Smoke Free Worcestershire

Worcestershire Smoke Free Tobacco Control Alliance

Tobacco Control Plan for Worcestershire

2014-2017

Summary

1. Tobacco use is the single most preventable cause of ill health in the UK and there is clear evidence that through reducing smoking prevalence we will improve the overall health and life expectancy of many people.

2. Reducing tobacco use is one of our most important health challenges. Smoking is the major cause of preventable death in England, responsible for more deaths than the next 6 major causes combined. Nationally, about 35% of all deaths from respiratory disease and 29% of all cancer deaths are attributable to smoking.

3. About 21.5% of the adult population of the County smokes, and smoking remains the primary cause of premature death and avoidable illness. About 835 people a year die from smoking attributable causes in Worcestershire each year.

4. Smoking is a crucial factor in health inequalities and is the single biggest cause of inequalities in death rates between the richest and the poorest communities so reducing tobacco use is one of our important health challenges. It accounts for half the difference in mortality between the richest and the poorest in society.

5. Smoking harms not only the smoker but those who inhale their smoke too. About a third of children live with a smoker. Passive or second-hand smoking increases the risk for babies and children of serious respiratory infections such as bronchitis or pneumonia. Women who smoke when they are pregnant are at increased risk of having a low-birth weight baby, a premature birth, a still birth and an increased risk of miscarriage.

6. The health care costs of smoking are high. It is estimated that smoking costs the NHS in Worcestershire about £27 million each year.

7. There is strong evidence as to the health benefits of stopping smoking. Health gain can be seen from minutes after smoking a final cigarette. Ten years after quitting, smoking related disease risk will have gone, and after five years, the elevated risk of smokers having a stroke has disappeared.

8. There is a robust evidence base too as to what support for smokers to quit is the most effective. It is known that about two thirds of current smokers say they would like to quit. Smokers are four times more likely to quit if they use stop smoking services delivered to NHS standards than they are if they try to go it alone.

9. National evidence has shown that reducing the incidence and prevalence of smoking requires action across more areas than just smoking cessation services, and the cost benefits of a comprehensive tobacco control plan have been modelled as far greater than those of a stop smoking service alone.

National Policy

10. This plan has been informed by national strategies, legislation and guidance as well as local strategies and priorities. The Government's *Healthy Lives, Healthy People: A Tobacco Control Plan for England* (March 2011) builds on the previous Government's Tobacco Control Strategy *'A Smokefree Future*' (February 2010) and identifies a range of measures to reduce smoking prevalence even further. These measures include:

    a. reduce smoking amongst adults from 21.2% in 2009 to 18.5% or less by the end of 2015;

b. to reduce smoking amongst 15 year olds from 15% in 2009 to 12% or less by 2015;
c. and to reduce smoking in pregnancy from 14% in 2009/10 to 11% by 2015.

11. Through this *Tobacco Control Plan for England,* the Government supports comprehensive tobacco control in England across the six internationally recognised strands, which are:

- Stopping the promotion of tobacco
- Making tobacco less affordable
- Effective regulation of tobacco products
- Helping tobacco users to quit
- Reducing exposure to second hand smoke
- Effective communications for tobacco control.

12. It also makes specific recommendations for good practice, drawn from the work of the DH National Support Team on Tobacco Control:

- Address tobacco control through strategic multi-agency partnership working, senior level accountability and a dedicated, co-ordinating resource.
- Promote compliance with tobacco legislation, for example activities to stop underage sales of tobacco, to promote smoke free legislation and to reduce the availability of illicit tobacco.
- Develop and communicate a clear understanding of the harm caused by tobacco, and understanding of the benefits of supporting smokers to quit, particularly by frontline staff.
- Provide local stop smoking services in ways that maximise accessibility and outreach, particularly for groups with high rates of smoking prevalence. These services should be provided in a way that maximises value for money.
- Get the most out of commissioning by developing and supporting existing and potential markets. Build in processes to ensure robust performance monitoring and management of commissioned service providers.
- Use local data and intelligence to develop a local tobacco control strategy and action plan that has appropriate and measurable outcomes.
- Encourage community engagement and development so that local people can get involved and become advocates if they wish to.
- Develop a co-ordinated local communication strategy.
- Encourage local people to make their homes and cars smoke free.

The Impact of Smoking

13. Nearly 80% of people in England do not smoke. There are many reasons for this, including the tobacco control legislation which has come into force over the last 10 years, Stop Smoking Services to support smokers to stop and national education campaigns. These campaigns have emphasised the danger to the health of the smoker and of their families and smoke free legislation has enabled a smoke free culture in workplaces and public places. Regular taxation increases have also resulted in the high cost of tobacco from retail outlets, thus reducing consumption.

Why do people smoke?

14. However, 20% of people continue to smoke and their reasons are varied and complicated. Smokers may:

- use smoking as a support for when things go wrong
- enjoy smoking with others as a shared activity

- use smoking to start conversations and meet new people
- smoke to make themselves look more confident and in control
- think that cigarettes help them to keep their weight down
- have a cigarette when they're feeling bored or lonely
- smoke when they need a break or a moment to themselves.

Smoking and Health

15. Smoking has a significant impact on the health of smokers and of their families and is a major contributing factor to inequalities in health. Smoking is damaging to almost every part of your body and is responsible for greatly reducing life expectancy in half of all smokers. Every year, more people die as a result of smoking than from obesity, alcohol-related causes, road accidents, illegal drugs and HIV/AIDS combined. If you smoke, you're at an increased risk of many serious health problems, such as:

    - different types of cancer, including lung, bladder and kidney
    - chronic obstructive pulmonary disease (COPD)
    - heart disease
    - stroke

Smoking and Health Inequalities

16. Smoking is a crucial factor in health inequalities, and is the single biggest cause of inequalities in death rates between the richest and the poorest communities. There is evidence that a smoker's level of nicotine dependence increases systematically with deprivation. Despite a reduction in the overall prevalence of smoking in the UK over the past 30 years, there has been little change in smoking rates among those living on low incomes and those who are least advantaged. Smoking prevalence remains far higher among people from manual as opposed to non-manual socio-economic groups and it accounts for half the difference in mortality between the richest and the poorest in society.

Smoking in Pregnancy

17. Smoking not only damages your health, your looks and your wallet, but it can also seriously affect the ability to become pregnant. It can also be harmful for both mother and baby if smoking during pregnancy. Cigarette smoke contains more than 4,000 chemicals, including cyanide, lead, and at least 60 cancer-causing compounds. When smoking during pregnancy, the toxins gets into the mothers bloodstream, and get passed on to the baby. On average, smoking during pregnancy doubles the chances that a baby will be born too early or weigh less at birth. Smoking also more than doubles the risk of stillbirth.

Second-hand Smoke

18. Smoking harms not only the smoker but those who inhale their smoke too. About a third of children live with a smoker. Passive or second-hand smoking increases the risk for babies and children of serious respiratory infections such as bronchitis or pneumonia. Second-hand smoke can cause other health problems too, including heart disease, stroke and breathing problems. Even 30 minutes of exposure to second-hand smoke can reduce blood flow in a non-smoker's heart. Every year, second-hand smoke kills about 11,000 people in the UK from lung cancer, heart disease and strokes.

What is the local picture?

Current prevalence levels

19. Overall, Worcestershire is mixed with regards to the percentage of adult people who smoke and this varies across the county. The table below sets out the percentage of adult smokers, as of December 2013, in each district within Worcestershire.

Local Authority	% who smoke
Bromsgrove	14%
Malvern Hills	14%
Redditch	23%
Worcester City	21%
Wychavon	16%
Wyre Forest	20%

Local adult smoking prevalence, source: ACORN (accessed Dec 2013)

20. Three of the districts, Bromsgrove, Malvern and Wychavon, are already at the Government's target to reduce smoking amongst adults to 18.5% or less by the end of 2015. The remaining three will require some focussed work to reach this target.

21. Under the Public Health Outcomes Framework, Worcestershire reports against Smoking Prevalence (Prevalence of smoking among persons aged 18 years and over) and Smoking Prevalence – Manual and Routine (Prevalence of smoking among persons aged 18 years and over – Routine and Manual). In 2012 the results were in the similar and better benchmark against England:

    Smoking Prevalence – 17.7% (similar)
    Smoking Prevalence, Manual and Routine – 23.7% (better)

Current uptake of Stop Smoking Services

22. The table below shows the data collected for Stop Smoking Services in the county for 2013/14 to date.

Key Performance Indicator	Q1 13/14	Q2 13/14	Q3 13/14
Increase number of service users setting a quit date	1321	1147	1088
No. of service users setting a quit date successfully quit at 4 weeks	495	490	601
No. of service users setting a quit date successfully quit at 12 weeks	495	490	313
No. Routine & Manual Workers setting a quit date	238	234	186
No. of Routine & Manual service users setting a quit date successfully, quit at 4 weeks	118	113	121
No. Pregnant service users setting a quit date	59	48	36
No of Pregnant service users setting a quit date successfully, quit at 4 weeks	15	20	21
No validated by CO verification at 4 weeks	480	472	524
% of 4 week quits validated by CO reading (85% minimum)	97%	85%	84%
No validated by CO verification at 12 weeks	195	472	246
% of 12 weeks quits validated by CO reading (85% minimum)	39%	85%	76%
No. of service users who receive Champix	235	232	232

Providers with less than 20 service users setting a quit date between Apr 2013-Mar 2014	20	11	11

Data for Quarter1–Quarter3 2013-14

23. It is worth noting that activity is always considerably higher in Q4 as most smokers quit at New Year and during this quarter. Q2 usually has the lowest level of performance because of the summer and school holidays.

