Bournemouth and Poole Voluntary and Community Sector Contribution to Health and Wellbeing

One to One Interviews

Background and Methodology
In August 2014 BCVS and PCVS launched a survey of the voluntary and community sector in Bournemouth and Poole asking them to give details of their work that contributed to health and wellbeing. We had 104 completed surveys. 63 organisations that responded said they would be willing to take part in further research. 48 organisations were asked if they would be willing to take part in a more detailed one to one interview that would take between 1 and 1.5 hours. The organisations asked were chosen to give a range of sizes, user groups and localities worked in. 40 organisation agreed to take part. Most interviews were carried out face to face in a structured way (see attached) but a few were either done by telephone or completion of a questionnaire with any necessary follow up to clarify any answers.

The 40 organisations were:
1. AGE CONCERN POOLE
2. Age UK Bournemouth
3. Autism Wessex
4. Bournemouth BMX Club
5. Bournemouth Churches housing Association
6. Bournemouth Parent Carer Forum
7. BOURNEMOUTH SOCIETY FOR THE VISUALLY IMPAIRED
8. Bournemouth YMCA
9. British Red Cross
10. Caring Canines
11. Chestnut Nursery
12. Dorset Blind Association
13. Dorset Reclaim
14. East Cliff Church & Community Centre
15. EDAS
16. Faithworks Wessex
17. Help and Care
18. Holton Lee
19. Home-Start South East Dorset
20. Independent Age
21. Kings Park Alternative Sports Club
22. Moore Avenue Park Community Group & Gardening Club
23. Motor Neurone Disease Association
24. Pelvic Pain Support Network
25. Pokesdown Children's Centre
26. Poole Heart Support Group
27. Prama
28. Restore Support Network

29. Royal Voluntary Service
30. SEDCAT
31. Shelter
32. SOBS Bournemouth Group
33. Space Youth Project
34. State of Play Arts
35. THE C.R.U.M.B.S. PROJECT
36. The Training and Learning Company
37. UK Nepal Friendship Society
38. Vita Nova
39. West Howe Community Enterprises
40. Winton Salvation Army

Services provided

The 40 organisations described the services they provided that contributed to health and wellbeing. Some organisations are fairly single purpose and so just described what they did e.g. Chestnut Nursery, whereas some organisations, even quite small ones, described several. Also some services more directly impact on health and wellbeing than others. Overall the 40 groups listed 170 services. Services provided may be one to one or through groupwork and may be free to participants, or asked for a small contribution or the full cost. For some services the individuals may be asked for the full cost but this may be charged to a third party e.g. the local authority or housing association. However most groups said they keep the costs down so that they are as affordable as possible.

When asked if the services provided were preventative, help individuals self-manage their health or was a specialised service the most common categories were preventative (however many organisations did not answer this question).

In terms of how individuals accessed the services for most organisations people self-refer but many also receive referrals/signposting from third parties. However many organisations did say that they felt many in the NHS could be sending more individuals their way. Word of mouth seems to be a very common way that individuals find out about services. Some very specialised services require assessment before accessing but these were a minority. Most services are running at or over capacity (i.e. have waiting lists), for some those organisations with multiple services their capacities can depend on the service.

When asked about plans for the future a variety of individual aspirations were recorded from maintaining the work they currently carry out to expanding all their services. Three groups mentioned wanting to develop cookery classes.

	% of 40 groups
Services provided to individuals	70
Services provided via groupwork	60
Services free to participants	78
Participants asked for a contribution	35
Participants/sponsors pay full cost	43
Services are preventative	40
Services help individuals self manage their health/wellbeing	35

Services are specialist	18
Individuals self refer	68
Individuals are regularly referred/signposted	60
Individuals are occasionally referred/signposted	15
Individuals require assessment	10
Individuals identified through outreach (1 organisation)	2.5
Have no capacity to take more people	73
Have capacity to take more people	25

How do services improve health and wellbeing
When asked to identify how services improved health and wellbeing the most common impacts were related to decreasing loneliness/staying in contact and increased confidence and self-esteem. This is reflected by the wider survey and the Networking meeting on 24 September 2014.

