n=12), Mansfield 12.2% (n=8), Newark and Sherwood 15.2% (n=10) and Rushcliffe 13.7% (n=9). The detail of this is shown in Table 1.

All responses split by district/borough	Number	Percent
Ashfield	5	7.6%
Bassetlaw	19	28.8%
Broxtowe	3	4.6%
Gedling	12	18.2%
Mansfield	8	12.2%
Newark and Sherwood	10	15.2%
Rushcliffe	9	13.7%
Total	**66**	**100%**

Table 1 Source all participants (n=66)

HWNN consulted with people who would benefit from using the wellbeing services but were not current users. Of these 40.9% (n=27) were smokers, 18.2% (n=12) were low level alcohol users, 39% (n=26) had weight management issues and 13.6% (n=9) had mental health issues. (NB this total adds up to more than 100% as some people ticked 2 or more categories).

All responses split by unhealthy behaviour	Number	Percent
Low level alcohol use (14+ units of alcohol /week)	12	18.2%
Low level mental health issues	9	13.6%
Smokers	27	40.9%
Weight management	26	39.0%

Table 2 Source all participants (n=66)

A wide range of age groups were targeted in order to gather different views. The youngest participant was 17 and the oldest was 87. 60.8% (n=40) were aged 35-74. People under the age of 16 were not targeted as the new service is aimed at 18+ from 2020. The ages of participants is shown in Table 3.

All responses split by age	Number	Percent
16-17	2	3.0%
18-24	7	10.6%
25-34	7	10.6%
35-44	10	15.2%
45-54	10	15.2%
55-64	10	15.2%
65-74	10	15.2%
75-85	6	9.1%
85+	1	1.5%
Not collected	3	4.5%
Total	**66**	**100.0%**

Table 3 Source all participants (n=66)

The nationalities of participants is shown in Table 4. 78.8% (n=52) were British and 9.1% (n=6) were Polish and Romanian. According to Census 2011 people holding EU passports was 13,654 which is 1.7% of the Nottinghamshire population. Our Eastern European participants represent 9.1% of our sample as per the NCC requirement to consult with this cohort.

All responses split by nationality	Number	Percent
British	52	78.8%
Polish	5	7.6%
Romanian	1	1.5%
Unanswered	8	12.1%
Total	**66**	**100.0%**

Table 4 Source all participants (n=66)

The full demographics can be found in Appendix 2.

Barriers to accessing Wellbeing services

Findings have been grouped into barriers that prevented participants accessing wellbeing services followed by the solutions to overcome these barriers. The categories of the groupings are institutional, psychological, financial, geographical and environmental and technical. They are presented in order of importance and amount of dialogue that participants gave to each barrier. In general people who had accessed wellbeing services in the past were better able to detail the barriers and solutions than people who had never accessed wellbeing services – the latter tended to make assumptions around the issues.

Institutional Barriers

Institutional barriers were mentioned by participants at each focus group.

The barrier to accessing wellbeing services most frequently mentioned was not knowing who or where to contact.

'There's lots of things out there but we don't know about them. Now things are so fragmented. Services here, there and other areas.'

This barrier was amplified by participants beliefs that services frequently changed names due to being recommissioned, closing down due to lack of funding or relocating from local areas to District or County locations. Participants described being further hampered finding services due to out of date information leaflets and out of date information on the internet. One person with dyslexia described not being able to access any information as it is all in written format.

Many participants described their experiences of delays in accessing wellbeing services, this was initially delays in accessing a GP appointment to gain a referral and then delays to access this service once referred.

'My GP suggested I got into the Let's Talk Wellbeing which I did. That was March and I'm still waiting [in July]*.'*

Participants with anxiety and depression (or family and friends with the same) described the delay waiting for treatment having had a negative effect on their mental health i.e. that they needed support at that time. Smokers also raised the issues of delays, they described the importance for an immediate referral before they lost the motivation,

'because it took so long, by the time I got it in my mind, and knew what I wanted and actually got it, that motivation had dwindled.'

Smokers who had dropped out of treatment part way through felt frustrated at having to go back to the GP to be referred again – another delay.

Once into the service smokers described providers as not being sufficiently knowledgeable particularly around smoking, *'being an addiction'*. This feeling was echoed by carers of people living with dementia who felt that services did not understand the stresses of caring for someone 24 hours a day.

A third issue was the short treatment times, for example 6 weeks to lose weight, 10 weeks of mindfulness sessions, 4 sessions of Cogitative Behavioural Therapy (CBT), 12 weeks of a *'wellbeing buddy'*, and a 12 week exercise programme. As *'one size does not fit all'* this had resulted in weight regain and restarting smoking for some. One smoker spoke about being told to, *'come back in a week'* which they felt was insufficient given the highly addictive nature of tobacco.

Support groups such as Music for Wellbeing and Eton Avenue Growers Association mentioned that providers, particularly GPs and key workers were not referring clients to them. Constant personnel changing e.g. in Mind, Framework and the Job Centre further amplified this situation. This lack of consistency of staff was also a barrier to service users. Participants described finding it easier to talk to key workers they know or had built a relationship with, particularly about mental health concerns.