Data for the last three years

24. The overall trend coming through the services has dropped over the last 3 years. This is common across England, and may be attributable to falling prevalence. Given the success of the 10 year national tobacco control programme, which achieved target reduction in national prevalence, there are fewer smokers to help to quit. But the highest prevalence and the most heavily addicted group remains amongst routine and manual workers and this is still a key national target.

Key Performance Indicator	10/11	11/12	12/13
No. of service users setting a quit date	5793	6475	5601
No. of service users setting a quit date successfully quit at 4 weeks	2730	2818	2486
No. Routine & Manual Workers setting a quit date	1590	1780	1511
No. of Routine & Manual service users setting a quit date successfully, quit at 4 weeks	763	855	758
No. Pregnant service users setting a quit date	79	197	253
No of Pregnant service users setting a quit date successfully, quit at 4 weeks	17	60	99
No. of service users who receive Champix and successfully quit at 4 weeks	584	612	658

25. In 2013, we lost a significant countywide provider who had historically delivered the highest number of quitters of all providers, per year. This provider withdrew services from across the West Midlands and this could have contributed to the drop in quitters.

26. A group that has seen an increase in quitters over the last three years is pregnant women. This may be due to the increase in number of providers offering a service to pregnant women including home visits, which we know from experience are popular with this group.

27. There is also a local variation with an increase in the number successfully quitting with Champix. The stop smoking treatment Champix was launched during 2013 in Worcestershire. In just two months, 62 people in Worcestershire give up smoking with the support of this treatment. Champix is available through accredited 52 Worcestershire pharmacies for people who wanted to quit smoking

The benefits of Stopping Smoking

28. The benefits begin straight away. The risk of getting serious disease reduces no matter what age someone stops smoking. However, many smokers continue smoking not by choice but because they are addicted. Some of the health benefits from stopping smoking can occur quite quickly as the table below shows. Other health improvements are seen over the course of a number of years, depending on how long a person has smoked.

Time since quitting	Health benefits to quitting
20 minutes	Pulse return to normal.
8 hours	Nicotine is reduced by 90% and carbon monoxide levels in blood reduce by 75%. Circulation improves.
24 hours	Carbon monoxide and nicotine almost eliminated from the body. Lungs start to clear out smoking debris.
48 hours	All traces of nicotine are removed from the body. The ability to taste and smell improves.
72 hours	Breathing is easier. Bronchial tubes begin to relax and energy levels increase.
2-12 weeks	Circulation improves.
1 month	Physical appearance improves – skin loses its grey pallor and becomes less wrinkled.
3-9 months	Coughing and wheezing declines.
1 year	Excess risk of a heart attack reduces by half.
10 years	Risk of lung cancer falls to about half that of a continuing smoker.
15 years	Risk of a heart attack falls to the same as someone who has never smoked.

Aims

29. The Worcestershire Health and Well-being Board vision is that

Worcestershire residents are healthier, live longer and have a better quality of life, especially those communities and groups whose health is currently poorest.

30. To meet this vision, preventing people from taking up smoking and supporting those to stop smoking is fundamental to ensure the residents of Worcestershire are healthier, live longer and have a better quality of life. This Tobacco Control Plan for Worcestershire has set the following three aims to help achieve this vision:

- To prevent young people from becoming smokers
- To empower every smoker to stop
- Protecting families and communities from smoking-related harm

Aim 1 **To prevent young people from becoming smokers**
This will include: ✓ Support agencies who work with children and young people to ensure that tobacco products and accessories are not promoted to young people in Worcestershire ✓ Encourage schools to promote non-smoking messages in all their communications ✓ Develop materials, including for use in schools, aimed at children who can encourage parents to quit ✓ Work with partners to create smoke free areas where children are e.g. public play areas ✓ For young people who are already smoking, ensure services and material to enable them to stop are appropriate. ✓ Ensure that all primary and secondary schools have no smoking policies. The policy will support both prevention and stop smoking activities and should apply to everyone using the premises (including the grounds).

Aim 2

To empower every smoker to stop

This will include:

- ✓ Continue to support the commissioning and development of specialist stop smoking services across Worcestershire
- ✓ Improve awareness, training for all public, private and third sector frontline workers on tobacco control and smoking cessation;
- ✓ Promote the use of self-help materials for people who want to stop smoking without the support of the Stop Smoking Service, ensuring that these materials are appropriate and accessible to local populations;
- ✓ Proactive work with pregnant smokers through ante-natal clinics and children's centres
- ✓ Support primary, community and secondary care to ensure that all opportunities within care pathways are taken to encourage and support patients to quit, particularly in the case of pregnant women, mental health service users and pre-operative patients.
- ✓ Ensure support is targeted to those who want to quit from all hard -to-reach or under-represented population groups in all settings, ensuring services are accessible and meet the diverse needs of these groups.
- ✓ Make Champix increasingly more accessible
- ✓ Map to see if the withdrawal of the main provider has led to a gap in service
- ✓ Increase support to providers and discuss with other providers who may then wish to increase their reach to areas that may have been affected by the main provider withdrawing
- ✓ Extend current contract with high performing providers for a further 2 years
- ✓ Increase campaigns targeting relevant groups (young people, harder to reach quitters, districts with higher take up of smokers)

Aim 3

Protecting families and communities from smoking-related harm

This will include:

- ✓ Implement the NICE guidance on Harm-reduction approaches to smoking
- ✓ Support measures to stop second-hand smoke exposure for children including the provision of smoke free homes and cars programmes;
- ✓ Support media campaigns on second-hand smoke;
- ✓ Support public, private and third sector frontline workers to deliver second-hand smoke brief interventions during routine contacts with clients through training;
- ✓ Ensure all local authorities commit to the Local Government Declaration on Tobacco Control.
- ✓ Increase awareness of the current unlicensed status of electronic cigarettes with both the public and partners and monitor updates to national policy;

Implementation and governance

31. This plan is accompanied by an action plan (Appendix 1) which outlines milestones to be achieved over the next three years. This plan and action plan will be reviewed on an annual basis and updated according to any new evidence, policy developments or changes in legislation.

32. A Tobacco Control Alliance as met for a number of years within the county, with the aim of bringing together a range of partners across the local area that are committed and active in making their own contribution to reducing the adverse impact of smoking on health and health inequalities. National guidance on excellent practice for TCA covers

data gathering; communication; an integrated approach to stop smoking services; tackling cheap and illicit tobacco; focus on children and young people; maintaining and promoting smoke free environments. The TCA locally and nationally was particularly active in the past in coordinating a work stream around the successful implementation of the smoke free workplace ban.

33. However, there is a continuous change in partnership working and capacity that means the TCA needs renewing, revitalising and refocusing from time to time. In the current partnership environment and fast changing policy arena, these areas of work can be delivered through means other than an formal TCA.

34. For the past 2 years the TCA has struggled to achieve good attendance at Alliance meetings. Therefore, during 2012/13, the TCA has, under the chairman ship of the Cabinet Member for Health well-being, considered how best to move forward together on the Tobacco Control agenda. The TCA has agreed that it change from its quarterly meeting format and that the following changes be embedded:

- Establish a virtual network of those who have influence on the TC agenda, and ensure that this is actively managed with updates and a possibility to develop a community of practice;
- Continue to monitor the implementation of the TC action plan, led by Public Health at WCC, with Emily Martin, as the lead contact;
- The HIG to receive an annual report and action plan on Tobacco Control and to include Tobacco Control within a wider annual report to the HWBB on key health improvement outcomes;
- Arrange an annual workshop focussed on updating knowledge; reviewing/mapping actions against the plan; and updating priorities for action in the next planning period.

References

ASH 2014 Young People and Smoking

ASH 2013 The economics of tobacco

ASH 2013 Stopping smoking: The benefits and aids to quitting

DH March 2011 Healthy Lives, Healthy People: A Tobacco Control Plan for England

NCST 2013 Stop Smoking Services and Health Inequalities

NHS Choices website 2013 Stop smoking in pregnancy

NICE 2008 Preventing the uptake of smoking by children and young people

Tobacco Control Action Plan 2014-2017

Aim 1 – To prevent young people from becoming smokers			
	Action	**Timescale**	**Lead**
A.1	Support agencies who work with children and young people to ensure that tobacco products and accessories are not promoted to young people in Worcestershire	Year 2	WCC PH
A.2	Encourage schools to promote non-smoking messages in all their communications	Year 2	WCC PH
A.3	Develop materials, including for use in schools, aimed at children who can encourage parents to quit	Year 1	WCC PH
A.4	Work with partners to create smoke free areas where children are e.g. public play areas	Year 2/3	WCC PH
A.5	For young people who are already smoking, ensure services and material to enable them to stop are appropriate.	Year 1	JCU Lead/WCC PH
A.6	Support all primary and secondary schools to have no smoking policies. The policy will support both prevention and stop smoking activities and should apply to everyone using the premises (including the grounds).	Year 2/3	WCC PH
Aim 2 - To empower every smoker to stop			
	Action	**Timescale**	**Lead**
B.1	Continue to support the commissioning and development of specialist stop smoking services across Worcestershire	Year 1	JCU Lead
B.2	Improve awareness training for all public, private and third sector frontline workers on tobacco control and smoking cessation;	Year 2	JCU Lead/WCC PH