Improvement	% of 40 groups
Reducing isolation/increased contact with others	58
Increased confidence/self-esteem	48
Increased mental health	40
Increased physical health	35
Increased skills (particularly employability)	18
Improved diet/nutrition	13
Better awareness of services/assistance	10
Improved accommodation	8
Better healthy choices	5

Measuring the difference made
Only five organisations said they did nothing to measure the difference they make, usually because they do not know how (particularly as the difference may be subjective) and/or they lack the resources to do it effectively. For those who said they measured the difference for many it depended on the project, and sometimes on the requirements of the funding. Of those who detailed how they measured it the most common comment given was ‘informal’, which tends to be based on one to one conversations. More formal methods use a variety of methods, the most common being questionnaires followed by individual stories/case studies and feedback/satisfaction forms. Otherwise a variety of techniques are used with four organisations using detailed home grown systems. Some external tools used include Outcome Stars, ONS Wellbeing Scale, NEF tool, and those used by the funder/referral agent. Three organisations use accredited achievements as a measure e.g. a qualification. Interestingly one organisation said they did not want to formalise any systems as would be inappropriate for their users and three, who do carry out evaluations, said they did not have the time or resources for good, detailed analysis.

Measuring the difference	% of 40 groups
None	13
Do measure	87
Use informal methods	25
Use active dialogue	13
Case studies etc.	10
Satisfaction/feedback forms	10

Improvement Hub Priorities

Organisations were asked which of the four behavioural priorities they directly impacted on. Improving physical activity was the most common, closely followed by improved/healthy diet. Decreasing smoking was only mentioned by three organisations. Two organisations said they would like to offer such direct work but at present lacked the capacity to do so.

Improvement Hub Priorities	% of 40 groups
Reduced smoking	8
Reduced alcohol consumption	15
Improved physical exercise	68
Improved healthy diet	53
Would like to develop this work	5

Users

38 organisations gave us total numbers of those benefitting from their health and wellbeing services. Based on the responses we estimate that about 17,000 people benefit a year, an average of 447 and median (mid-point) of 200. However responses ranged from 17 per year to 3,350. Even if we disregard the largest value as a statistical outlier the median value remains as 200 people per year per organisation. We asked organisations to provide us with a breakdown of their users by gender, disability and ethnicity. Fifteen groups could easily give us estimates of the gender breakdown, being 59% female and 41% male. Eleven groups gave numbers of disabled users and if the outlier is disregarded (i.e. a specialist organisation for disabled people with a large number of users) gives a result of 66%. Seventeen groups gave an estimate of the age range of their users. The figures reflect some of the ‘age specialism’ of some groups (e.g. older people, young people and under-fives). Eleven groups were also easily able to estimate the ethnicity of their users.

Demographic	VCS %	B&P %
Male	41.2	49.4
Female	58.8	50.6
Disabled people	66.0	18.6
Under 5s	3.6	5.7
5-11	5.0	6.5
12-18	10.9	7.5
19-24	4.3	9.2
25-44	10.5	27.7
45-64	7.8	24.5
65 and over	57.9	18.9
White British	93.6	88.2
White other	2.2	5.5
Mixed	0.4	1.8
Asian/Asian British	0.4	2.4
African/Caribbean/Black British	0.1	0.7
Chinese	0.0	0.8
Other	3.4	0.6

Looking at the results we see the very common result amongst health and social care providers that men are less likely to be taking up services than women. Also not unsurprising is that there is a much higher proportion of disabled people using services than in the general population, reflecting that these people are more likely to be accessing services than those without long term health needs. The age breakdown is perhaps more difficult to interpret. As mentioned above of the seventeen groups who gave age breakdowns of their users some were age specific services. Also as people do get older they are more likely to take up health and social care services, so perhaps explaining the high skew to the over 65s. However the much lower proportion of users between 45 and 65 should be of note, particularly if groups want to develop preventative services. Looking at ethnicity overall users of organisation's services are more likely to be white British than not. However this may be a reflection of the skew towards the over 65s which has a much smaller BME population but the issue of BME uptake should be something that all groups should consider.

Use of volunteers

Only one organisation said they did not use volunteers. 37 groups gave us numbers of volunteers ranging from 2 to 750 giving a total of 3,387 and a median of 40. 65% are women and 53% are over 65 (very few organisations were able to easily give statistics on disability or ethnicity). For those that do use volunteers the majority of groups involve them in direct service delivery, followed by administration support, and significant numbers used for fundraising and management. Six organisations say they have problems recruiting volunteers but usually this is either for specific positions (particularly drivers but also skilled administrative and fundraising) or issues such as those with enough commitment and time. Organisations were asked about the training needs of their volunteers and the responses were either that it is provided in house (usually given by those plugged into national bodies such as Home Start) or not required. Also when asked about their own training needs for the management of volunteers no detail was given, with many saying this was not a need, or it was supplied elsewhere (again more likely for those who are part of national networks, e.g. Independent Age).