'At the moment we're passed between different social workers, different OT's. We don't get to know them.'

The method of engagement described as causing the most barriers was the internet because, *'not everyone's got internet…especially the older generation.'* The phone was also described as being a barrier for some.

The chart below shows of summary of the institutional barriers.



Chart 1: Institutional Barriers

Psychological Barriers

Psychological barriers were mentioned by participants at each focus group.

The most named psychological barrier for participants was deciding to make the change, whether it be stopping smoking or losing weight. For many, mental health issues like anxiety or the stress of being a carer had led to them to start to smoke, drink alcohol or eat more. Only when their mental health was good did they feel they could address these issues. For some the lack of knowledge of *'what I was getting into'* or lack of confidence - *'didn't have the guts to phone them'* caused further anxiety and was a big barrier preventing them from contacting services. Further the anxiety of *'travelling into Nottingham [by bus from Newstead]'* for an appointment, asking for help, going into a gym or the worry about what would be said at the appointment was identified as a barrier.

'My very first time I was stood at the back for absolutely ages and I was thinking, I want to run, because it's really hard getting through the door.'

For others, the embarrassment about their weight, the number of cigarettes they smoke or how much alcohol they drink prevented them from telling services the true extent of their unhealthy behaviour. Smoking participants described under-reporting, and one person described a friend who drank 60 cans a week who, *'told the Doctor he drank 16.'*

Participants also spoke of feeling shame in front of peers, family, friends and neighbours. *'I'm sorry I'm not going to walk up in the middle of the shopping centre where everyone is likely to know me and start talking to the stop smoking practitioner.'* For another, *'it's that stigma if you have a worker coming to your house… it's like being under social services or something.'*

While many welcomed the idea of counselling, not everyone felt comfortable with this, *'the times I go to my Doctor about my mental health he doesn't understand at all. He just says go to counselling, go to counselling, but I don't like to talk to people about it.'* Another participant described their mother *'of a generation that won't open up and talk, but she needs to talk to somebody a bit more than her just sitting there nodding.'*

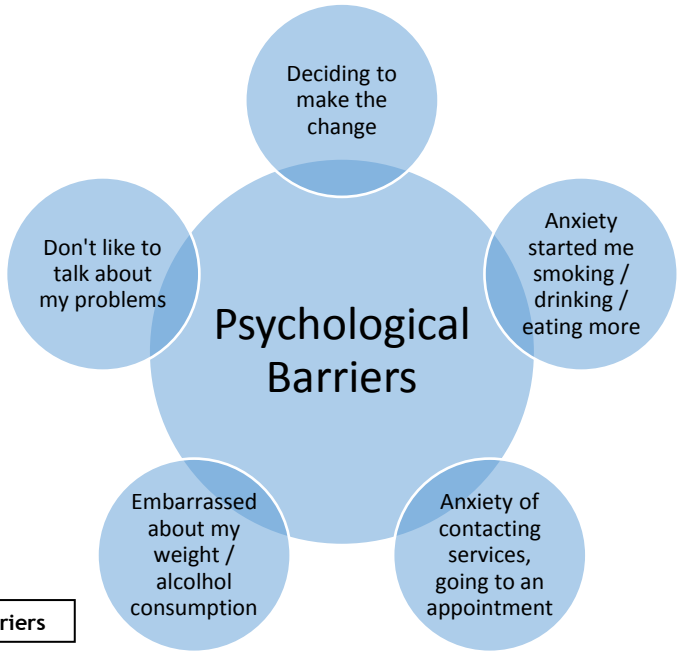


Chart 2: Psychological Barriers

Financial Barriers

Financial barriers were mentioned by participants at six of the focus groups.

A number of people spoke about the greatest barrier to reducing weight is the price of healthy food *'salad is a fortune', 'it's cheaper to eat rubbish food'* and *'you can buy a pizza for a £1.'* Along with, *'if you go out to the pub, there aren't that many healthy options to choose, so it's difficult, as in food wise, what can I eat?'* Even working people stated that they couldn't always afford healthy food. Weight Watchers at £20 per month was prohibitive for some, similarly with Slimming World. These prices prevented a couple of participants continuing which then led to regaining weight after stopping the classes.

Gluten free food was also named as expensive and while it's cheaper to bake at home gluten free flour is about £1.70 in comparison to regular flour at 90p per kg, *'for some people though, that little bit of extra cost, maybe people can't always afford it.'*

One respondent was offered a reduced membership fee at a Rushcliffe gym of £30 per month by their doctor but found it was cheaper to access a gym in Nottingham City at £15 per month. Another described having to travel from Eastwood to Beeston (11 miles) on 2 buses to access services, and another travels from Kirkby to Mansfield. Both cost around £6.50 on the bus.

While smokers recognised that it would sometimes be easier to access Nicotine Replacement Therapy over the counter from a pharmacist, they commented this could be up to 3 times more expensive than through a prescription.