B.3	Promote the use of self-help materials for people who want to stop smoking without the support of the Stop Smoking Service, ensuring that these materials are appropriate and accessible to local populations;	Year 1/2	WCC PH
B.4	Proactive work with pregnant smokers through ante-natal clinics and children's centres	Year 2	WCC PH/Acute Trust
B.5	Support primary, community and secondary care to ensure that all opportunities within care pathways are taken to encourage and support patients to quit, particularly in the case of pregnant women, mental health service users and pre-operative patients.	Year 2	JCU Lead/WCC PH
B.6	Ensure support is targeted to those who want to quit from all hard -to-reach or under-represented population groups in all settings, ensuring services are accessible and meet the diverse needs of these groups.	Year 2	JCU Lead/WCC PH
B.7	Make Champix increasingly more accessible	Year 1 and 2	JCU Lead
B.8	Map to see if the withdrawal of the main provider has led to a gap in service	Year 1	JCU Lead/WCC PH
B.9	Increase support to providers and discuss with other providers who may then wish to increase their reach to areas that may have been affected by the main provider withdrawing	Year 1	JCU Lead/WCC PH
B.10	Extend current contract with high performing providers for a further 2 years	Year 2	JCU Lead
B.11	Increase campaigns targeting relevant groups (young people, harder to reach quitters, districts with higher take up of smokers)	Year 1 and 2	WCC PH
Aim 3 - Protecting families and communities from smoking-related harm			
	Action	**Timescale**	**Lead**
C.1	Implement the NICE guidance on Harm-reduction approaches to smoking	Year 1	WCC PH
C.2	Support measures to stop second-hand smoke exposure for children including the provision of smoke free homes and cars programmes	Year 1/2	WCC PH

C.3	Support media campaigns on second-hand smoke	Year 2	WCC PH
C.4	Support public, private and third sector frontline workers to deliver second-hand smoke brief interventions during routine contacts with clients through training	Year 2	WCC PH
C.5	Ensure all local authorities commit to the Local Government Declaration on Tobacco Control.	Year 1	WCC PH
C.6	Increase awareness of the current unlicensed status of electronic cigarettes with both the public and partners and monitor updates to national policy;	Year 1/2	WCC PH

WCC Public Health Department: Consultation on the discontinuation of Stop Smoking Services except Pregnancy Stop Smoking Services

The current situation

The Council currently commissions Stop Smoking Services for smokers in the county, and supports a Tobacco Control Alliance. Free services to support smokers to stop smoking are available across the county.

Proposal

The Council proposes to maintain Stop Smoking Services for pregnant women, and to continue our work on tobacco control. However, it proposes to discontinue Stop Smoking Services for the general population.

Background

Smoking has declined dramatically in Worcestershire over recent years, down to below 15% in the general population. Fewer people than ever are coming into Stop Smoking Services, in Worcestershire and nationally. This downward trend is likely to continue and is caused primarily not by the take-up of Stop Smoking Services, but by the introduction of wider Tobacco Control measures such as:

· the ban on smoking in public places;
· the ban on smoking cars with children;
· advertising controls;
· plain packaging legislation;
· evidence about the safety of 'vaping' as an alternative to tobacco.

The Council has already done some early consultation about proposals to restrict Stop Smoking Services. This found that these services are no longer a priority for the CCGs or the general public: during the Council's 2015 roadshows the services elicited a low level of support among non-smokers, ex-smokers and current smokers.

Rationale for change

· Stop Smoking Services are funded by the Council from the Public Health Ring-fenced Grant which comes to us directly from central government. On 11th June the Treasury announced that the government intended to reduce this Grant by 7.5% in 2015/16, and further reductions have since been announced by the Treasury through to 2020.
· All services funded by the Grant are being reviewed and savings considered.
· Recent evidence suggests that e cigarettes are 95% safer than cigarettes, and that they are not associated with uptake of smoking amongst young people. This will provide an effective alternative to Stop Smoking Services, and support people who are ready to make changes.
· A vaporiser is due to be licensed and available on the market to smokers who want to quit from December 2015/January 2016. This will again open up alternatives to the Stop Smoking Services, and will be affordable for smokers

· There is a national and local decline in numbers quitting with local Stop Smoking Services.
· Most smokers in the county do not access local Stop Smoking Services.
· The population based Tobacco Control is a promising system approach.
· National campaigns to stop smoking have impact in the County, and for example Stoptober 2015 resulted in nearly 2000 people from Worcestershire signing up to a national website. We will continue to promote the stop smoking message through our Tobacco Control work.

· The proposal works to the advantage of pregnant women, compared with men or women who are not pregnant. This is because smoking is especially harmful to the developing unborn child. The impact of tobacco control measures alone is long term, but the unborn child is at a critical stage of vulnerability and development and we want to do all we can to promote the health of that child. We are therefore proposing to pay for the mother to access Stop Smoking Services during her pregnancy.
· Smoking is more common among disadvantaged communities, but smokers from advantaged communities are more likely to take up the service effectively. In removing free services from the general population and focussing Tobacco Control work in disadvantaged areas, this proposal is unlikely to significantly affect the health gap between deprived and non-deprived areas.

Proposals

- To stop paying for Stop Smoking Services for men;
- To stop paying for Stop Smoking Services for women who are not pregnant;
- To pay for Stop Smoking Services for pregnant women, so as to protect the development of the unborn child;

This survey will run for three weeks and the closing date is 4th January 2016

Consultation questions:

Q1 - It is proposed to stop free Stop Smoking Services for all smokers except for pregnant women. Do you

- Strongly Agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

Q2 - Do you have any further comments about the proposal?

Q3 - Are you a provider of Stop Smoking Services?

- Yes
- No

Q4 - Are you currently a user of Stop Smoking Services?

- Yes
- No

Q5 – (if no) - Have you been a user of Stop Smoking Services in the past?

- Yes
- No

Q6 - Are you currently a smoker or a non-smoker?

- Smoker
- Non-smoker

Q7 – (if non-smoker) - Have you ever been a smoker in the past?

- Yes
- No

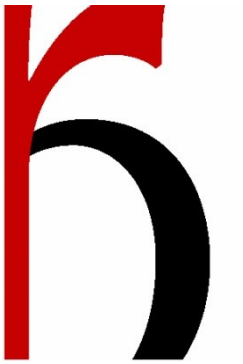
Thank you for your responses - please hit "submit" to register your replies

worcestershire county council

Understanding Resident Attitudes to Spending on Prevention

FINAL REPORT

4th January 2016



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1. Introduction

1.1 Background

As is the case amongst all local authorities, Worcestershire County Council is experiencing increased demand for its services – with this trend likely to continue over time as a result of legislation and changing demographics. Equally, resources available to local government are reducing and will continue to do so in the coming years. The council recognises that it will be increasingly important to manage the demand for its services in the future.

One way to manage demand is through preventative activities – stopping something from happening, or delaying or reducing the intervention needed. Prevention activities might include action in relation to a wide range of issues including sexually transmitted infections, drug and alcohol addiction, mental health difficulties, smoking, the health of expectant mothers and young children, and the support of vulnerable families.

Worcestershire County Council commissioned The Research Box to undertake research to investigate resident attitudes to council spending on services that would prevent, delay or reduce the need for costly intervention at a later date. The research followed on from a series of six resident roadshows that were held in towns across the county during the summer, where members of the public were asked which service groups they thought the council should spend this money on.

The specific objectives for the present study were to understand:

- whether Worcestershire's residents support or do not support Worcestershire County Council spending money on prevention activities
- the relative value Worcestershire residents place on prevention compared to specialist services (e.g. social care)
- how Worcestershire residents would prioritise spend on a given set of possible prevention activities
- what residents consider the council's role to be in empowering communities and individuals to take more responsibility over their own prevention activity
- how Worcestershire County Council can communicate around 'Demand management' in a way that is accessible and meaningful to residents
- whether there are significant differences in opinions by demographic group, geographical location (District and Rural/Urban), those with knowledge or experience of the services versus those without knowledge or experience of the services, and Protected Characteristics (as relevant)

1.2 Report Structure

This report contains the full findings from the research.

The report contains six further chapters, as follows:

- Chapter Two provides an executive summary of the key findings
- Chapter Three provides some context for the results by examining the language people use when thinking about prevention
- Chapter Four presents the study findings concerning awareness of the council's spending on prevention
- Chapter Five sets out the residents' priorities for spending on prevention by the council
- Chapter Six examines the issue of demand management – the public's support for actions by the council in this area and how they see the council empowering communities and individuals to take more responsibility
- Chapter Seven presents a series of conclusions and recommendations.

The results in each chapter describing the findings from the research are generally organised so that a county-wide overview is shown first, followed by the results for specific sections of the population, where these differ from the county-wide average. The results have been weighted to correspond with the population profile of Worcestershire (see section A.8 in Appendix A).

The report contains five appendices:

- Appendix A describes the methodology that was used for the study
- Appendix B sets out the profile details of the residents who contributed to the survey
- Appendix C contains a copy of the questionnaire that was used to recruit people, to ensure that they met the quotas and were willing to be interviewed further
- Appendix D contains a copy of the full survey questionnaire
- Appendix E contains copies of the show material that was used during the course of the full survey interview.

In addition to this report, a full set of the survey tabulations has been provided to the County Council as an annexe to the report. This annex contains the full results, showing the overall answers to each question and how these answers vary according to the major characteristics of the population of Worcestershire:

i. by the respondents' age, gender, rurality, and location
ii. by whether the respondent was a service user, or a carer
iii. by the respondents' employment, disability and ethnicity status.

The annexe also includes a listing of the full verbatim answers to the open-ended questions that were included in the questionnaire.