Use of volunteers	**% of 40 groups**
Service delivery	88
Administration	40
Management	25
Fundraising	23
Problems in recruitment	15
Problems recruiting drivers	10

Income

30 of the 40 organisations gave estimates of the annual expenditure on health and wellbeing activities. For most of these it was their entire annual expenditure as they believe that all their activities contribute towards health and wellbeing. The totals ranged from £100 per year to £22,223,000 (BCHA), giving a total expenditure of £30,077,436. However if we exclude the outlier value for BCHA this gives a total expenditure on health and wellbeing of £7,854,436 and a median (i.e. midpoint) of £28,000 per organisation. 23 organisations were easily able to give us a breakdown of where the income for their health and wellbeing activity came from.

Income source	Total	%	Median	%
Statutory grants	1,407,700	22.6	60,000	25.9
Statutory contracts	772,268	12.4	72,228	31.1
NHS grant	0	0.0	0	0.0
NHS contract	0	0.0	0	0.0
Lottery funding	118,000	2.9	40,000	17.2
Other grants	321,239	5.1	12,500	5.4
Charges	3,010,080	48.2	16,000	6.9
Donations	248,399	4.0	3,173	1.4
Other fundraising	364,265	5.8	28,081	12.1
Sponsorship	0	0.0	0	0.0
Own reserves	116	0.0	116	0.0
Total	**6,242,067**	**100**	**232,098**	**100**

Organisations differ enormously in the breakdown of their income sources e.g. some rely heavily on charges and others on donations. Therefore the percentage breakdown of the median values gives a better picture of the sector as a whole. Overall income from statutory sources represents 57% of the sector's income with Lottery funding being the next largest contributor. It is interesting to note that not one of the 23 organisations received funding from the NHS for its health and wellbeing work.

Supporting people to change their behaviour

Interviewees were asked for ideas about how to better support people to quit smoking, reduce alcohol consumption, take more exercise or lose weight/eat more healthily. The most common suggestion was the use of peer support through groupwork and mentoring, and one organisation said that groupwork was perhaps less judgemental than one-to-one work. Four organisations mentioned that any support needs to be motivational and must avoid patronising or judgemental attitudes. Two organisations suggested that talks and visits from Hub personnel, or similar, to existing groups would be an effective means. Groups identified a number of barriers including the perceived cost of healthier choices, lack of money to pay for healthy activities, lack of access and transport to leisure and other facilities.

Ways to support behavioural change	% of 40 groups
Peer support/groupwork	18
Motivational and not judgemental	10
Visits/talks	5

Referring to health bodies

When asked about their experience of referral to or from the NHS only three organisations explicitly said there were none and four that there had been a mix of experiences (very often depending on the individuals they contacted in a health body). For some part of the problem had been not knowing who best to contact to make a referral and conversely health bodies not making appropriate referrals to their organisation (many organisations recognise that PR relating to their services needed to be strengthened). Two groups pointed out that there had been problems with inadequate levels of user consents. In conversation with the interviewees what was a clear message was that any referral mechanism needed to be based on good working knowledge of each other's service and operations, good working relationships and inevitably high levels of reciprocal trust.

Referrals	% of 40 groups
No problems	8
Mix of good and bad experience	10
Need to know who is who	8
Inappropriate referrals from health bodies	5
Problems with user consents	5
Need for good working relationships and trust	23

Contact with the Health Improvement Hub

The next set of questions led onto discussions about communication, referrals and feedback with the Hub. The main point from above about there needing to be a good awareness of what was provided by front line groups was also expected of the Hub (five groups mentioned it). Common suggestions to developing a trusting, aware relationship was through visits by Hub staff to frontline groups and their activities. For ongoing referrals and communication there was a mix of those who had a single preference to some who suggested a variety of means. However looking at all the comments the use of the phone and e-mail were by far the most common preferred means. On-line, including use of Facebook, was the next preferred means. Some groups mentioned that communication and referrals needed to be simple and quick to carry out. One organisation did not see the relevance of the Hub to their work as there already existed well developed referral pathways for their area of work.

When asked about feedback there was a mix of responses with only two organisations definitely wanting feedback from the Hub (for one, the reason was so they could chase the individual if they had not taken up the Hub service). Four groups said they might be able to provide feedback to the Hub (but was often qualified by being dependent on the detail the Hub might require) and two groups said they did not have the resources to do so. The only method identified was by e-mail.