Carers described having to pay for another carer to sit with the person they care for while they access a service. They commented that even though the County Council can offer financial support in these situations it can be hard to access.

Finally the funding cuts to community transport and rising thresholds to access this service were reported as a barrier to participants without access to a vehicle.

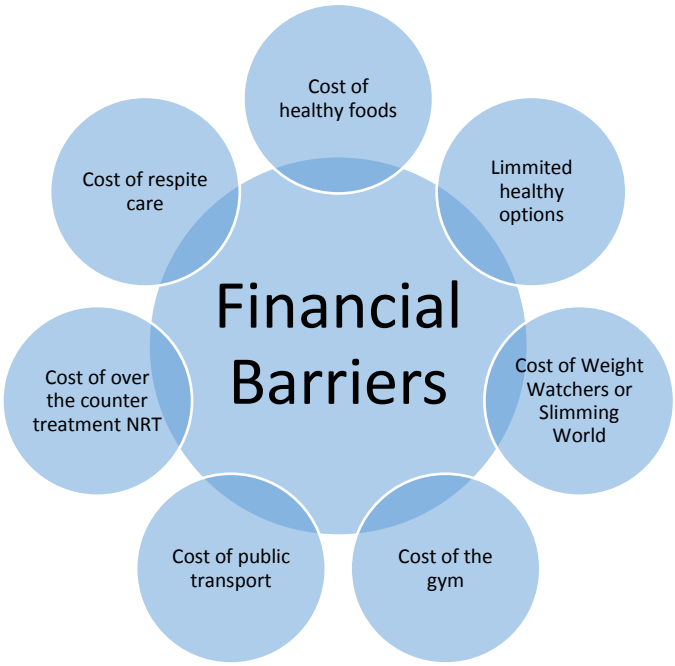


Chart 3: Financial Barriers

Geographical and Environmental Barriers

Geographical and environmental barriers were mentioned by participants at seven of the focus groups.

Distance was discussed a number of times as prohibitive to accessing services, such as the bus journey from Kirkby to Mansfield which takes 30 minutes and travelling from Worksop to Mansfield which takes one and a half hours. Within a district the locations and community vary greatly which in itself proved to be a barrier, *'So much of Broxtowe's work goes on in Beeston it's alien to Eastwood.'*

One person who was trying to lose weight spoke about their locality, *'There's a lot of temptation in the area where I live, there's a lot of takeaways, and a lot of temptation.'* This participant went on to talk about the gym, *'there is one thing I don't like about the gym, the air conditioning is rubbish, it's hard work, it should be a lot cooler, gyms are so stuffy.'*

A few felt that whatever was provided would be disadvantageous for people living in rural areas who would need to travel to access services.

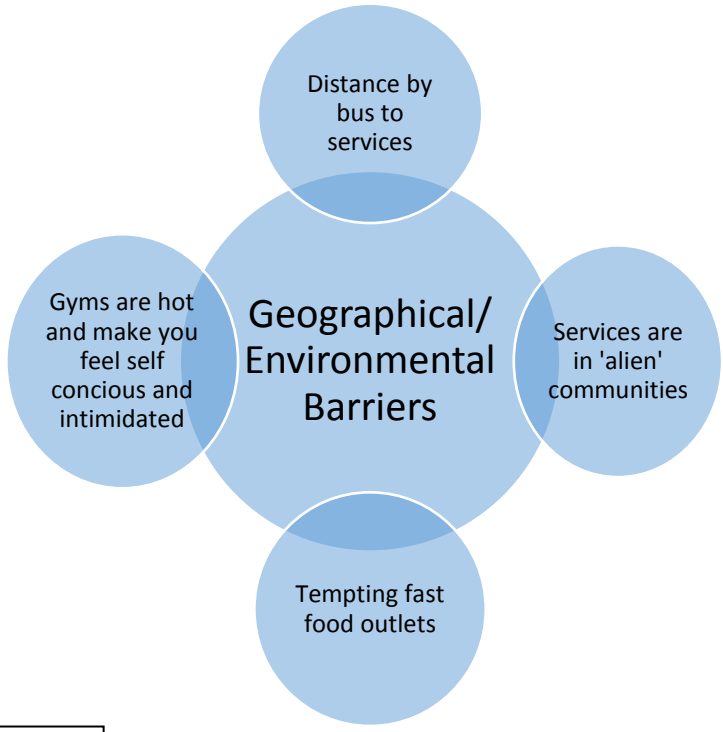


Chart 4: Geographical Barriers

Technical Barriers

Technical barriers were mentioned by participants at six of the focus groups.