2. Executive Summary

Introduction

A survey was carried out with residents of Worcestershire during late November and early December 2015 to examine their perceptions of, and attitudes to, the idea of preventative actions and spending by the council. A total of 532 interviews was achieved and the results weighted to reflect the characteristics of Worcestershire's population.

Context and Language of Prevention

Almost everyone understands common phrases that relate to prevention (for example, "prevention is better than cure") and almost everyone can provide examples of where their own spending on prevention might stop problems happening in the future. Many examples respondents gave related to healthiness and education.

Awareness of the Council's Preventative Actions

More than half of residents surveyed (58%) were aware, to some degree, that the Council spends money on prevention. Much of their understanding relates to roads and pavements – and more particularly pot-holes and their impact on accidents. Nevertheless, many examples were also given in the areas of health.

When prompted, a majority of residents were aware, to some degree, of the Council's preventative activities in ten service areas that were examined in the survey. Four areas stood out as having most **awareness** amongst the population of the county:

- support for carers (75%)
- support for older people (74%)
- advice/ support for those in social housing or homeless (75%)
- help for those with mental health difficulties (75%).

Priorities for Preventative Action

A very large majority of residents (93%) thought that it's a good idea for the Council to spend money on prevention. In terms of service areas, their top five unconstrained[1] **priorities** were:

- support for older people (96% very or quite high priority)
- support for carers (92%)
- help for those with mental health difficulties (89%)
- advice/support for those in social housing or homeless (88%).
- support for vulnerable families to tackle their problems and prevent family breakdown (83%).

[1] Residents were allowed to place a high or low priority on as many areas as they wanted to. These *unconstrained* priorities were later constrained by forcing them to allocate a fixed amount of funding between the priority areas.

Residents questioned in the survey were asked to allocate a notional £100 of council budget between spending on existing social care or spending on prevention. Their responses reveal that both are almost equal in priority – £52.57 was allocated on average for existing care and £47.13 on prevention (some people were unwilling to allocate the full £100, which is why the two amounts don't sum to £100).

Residents were also asked to allocate £100 between the ten potential service areas, thus constraining their priority choices. Three areas stood out as having most **priority** attached to them. Between the three, residents allocated nearly a half of the £100. They were:

- support for older people (£16.99)
- help for those with mental health difficulties (£14.47)
- support for carers (£14.10) .

The lowest priorities were helping people to quit smoking (£3.94) and the prevention of sexually-transmitted infections (£4.91).

Demand Management

The idea that the Council might take other actions that would reduce demand, or entail managing it differently, was also examined. A significant majority (87%) think that it's a good idea that the Council manages demand for its services in ways like these. However, there is a low level of understanding about the concept of 'demand management', as well as concerns about its connotations and implications.

There was one potential action area that had most support – 'joined-up working (with the NHS, for example) to avoid duplication and waste'. Ninety-one percent of survey respondents gave this a quite or very high priority rating.

Community Empowerment

When asked what they thought the role of the Council should be in terms of empowering communities and individuals to take more responsibility for reducing their demand for Council services, there was a strong emphasis on 'information', 'encouragement' and 'involvement'. There was also quite a strong belief that people should be taking more responsibility for themselves, either as individuals or as part of community action, as well as a call for more volunteers or closer working with the voluntary sector.

Conclusions and Recommendations

Levels of accurate awareness might not be high, but the survey has revealed a **strong level of support** amongst the population of Worcestershire for council spending on prevention. This support is widespread amongst the different resident sub-groups that exist within the county.

This level of support is such that residents, when asked, would themselves allocate **the same proportion of the budget on preventative services** as they would on existing social care.

Residents think that there are **a few key priorities for spending on prevention**: support for older people, support for carers and help for those with mental health difficulties.

There is also **strong support** amongst Worcestershire residents for the idea of the council managing demand for services. One potential area had support from almost the entire sample of residents – that of having joined-up working, for example with the NHS. Many other potential areas were also supported. Nevertheless, there is sufficient evidence to suggest the phrase "demand management" should not be used in public discourse or communications.

There are initial indications from this research that suggest that most residents would be **open to ideas around community and personal empowerment**, providing the circumstances were right. Such circumstances include adequate information, as well as encouragement.

So, overall, there is ample evidence from this survey of residents to suggest that the council will get widespread support when it comes to making policy on prevention, demand management and community responsibility. Support will not be total, as there are sections of the population that are against these ideas and, no doubt, some of this opposition will be heartfelt.

The degree of support may well be dependent upon the way in which the concepts are introduced to the population. The research very carefully introduced the concepts using simple and clear language, so a similar approach would seem to be a prerequisite. The report supports this suggestion by showing that the language and concepts used by residents themselves can also be simple.

The degree of support may also depend on the emphasis that the council places on which people in society will benefit from preventative spending – vulnerable people are clearly very important, but people with habits such as smoking are deemed less so and, as such, preventative spending on groups such as smokers (no matter how justified economically) would probably be resisted by Worcestershire residents.

There are two further issues to consider here:

i) it is important to note that some of the topics were explored only briefly in the interview – and this particularly applies to the issues around community empowerment. This is a complex topic and one that deserves dedicated qualitative research to understand fully – the results from a single open-ended question at the end of a long interview can only give an indication of opinion on this matter

ii) the concepts concerning prevention and demand management were largely explored in positive terms, without explaining that there may be losers as well as winners. People allocated funds between services, but may not have fully realised that their smaller allocations might mean cuts in services. Their support might depend, therefore, on positive framing.

3. Context and Language

3.1 Introduction

The interview started with a series of questions to slowly introduce the resident to the idea of prevention, and spending money on prevention rather than trying to cure a problem after it has happened. These questions asked:

- do you understand what is meant by the phrase ... a stitch in time saves nine?
- do you understand what is meant by the phrase ... prevention is better than cure?
- can you give an example of how you might spend money on preventing something from happening, rather than curing a problem after it has happened?

The answers to these questions illustrate the level of understanding that people have about the topic, the language that they use and their mindset in relation to the idea of prevention. They are contained in this chapter.

This early section of the questionnaire also asked "what, if anything, do you understand by the expression 'demand management'"? The results to this particular question are reported upon in Chapter 6.

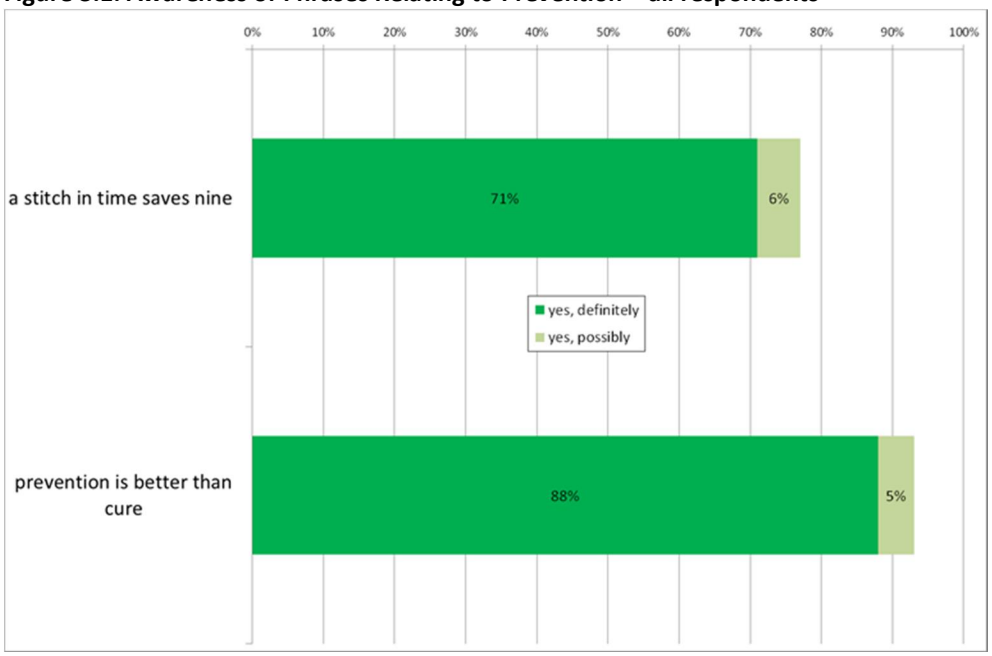
3.2 Overview

Almost everyone understands common phrases that relate to prevention (for example, "prevention is better than cure") and almost everyone can provide examples of where their own spending on prevention might stop problems happening in the future. Many examples that they gave related to healthiness and education.

3.3 Everyday Phrases for Prevention

Most people recognise and understand the meaning of everyday phrases that relate to prevention. More than 90% understood the phrase "prevention is better that cure" and more than three-quarters "a stitch in time saves nine". The first chart, overleaf, shows this finding.