Communication with the Hub	% of 40 groups
Hub needs good knowledge of what is on offer	13
Use telephone	43
E-mail	43
Online	18
Facebook	10
Simple and quick	20
May provide feedback to the Hub	10
Lack resources to feedback to the Hub	5
Would want feedback from the Hub	5
E-mail is preferred means to receiving feedback	10

Conclusion

We would like to thank the 40 organisations who gave of their time and information as it has greatly helped us to improve our own awareness of the breadth of services groups provide and the contribution it makes to health and wellbeing. The findings will be used in the final report we produce for this project and in the coming work with the Hub on developing appropriate support, referral and feedback systems.

February 2015

Appendix 1
Interview questions

Many thanks for agreeing to be interviewed. The interview should take about 1hour and will be confidential. Information you give us will be reported anonymously but if we want to quote you for any report or material we will seek your permission first.

We intend to write a report for Public Health Dorset setting out the contribution the voluntary and community sector makes to improving health and wellbeing. We have already sent out a survey to the local sector asking them to give us some information and you kindly said you were happy to take part in further research. We will be carrying out a total of 40 in depth interviews, including you, to add more detail to the results of the wider survey. Over the next hour I will be asking for more detail on the answers you gave in your completed survey form.

1. Can you confirm your contact details

2. On your completed survey form you identified a number of services that contribute to health and wellbeing. Can we go through each of them in a bit of detail?

a) In what way does it improve health and wellbeing?
b) Would you say the service is about prevention, helping people to self manage their health/wellbeing, or a specialist referred service (i.e. needs specialist staff or equipment and can't be dome at home etc. e.g. counselling, physiotherapist)
c) How many people benefit each year (ideally) or each month
d) Is it open to all or particular parts of the community (if so which!). What sort of people use it i.e. ages, gender, ethnicity, disability, etc.
e) What geographical area do they come from?
f) How often is the service run?
g) Is any charge made to individuals and what?
h) How is it funded? (Form charges alone, grants, other fundraising, contract (NHS or local authority)
i) Do you measure the difference you are making? If yes how, if no why not?
j) How do people get to know about this service i.e. contact you themselves, you recruit them, signposted/referred by other VCO, signposted/referred by LA, signposted/referred by NHS, other (specify)
k) Do you have problems getting enough people coming or is it over subscribed?
l) Why did you start it?

3. In what ways, directly or indirectly, do you think you are helping people to:

- Quit smoking
- Reduce alcohol consumption
- Increase their physical activity
- Eat more healthily/balanced diet

4. In your survey you said that X number of people were using your services each month. Would you be able to break these figures down into different age groups, genders, ethnicity? If so I will send you an e-mail.

5. Also you said you spent about £X on improving health and wellbeing. Would you be able to say where the money came from i.e. LA, NHS, lottery, fundraising, etc.? If so I will include this in my e-mail.

6. On the form you said you used X hours of volunteers.

a) About how many individuals is this?
b) Roughly what is their makeup i.e. age, gender, ethnicity, disability, etc.
c) What sort of tasks are they doing?
d) Do you have any problems recruiting or managing them
e) Do they need training about health promotion, health advice, supporting people to make healthy choices, etc.?

7. On your form you said you wanted advice/support/training, can you give me a bit more detail about:

If there were charges made for advice/support/training would you still use them?

8. From your work with people do you have any ideas about how better to support people to quit smoking, reduce alcohol consumption, take more exercise , lose weight and eat more healthily.

From April 2015 Public Health Dorset will be funding a Health Improvement Hub which will be a one stop shop for people in Bournemouth, Dorset and Poole who want to improve their health, in particular by quitting smoking, cutting down on alcohol, taking more exercise, losing weight and eating more healthily. This Hub will be staffed by people skilled in customer relations, engagement and motivation to help people change their behaviours. This Hub will have an extensive database of services and activities so they can make the best match to individual's needs. The voluntary and community sector will be an important part of this database and we will be surveying you in the New Year to share the data with the Hub. The Hub will also develop ways for you to appropriately refer people you are working with to them. They will also be offering advice, support and training in health improvement to voluntary and community groups. We will be working with you and the Hub to design appropriate referral mechanisms, support and training.

9. In the past have you had good or bad experiences of referring people from or to Health Services. If so what was your experience and why do you think they were like this?

10. What would need to be in place to make it easy for you to refer people to the Hub for advice and support?

11. How would it be best for the Hub to signpost people to your services?

12. What plans do you have to expand your work on health and wellbeing?