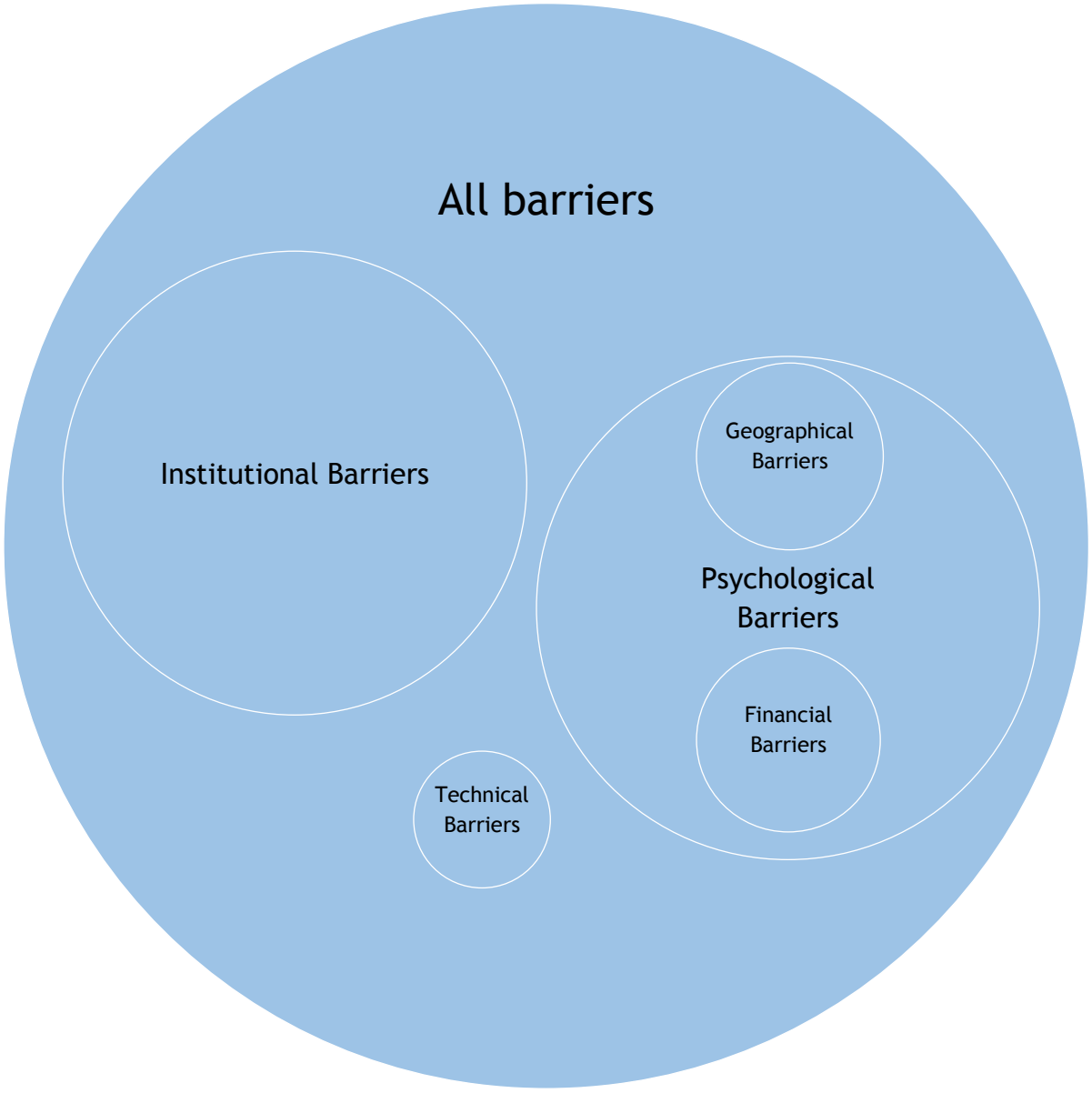
The technical barriers that were raised were not being offered the support or treatment options that was needed i.e. *'I've tried the [nicotine] patches, what I'm looking for is another option, are there other options?'* for smokers and, *'patches kept me awake at night.'* Other issues described were Champix (a stop smoking medication) only being available on prescription not over the counter, whether hypnotherapy was available on the NHS or not and if e-cigarettes are available on the NHS.

One participant described how the combination of medication for their epilepsy had led to weight gain, *'It's the mixture between that tablet and the epileptic tablet and the Warfarin. There's three of them playing together.'*

Relationship between Barriers

The diagram below shows how the barriers are interconnected. The size of the circles indicates the importance participants gave to each of the barriers.

Institutional barriers were the most mentioned, followed by psychological barriers. Psychological barriers are a confounding factor i.e. they influence the financial and geographical/environmental barriers.



Participant story - 1

“My mental health issues have stopped me from going forward to actually ask for help to give up smoking

Because of my anxiety which stops me from doing things that I want to do, so if they gave me an appointment I’d worry about getting there, I’d worry about what they’d say. I don’t think that they really understand well to be honest. My smoking started because of my mental illness. They chuck tablets and patches and stuff at you. I think, “why should I go to all that effort just to get patches and tablets,” you know what I mean.

Smoking isn’t the real issue it’s the mental health that’s the issue they should be recognising.