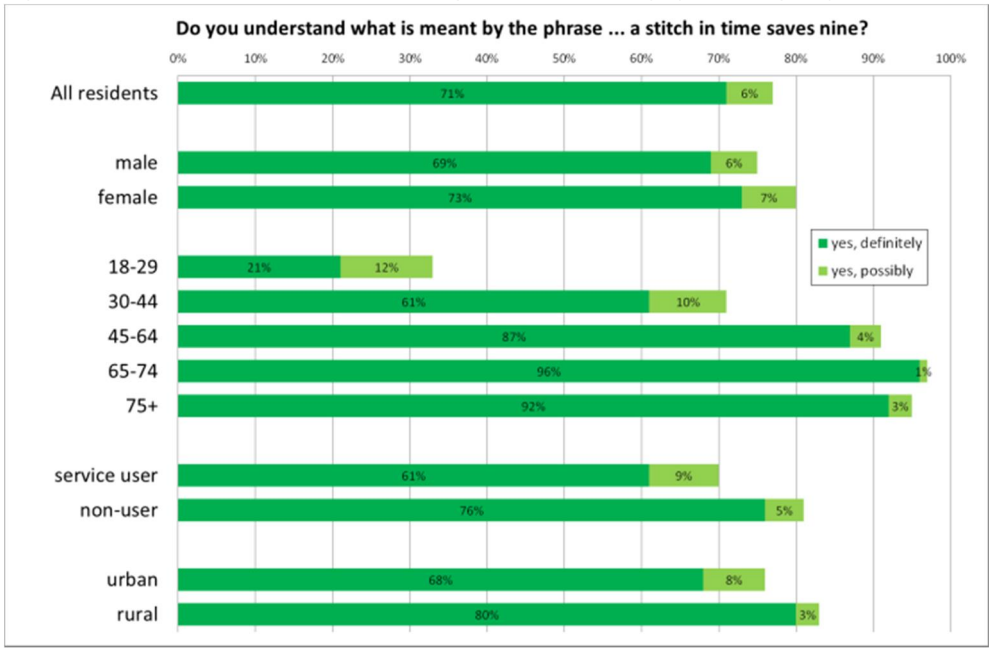
Figure 3.1: Awareness of Phrases Relating to Prevention – all respondents



There are some significant differences between the various groups that make up the population of Worcestershire on the question of phrases that describe prevention. Young people are far less likely to recognise the phrase "a stitch in time saves nine", although it is recognised by most people over the age of 45. It's also slightly more likely to be recognised by females and those living in rural areas.

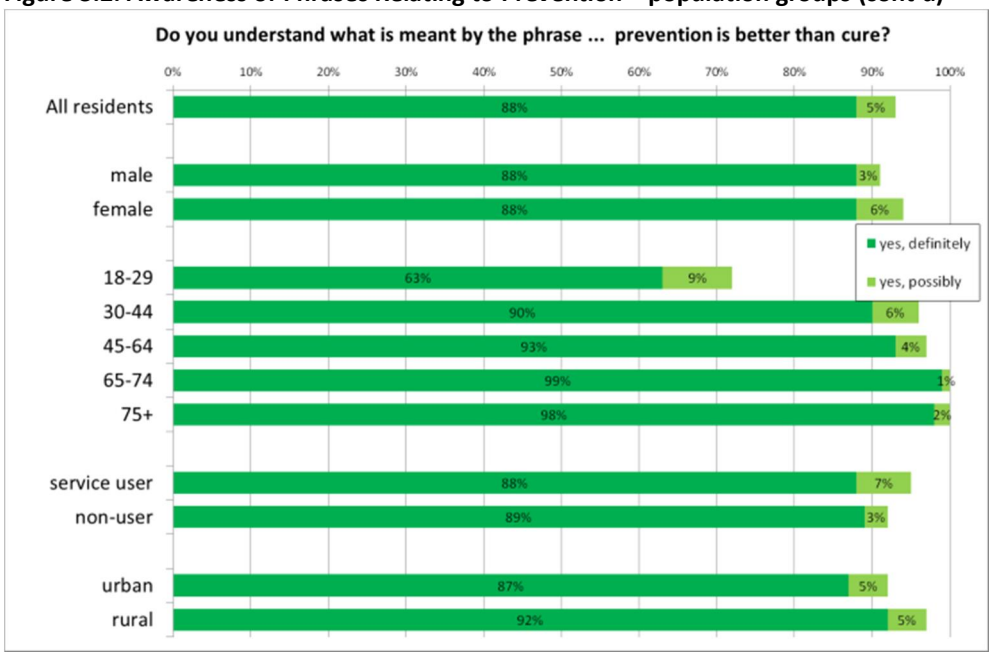
In contrast, the phrase "prevention is better that cure" is more universally recognised.

Figure 3.2: Awareness of Phrases Relating to Prevention – population groups[2]



[2] For the purposes of this report, 'service users' are defined as being anyone who uses any one of eleven service groups (see Figure B.4 in Appendix B). In other words, all service users have been grouped together.

Figure 3.2: Awareness of Phrases Relating to Prevention – population groups (cont'd)



Having (if necessary) had the phrase "prevention is better than cure" explained to them, respondents were asked to give examples of how they might spend money to prevent things from happening. Almost everyone was able to provide at least one example. What is immediately interesting from their answers is the number of people who related the phrase to health and education services – children also featured, as did examples relating to cars and roads (potholes).

The full list of verbatim responses to this question (and other open-ended questions) is contained within the Tabulations Report, issued as an annex to this final report. Example responses to this question included:

Fire prevention methods & safety precautions

Education in the schools to stop children from smoking

Younger generation - build better skate parks to keep younger people out of trouble

Flu jabs, prevents flu

House alarms to prevent burglary

Cancer research

Buying toothpaste to prevent dental problems

Fix the tile before you need a new roof

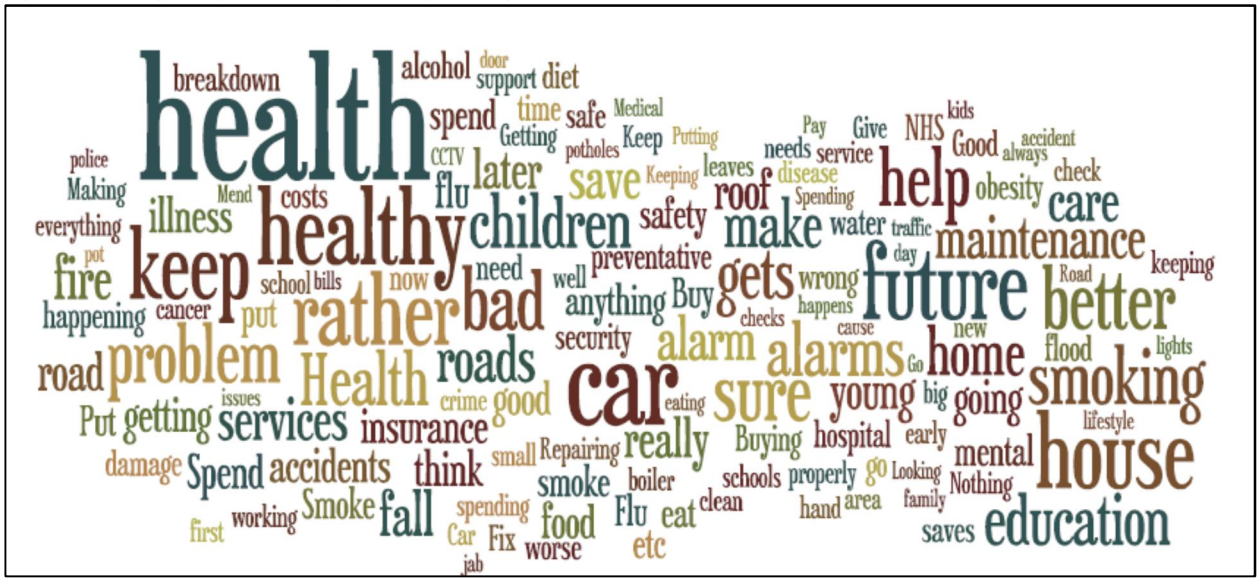
Repair the road to stop claims

Service your car, to prevent later problems

Preventative screening for alcohol disorders

Replacing rotten fencings before it gets blown down

Figure 3.3: Unprompted Examples of Spending on Prevention



4. Awareness

4.1 Introduction

Awareness of the concept of "prevention" was examined in a number of ways:

- unprompted
  - residents' knowledge that the council spends on prevention, in theory
  - their understanding of where the council might spend on prevention
- prompted
  - the specific areas where the council spends on prevention (ten pre-defined areas)

4.2 Overview

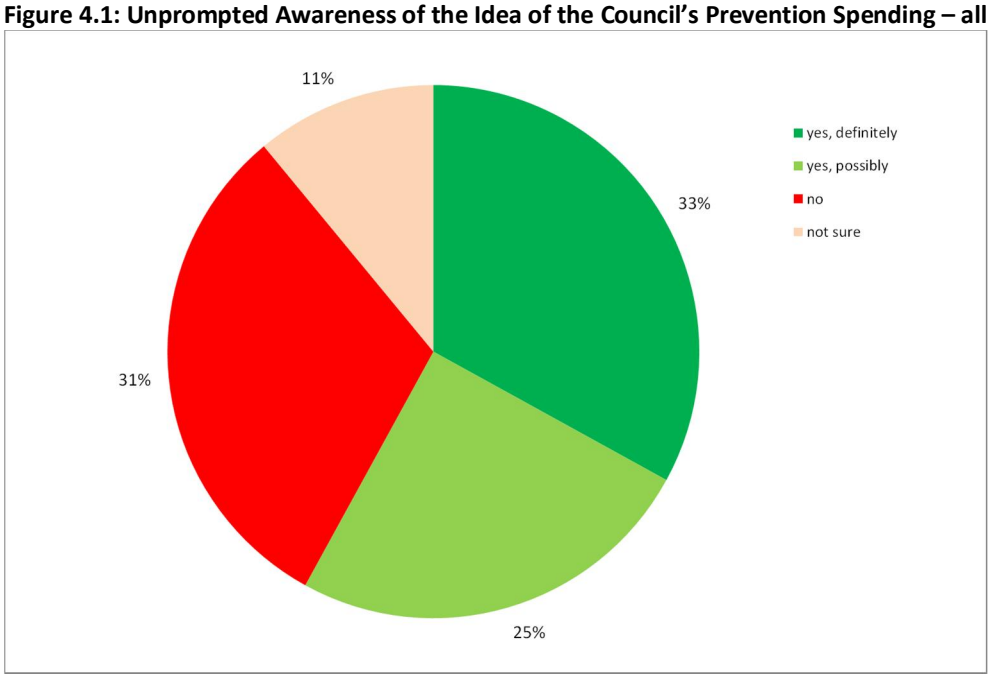
More than half of residents were aware, to some degree, that the Council spends money on prevention. Much of their understanding relates to roads and pavements – and more particularly pot-holes and their impact on accidents. Nevertheless, many examples were also given in the area of health.

When prompted, a majority of residents were aware, to some degree, of the Council's preventative activities in the ten service areas. Four areas stood out as having most awareness.

4.3 Unprompted Awareness

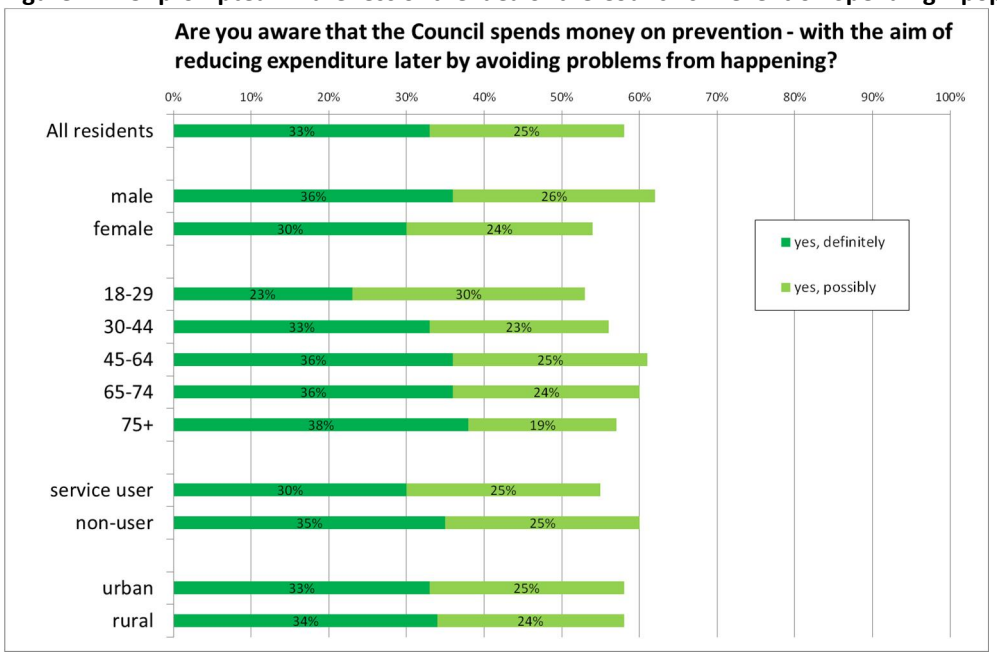
More than half of residents surveyed (58%) were aware, to some degree, that the Council spends money on prevention. This next chart shows this level of unprompted awareness.

Figure 4.1: Unprompted Awareness of the Idea of the Council's Prevention Spending – all respondents



Awareness is quite uniform across the population groups within the county. As may be seen below, unprompted awareness ranges from just over 50% to just over 60%. It is very slightly higher amongst males, the middle-aged and people who are not service users – but the differences are very small and not statistically significant[3].

Figure 4.2: Unprompted Awareness of the Idea of the Council's Prevention Spending – population groups



4.4 Perceived Examples of Council Spending on Prevention

When next asked to provide examples of how the Council might spend money "on preventing things from happening, rather than curing problems after they have happened" a significant number (about 20%) were unable to do so. The responses of those who were able to provide examples have been summarised through use of a word cloud and the results are shown overleaf. As can be seen, the framework that many people have relates to roads and pavements – and more particularly pot-holes and their impact on accidents. Nevertheless, many examples were also given in the areas of health.

Typical examples that people gave included:

Social work for kids to prevent something happening

Repairing pavements before someone trips and sues them

Communication of fitness to kids

Give older people more choice in their care and people with mental health issues, continue with drop in centres to help vulnerable people

[3] For a discussion about statistical significance as it relates to the findings of this study, please see Appendix A, section A.8.

Mend pot holes

Promotion of better diets

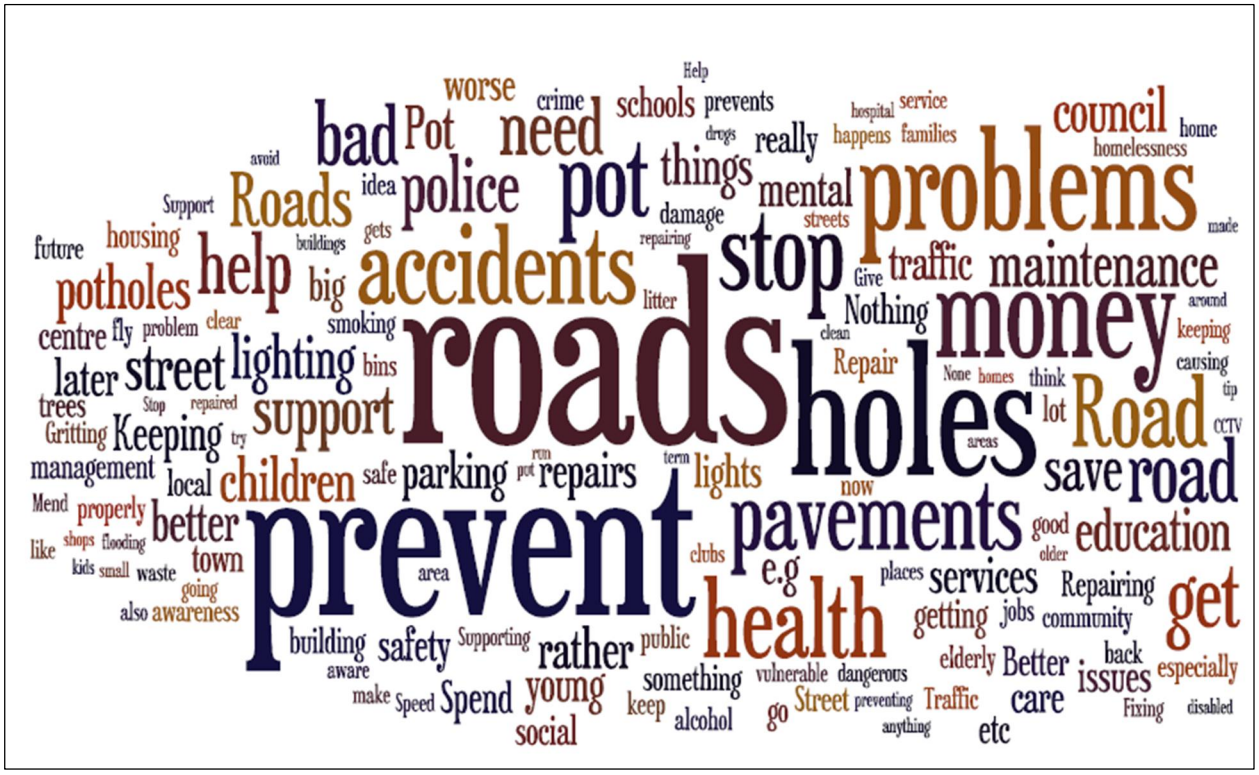
Drug or alcohol abuse before it happens

Resurfacing council playgrounds to prevent accidents

Possibly help vulnerable families to cope

A website for education in health

Figure 4.3: Perceived Examples of the Council's Spending on Prevention



4.5 Prompted Awareness, Ten Areas

Respondents were next given a list of ten areas where the Council might spend on prevention, with a preamble that said "*Preventative services help people maintain their independence and can prevent or delay the need for more intensive services in the future. They also help people get the most out of life*". The results are shown in the next chart (overleaf).

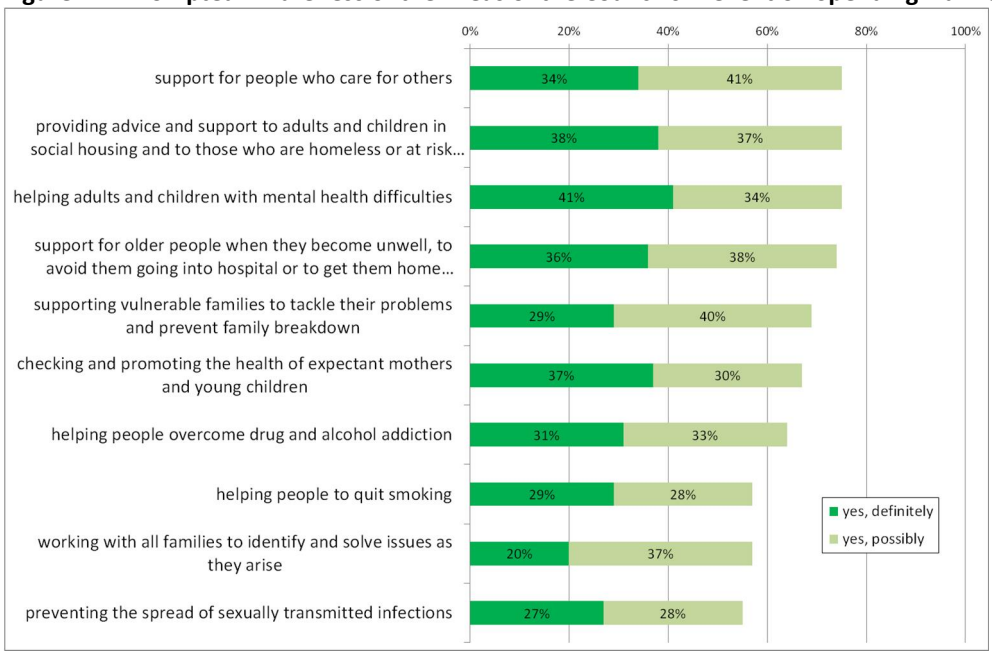
As can be seen, a majority of residents were aware, to some degree, of the Council's preventative activities in all ten areas presented to them. Four areas stand out as having most awareness:

- support for carers (75%)
- advice/ support for those in social housing or homeless (75%)

- help for those with mental health difficulties (75%)
- support for older people (74%).