If I know that I’m going into a stressful situation, I know that I can always escape and have a fag and go back in clear minded”

Participant story – 2

Female Speaker *“We've had doctors here and they don't want to understand this stress and what it takes out of somebody looking - caring for somebody 24/7.”*

Male Speaker *“We're not really interested in losing weight or stopping smoking.”*

Female Speaker *“I think what some of the others are trying to say is the mental health issues are the umbrella for carers and your weight and your smoking and your drinking are symptoms of. So, get the mental health. Get the stress levels. Get that sorted and the others will follow.”*

Female Speaker *“That’s what we’re saying. For us as dementia carers, if you address the mental health issues, then the others may fit into place.”*

Solutions to accessing Wellbeing services

Institutional solutions

A recurring theme that came up as a solution to not knowing where to go, was to have one person or one point e.g. in each District that could signpost you to the service you need. The GP Surgery, Community Care Coordinators, Co Workers, a central body, one telephone number and a one stop shop were the suggestions made. This, coupled with an out of hours service – one late night a week, one Saturday per month, and live chat via a website, were also mentioned, especially for full time workers. Above all, for most participants the consistency of name and location was vital.

'It doesn't need to be a fancy name every 2 or 5 years or whatever. If it's called that when I'm at school then it should be called that when I'm 30… I want a service to be familiar, I know what it's about, I know what it does, I'm not gonna have all these questions, Where is it? Who is it? Is it still there?'

One support worker backed up this suggestion having found they themselves were not always up to date with the new service and contact. They advocated for*, 'everyone in the network becoming familiar with the same location and same services'* in order to better support clients. This idea was also supported by a newcomer to Nottinghamshire who had no idea where to access services.

Face to face contact with services was the preferred approach for support in order to build rapport and trust. Face to face also enables additional questions to be asked and clarification sought – which you can't always achieve with information on the internet. A suggestion (by someone who is not in that demographic) was that an internet service would be most suitable, *'for young people, that's all they do, everything happens on the internet.'* It was summed up by one participant, *'You need really to have a service that's available. Well, that has all of them available. Phone, come to you, and go somewhere else.'*

Having all wellbeing services in one local location was important to many, *'local services is very much a plus.'* That would give a sense of anonymity i.e. that people wouldn't know what service you were going in for. A place in one location where you will have been before e.g. the GP surgery as it's familiar and easier to go where you know were the suggestions made.

Two people described the in prison stop smoking service as the best support they had received, however they did not elaborate on what aspects of this service were helpful.

Psychological solutions

Many participants stated it is only by addressing the root problem first that their unhealthy behaviours would stop i.e. overcoming a mental health issue. *'I think what some of the others are trying to say is the mental health issues are the umbrella for carers and your weight and your smoking and your drinking are symptoms of. So get the mental health, get the stress levels, get that sorted and the others will follow.'* Participants described dealing with mental health issues through counselling or through specific groups like FREED Beeches (an eating disorders service based in Worksop) for eating disorders.

In order to overcome the barrier of the unknown, participants suggested familiarity was best. When *'everyone in the network becomes familiar with the same location and the same services… you can say, Well, I've been before, I'll come along, I'll take you there.' It breaks down some of those barriers, some of those anxieties that people have about going somewhere new and different.'*

Frequently participants talked about the support that others had provided them with through groups. Examples given were, the camaraderie of weight loss programmes, having a *'buddy'* from the Co-production Project through NCC who came to their house and identified groups of interest, meeting up with new people, the family network or teaming up with someone else who wanted to give up smoking. Participants at Eton Avenue Growers Association said, *'We've found people who've got depression when they come here, it helps, doesn't it? There's a lot of laughter and laughter is a good medicine, you're outdoors, and you're doing something, you're keeping active. We don't let them stay depressed for long!'*

Having something, *'at a more basic level [than a gym] and that's more inclusive to people'* was an important factor in overcoming intimidating gyms.

A number of participants had decided to quit smoking and had, *'just done it,' 'went cold turkey'*. Others who like their privacy had told no one of their plans to reduce their unhealthy behaviours. Another mentioned an *'old school doctor'* who had said, *'the choice is yours, you give up smoking or you die.' 'That was enough for me, I chose to live'*. For others it is only through a total change of attitude and lifestyle, for another, getting *'out of the environment that made him drink'* (i.e. leaving their home town) that a change occurred.

Financial Solutions

Providing proper cooking lessons at school and improving people's general cooking ability were suggested solutions. Cheaper healthy food options whether from the supermarket or eating out were also proposed.

Incentives were described as a good idea for smokers or at least some sort of gift or goal to aim for.

The Co-production Project under which Music for Wellbeing sits at Ashfield Health and Wellbeing Centre was cited as a model NCC are trying to make sustainable. Co-workers provide support to set up the groups and then hand over to volunteers and group members to continue to run. *'The theory is that because their well-being's improved and sustained they're not using all the services as much.'*

Geographical and Environmental Solutions

Participants consistently spoke about the importance of local services and local groups, up to 5 miles away on a bus route with a few mentioning 10 miles. *'It has to be local. You got to think of the ones that don't have transport.'* Participants of the Music for Wellbeing group in Kirkby summed up the benefit of the Ashfield Health and Wellbeing Centre as, *'it's really in the heart of the community.'*

An offshoot of the service being available locally is that people get to know it and promote it to others, *'being able to talk to people who you've met on the street and say, that helped me, you could try going there, and it's close by, it really does make a difference.'* Participants also spoke of the support network that their local community provides, *'having a whole community around you so the burden doesn't fall on one'* was described as particularly important by carers.