Awareness is lowest in three areas: helping people quit smoking, preventing the spread of sexually-transmitted infections and working with all families. Nevertheless, even amongst these three areas, awareness levels were above 50% of the population.

Figure 4.4: Prompted Awareness of the Areas of the Council's Prevention Spending – all respondents

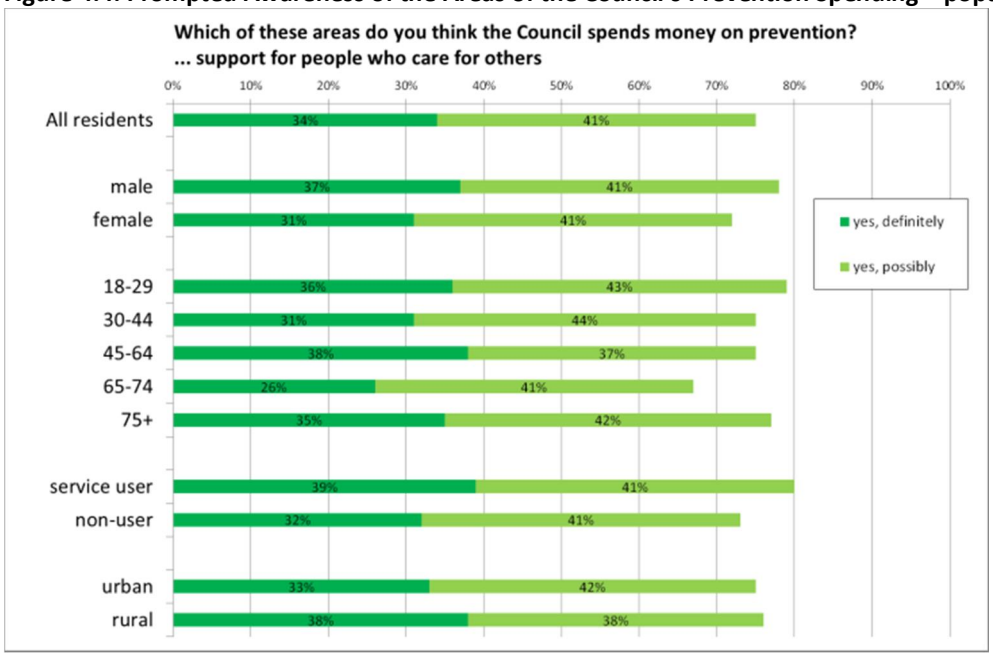


Levels of awareness of the council's spending across the ten areas do vary in some cases and are consistently strong in others. The different levels of awareness amongst the population groups (for the ten spending areas) are shown in the full set of thumbnail charts over the next three pages, with the key differences being:

- awareness of support for people who care for others is lower amongst the 65-74 age group
- awareness of support for older people is lowest amongst those over the age of 65 (and the difference is significant)
- for help to quit smoking, awareness is much higher (and significantly so) amongst the under 30s and lowest amongst those aged 75+
- with regard to support for vulnerable families, awareness is consistent amongst the population
- awareness of the council's preventative spending on those in need of social housing declines with age, being significantly highest amongst the under-30s – and slightly lower amongst the 65+ age group and those living in rural areas
- in terms of working with all families, there is a clear age difference – those under 45 are more aware than any other age group (and this difference is significant). Service users are also slightly more aware than are non-users
- this age difference for families is also evident when it comes to awareness of the council's work with expectant mothers and young children. This time, not only are service users more aware, but urban dwellers are too

- a similar age difference in awareness is notable when it comes to sexually-transmitted infections and drug/alcohol addiction. About three quarters of under-30s were aware of the council's work on STIs and drug/alcohol addiction, compared with about 55% awareness amongst the population as a whole (both are significant)
- awareness of the council's preventative work in mental health is fairly consistent across the population – but is also slightly higher amongst the under 30s.

Figure 4.4: Prompted Awareness of the Areas of the Council's Prevention Spending – population groups



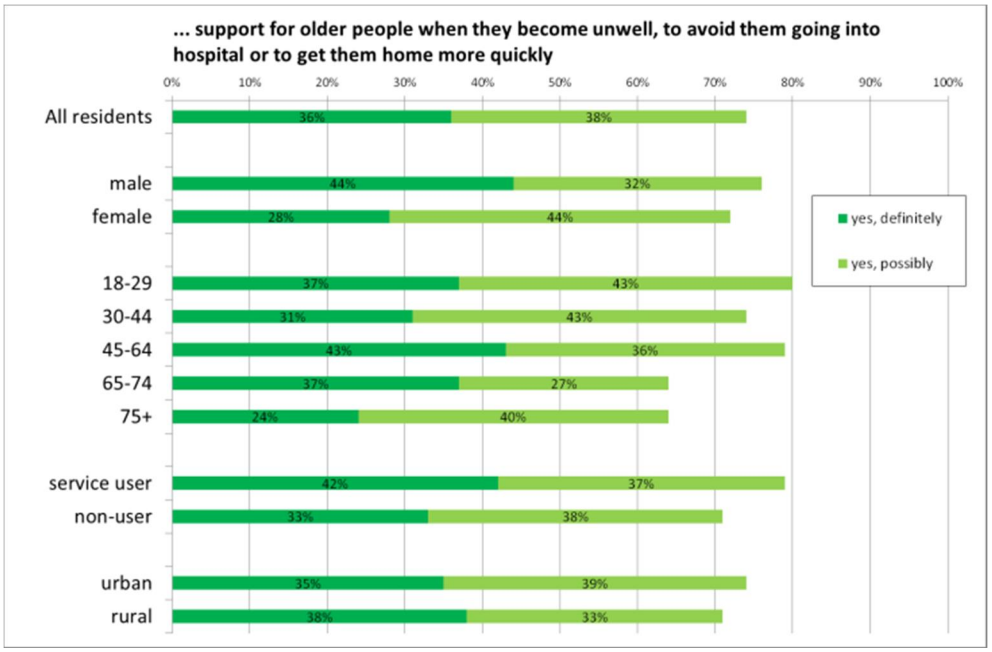
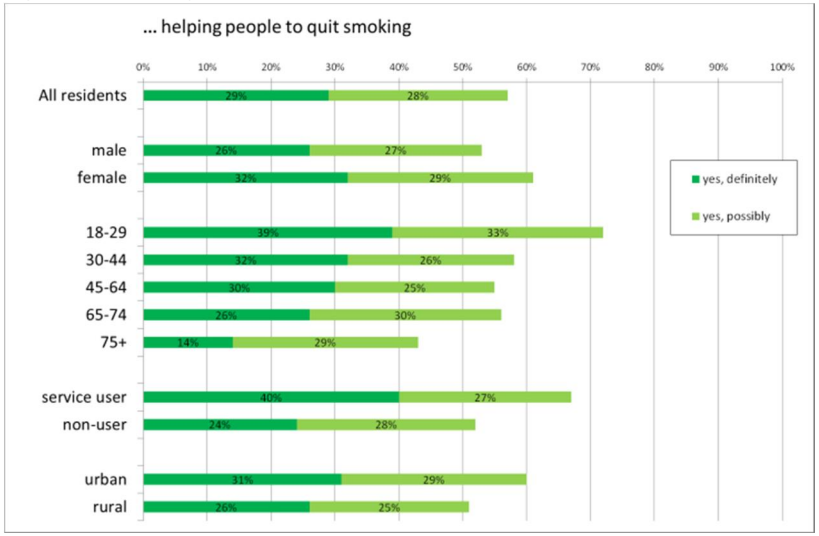
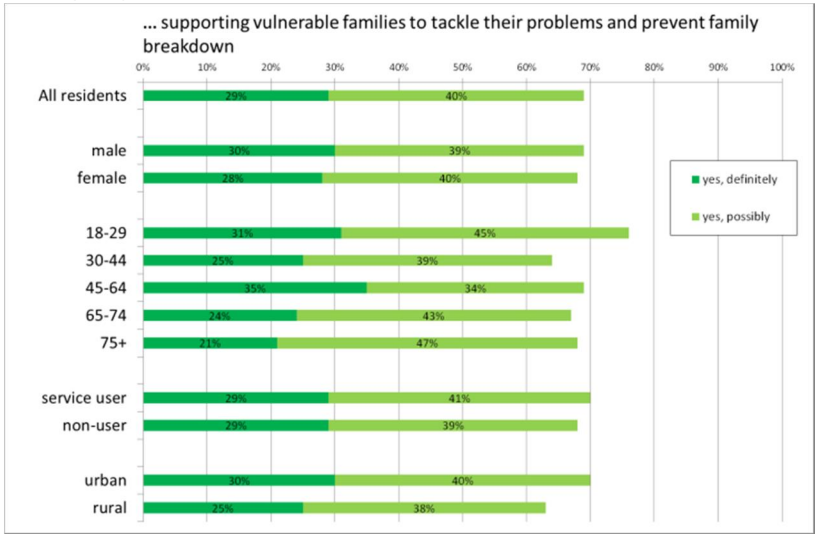
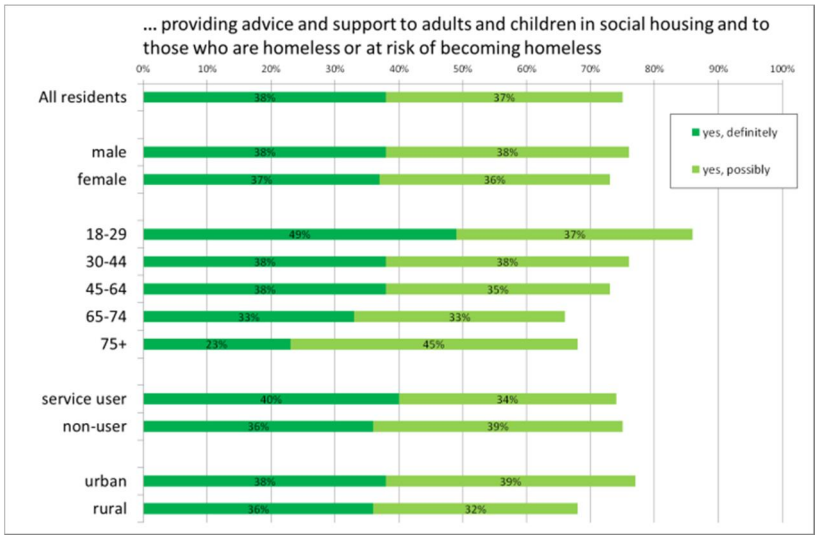