Dementia carers also mentioned the need for wellbeing home visits, whether this be an Admiral Nurse (specialist dementia nurse), Community Psychiatric Nurse (CPN), or a regular phone call from a health professional to check how they are doing. In answer to "What could be done to design services for people like yourself," one participant replied, *'To take the loved ones with you. For someone to care for them while we can't.'*

Technical Solutions

The range of stop smoking products available to smokers does not seem to be clear or what is/is not available on the NHS. Two people stated that a stop smoking book had been the most help in getting them to give up because, *'it sort of explains the psychology behind it (smoking)'*. One person described, *'regularly getting emails and going on a website which had helpful suggestions'* as useful from New Leaf stop smoking services.

Family vs Separate services

A range of answers were given to the question, "Would you use a service that is able to meet all your and your family's needs, regardless of age or a service for adults and a service for children and young people?" These are described below.

Family services

Only slightly more participants (14 in comparison to 11) felt it would be good to access services as a whole family as they, *'want to go with others'* as they could support each other. However, how well this would work would depend on how close the family was. One younger person felt that, *'a service for everyone would be ideal because then the staff as well would have the knowledge of different situations and different experiences.'* A co-worker per household was another suggestion.

As an all age service is already available it was felt this was the way it should continue, *'GPs are aimed to everyone, dentists are aimed to everyone. We already provide a service that aims at all age groups.'*

Separate services

The primary reason given for having a separate service was children being embarrassed by parents and not wanting their parent(/s) to know they smoke. Others mentioned not wanting to talk about smoking in front of their family and, *'for instance body weight, you might feel self-conscious about that, you don't want someone else hearing that.'* A younger participant also felt that parents may want to maintain their privacy, *'parents don't always tell you everything. They keep things for them…it's going to make you worse by finding out.'*

Another felt that adults and children have different needs and that, *'different people can help children because of their qualifications'* and, *'you will still need to have some form of division within there specialising in particular problems at particular times of your life.'* A different concern was that if the service is age specific and one person is off sick then the whole group has no service.

One issue described by a participant of having a co-worker per household was that only the higher-need people would be helped, as the worker would have too much to do, leaving the less needy family members out.

Dementia carers felt strongly that noisy children were particularly difficult for people with dementia and therefore a place without children was paramount for their needs.

Benefits and Challenges of an Integrated Wellbeing Service

For an integrated service

The majority of participants (19 for integrated in comparison to 4 for separate) were in favour of an integrated service. This was summed up by one person as, *'A one stop health shop, shall we call it. That's the first place everyone heads for, we all get this one phone number.'* Having all the information in one place, with other services there too and someone there to signpost you to the service you need was described as beneficial. One younger participant felt that,

'having one (service) means that they can more combine plans together to make one plan for one person.'

The other advantage given was that people would get to know it and so it would be easier to go a place that you already knew. Putting wellbeing services within GP practices was suggested as people wouldn't know what they were going in for.

One participant hoped the new service could provide, *'someone there to support you'* while waiting for your mental health referral.

A few participants felt it would help if they could self-refer to the well-being centre to stop smoking because *'doctors are too busy for smokers'* and also if they dropped out part way through they could re-join without having to go for another referral.

Dementia carers were particularly insistent that it needed to be relevant for them as their stress levels of caring for someone 24/7 were very high. Of particular importance was to be able to take their loved one with them while they access the service, as well as having an outreach service that could provide home visits.

One participant summed up the benefit of an integrated wellbeing service as, *'We're whole people you can't take this little aspect out of your personality... you can't just deal with weight on its own.'*

Against an integrated service

The four people that preferred a separate service had very strong views. The most common concern about an integrated wellbeing service was that the staff would have to be, *'Jack of all trades'* that services would be *'average'* and that it wouldn't be focussed enough. *'If I was recovering from alcohol I wouldn't particularly want to sit in a room with half smokers because I wouldn't feel like I'm getting the services that I need…I'd say have different groups as well.'* Specialists would still be needed, along with a range of staff in order to respond to the range of individuals.

Concerns were raised that there would be, *'a clash of people'* because some sorts of people are unable to mix with others. A few participants felt that alcohol services should be separate from smoking too. Alcohol because, *'you probably might have people that would like to start a fight'* and smoking because the smell of smoke, smell of people who smoke and smoking at the entrance, *'puts me off going in.'*

Lastly having one contact at the new wellbeing service was raised as being very important so that you could get to know them and build a rapport.

Conclusions

Most participants had a good idea what would work and what wouldn't having accessed a wellbeing service in the past. People who had accessed wellbeing services in the past were better able to detail the barriers and solutions than people who had never accessed wellbeing services (the latter tended to make assumptions around the issues).

Fifty-five out of the total sixty-six participants described themselves as having one or more of the issues of smoking, drinking, weight management or low level mental wellbeing. Some people described how their mental health issues had led to smoking, drinking and/or eating.

There were high numbers of psychological barriers that prevented participants accessing services, particularly related to anxiety about getting there, what to expect, just getting in the door and the shame of admitting there was a problem. A number of the psychological barriers raised are confounding factors i.e. that healthy eating is expensive, the service is too far away to access etc. This suggests that by addressing the mental wellbeing issues first the unhealthy behaviours will decline.

The greatest institutional barriers were finding out where services were and waiting for referral particularly for stop smoking and mental health.

Participants described face to face as the preferred method of treatment; very few people mentioned the internet, chat or the phone. Having the same co-worker throughout was extremely important to participants in order to build up a rapport.

Cost of transport, cost of healthy foods and the cost of groups were all prohibitive to people. Distance to services was also a barrier mentioned a few times.

Participants were very keen on more services being as local as possible perhaps even provided at GP level which is also a familiar environment.

Nineteen people were in favour of an integrated service in comparison to four for a separate service. Suggestions made to provide wellbeing services were within the GP Practice, in a health and wellbeing centre, a one stop shop, community centre or local meeting place. However a participant pointed out that if there was still going to be waiting lists, *'then it's pointless opening up this brand new service to work for these things when you can just go on the same way.'*

Slightly more participants (14 participants in comparison to 11) were in favour of a family service because of the network of support around them. Those that were against were mostly younger people who felt embarrassed about talking about their smoking or eating in front of their family.

Recommendations

- Agree a name for the service and keep this name consistently
- Reduce delays in being seen once referred or provide an ‘interim service’ particularly around mental wellbeing
- Support people with low level mental wellbeing to access services by offering a flexible approach that addresses their individual needs
- Provide an integrated well-being service but consider separate session times for smokers
- Address mental health wellbeing in order to reduce unhealthy behaviours
- Provide wellbeing services in local areas in familiar places e.g. GP surgeries and be able to access the same person each time/ a consistent practitioner each time
- Where possible provide services to carers in their homes or by telephone

Appendix 1. Focus Group discussion questions

Q1. We all know that sometimes, if we feel fed up, we might smoke, drink or eat more. With that in mind have you or anyone you know used a service to stop smoking, drink less alcohol, lose weight or feel better? If so what was it like?

Q2. What are the reasons/barriers you haven't accessed stop smoking, alcohol, weight management or mental health services before?

Q3. What are the solutions to overcome these barriers?

Q4. One idea is to provide a service for all your family needs. Would you use a service that is able to meet all your and your family's needs, regardless of age or a service for adults and a service for children and young people?

Q5. Another idea is to have an integrated Wellbeing service - a one stop shop where you can access stop smoking, alcohol, weight management and/or mental health services in one place, what do you think the benefits and challenges would be for you?

Appendix 2. Demographics of participants

Carers	Number	Percent
Carer	45	68.2%
Not a Carer	20	30.3%
Not answered	1	1.5%
Total	**66**	**100%**

Cared for	Number	Percent
Cared for	8	12.1%
Not cared for	44	66.7%
Not answered	14	21.1%
Total	**66**	**100%**

Disability status	Number	Percent
Limited a little	15	22.7%
Limited a lot	6	9.1%
Not limited	9	13.7%
Prefer not to say	2	3.0%
Not answered	34	51.5%
Total	**66**	**100%**

Disability type	Number	Percent
Hearing impairment	9	13.6%
Learning impairment	3	4.5%
Mental health condition	9	13.6%
Physical impairment	4	6.1%
Social impairment	2	3.0%
Visual impairment	6	9.1%
Not answered	33	50.0%
Total	**66**	**100%**

Employment status	Number	Percent
Full time	11	13.6%
Not working	4	6.1%
Part time	9	13.6%
Retired	20	30.3%
Student	2	3.0%
Unable to work	20	30.3%
Total	**66**	**100%**

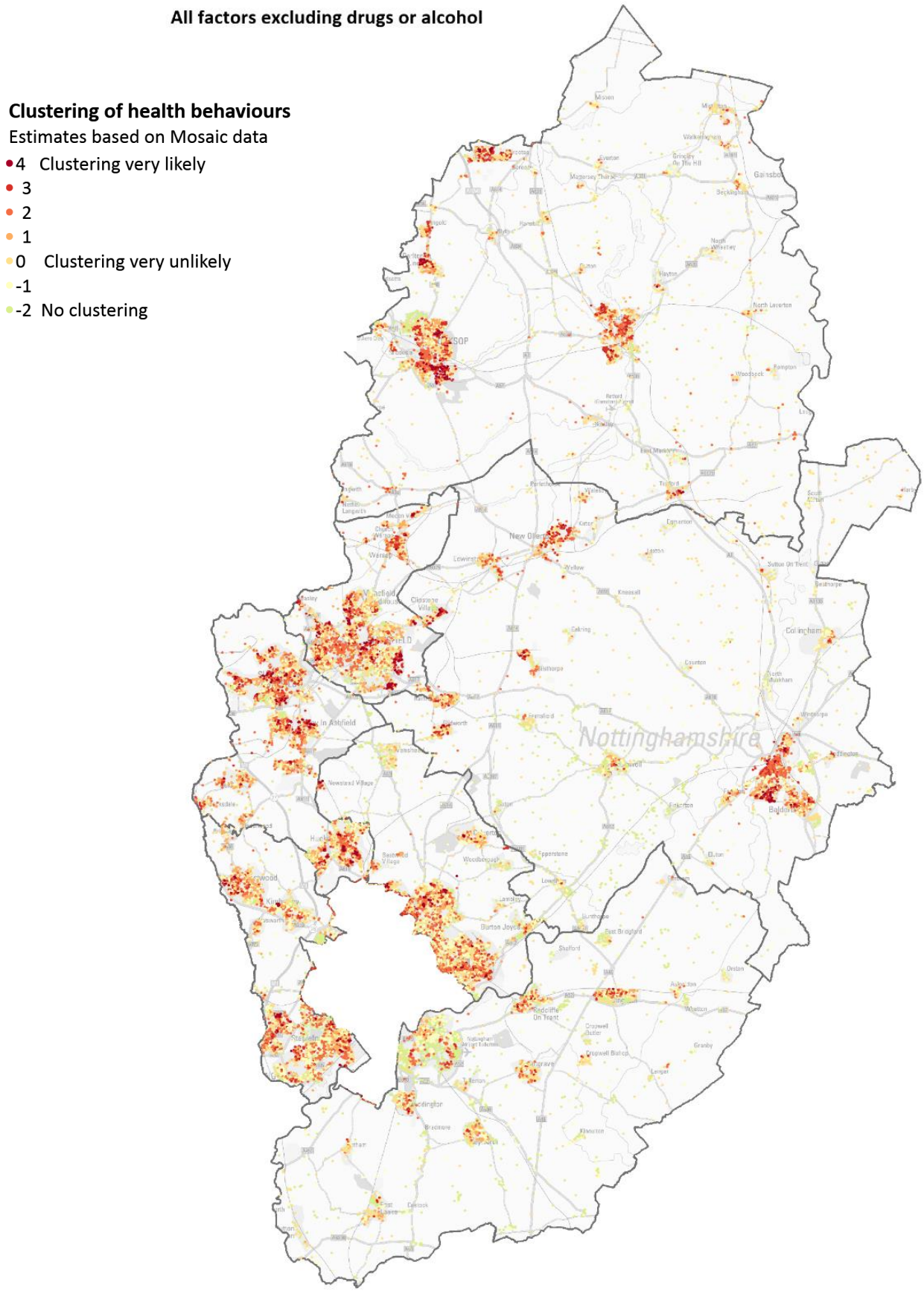
Ethnicity	Number	Percent
Gypsy or Traveller	1	1.5%
White	64	97.0%
Prefer not to say	1	1.5%
Total	**66**	**100%**

Gender	Number	Percent
Female	24	36.4%
Male	42	63.6%
Total	**66**	**100%**

Religion	Number	Percent
Buddhist	1	1.5%
Christian	30	45.5%
Jewish	1	1.5%
None	23	34.8%
Other - Agnostic	2	3%
Other - Spiritual	1	1.5%
Prefer not to say	6	9.1%
Unanswered	2	3.0%
Total	**66**	**100%**

Sexuality	Number	Percent
Asexual	1	1.5%
Bisexual	3	4.5%
Heterosexual	46	69.7%
Homosexual	3	4.5%
Not answered	6	9.1%
Prefer not to say	7	10.6%
Total	**66**	**100%**

Appendix 3. NCC Health data cluster



Appendix 4. Limitations

In carrying out this project HWNN met a number of constraints that affected the scope of the research. These were:

- The timeframe for carrying out this work was short which had the following impact:
    - While a number of BME and EE groups were identified and contacted they did not have the capacity to accommodate a focus group discussion within the time frame.
    - Dividing a finite number of focus groups across geographical areas and different populations was challenging.
    - In order to deliver 9 focus groups HWNN had to contact 68 groups as many declined because of the short time frame.
    - While 9 focus groups were planned, 8 were held plus one-to-one interviews with one replacement cohort due to time constraints.
- A number of groups were very willing to participate in this consultation but were closed for summer.
- Despite 18% (n=12) participants ticking, 'drinks more than 14 units per week', only two participants disclosed drinking a lot and no one commented on the barriers and solutions to accessing these services.
- The limitation of approaching existing groups was:
    - Not all participants spoke up during discussions
    - Frequently, participants talked of the support that their current groups gave them, which individuals may not have
    - Out of 20 people at the Eastwood Baptist Church (Broxtowe) only 3 agreed to join the focus group
    - Participants were asked to state if they smoked, were overweight, drank more than 14+ units of alcohol per week and had a mental health illness. This self-labelling can create bias.

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