Figure 4.4: Prompted Awareness of the Areas of the Council's Prevention Spending – population groups (cont'd)







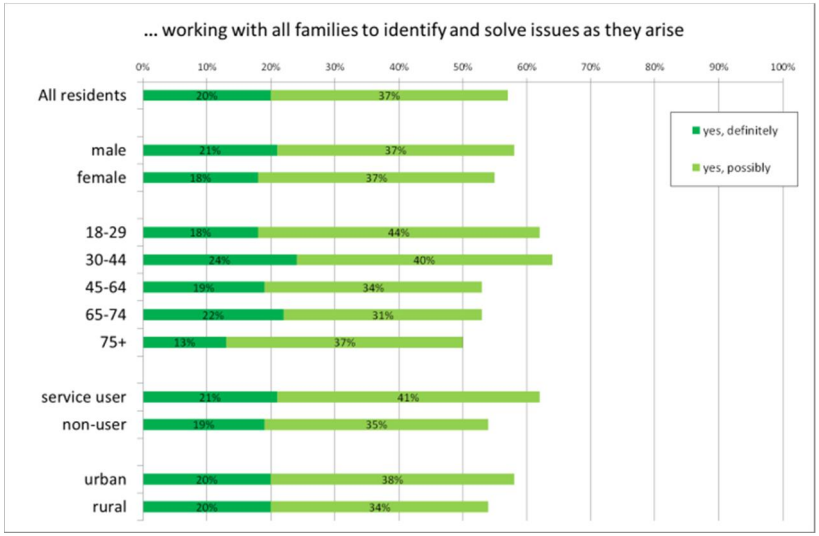
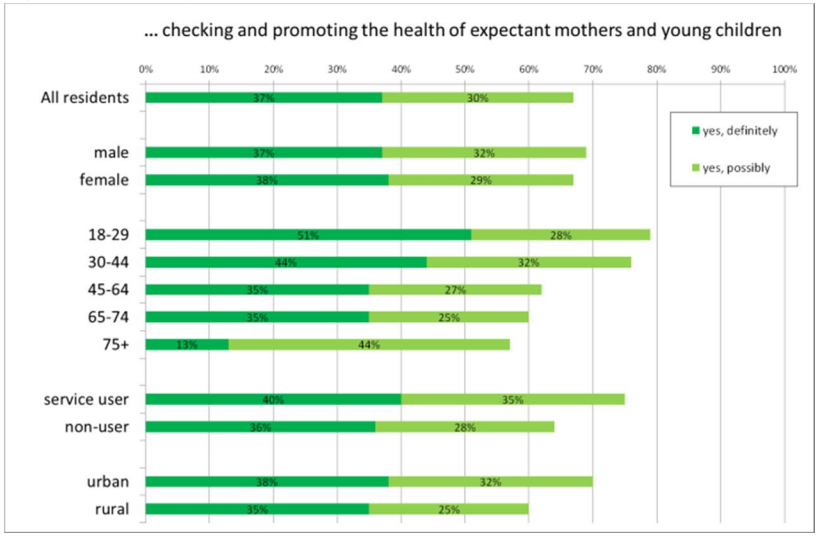
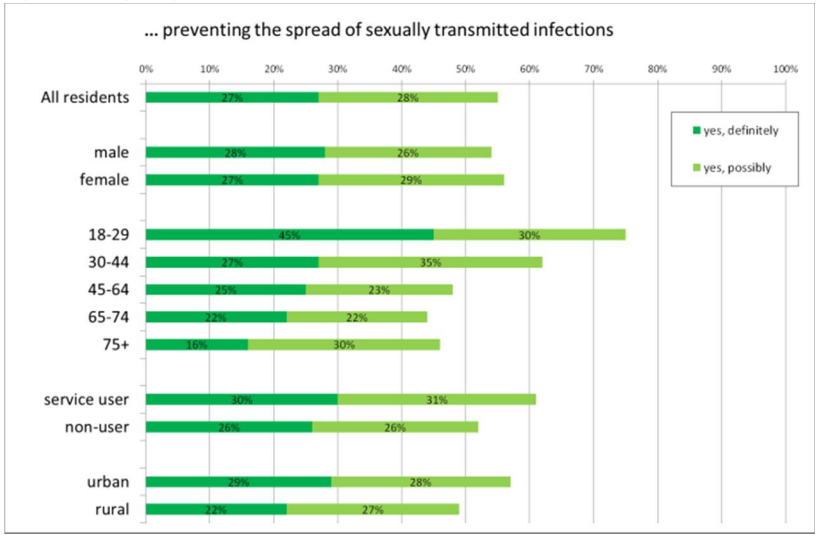
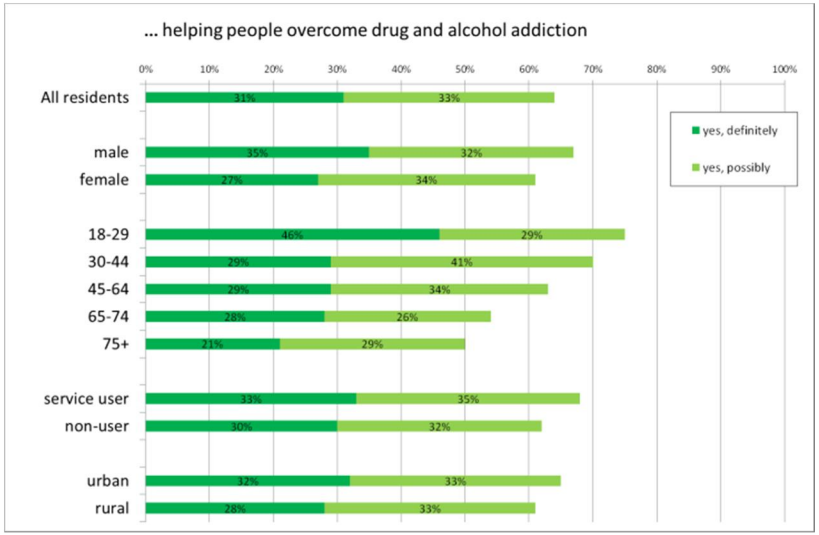
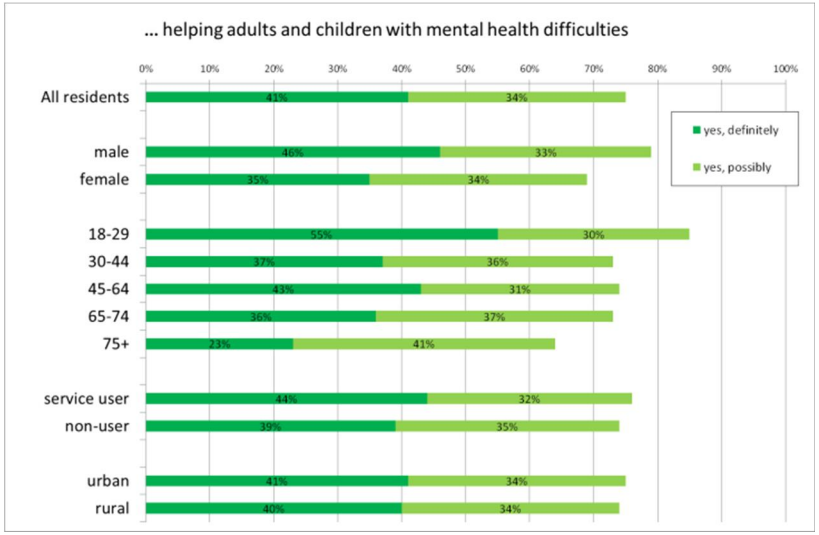


Figure 4.4: Prompted Awareness of the Areas of the Council's Prevention Spending – population groups (cont'd)









5. Perceived Priorities for Prevention

5.1 Introduction

Residents' perceived priorities for action and spending by the council on prevention were examined in a number of ways:

- the level of priority that the council should place upon prevention across the ten spending areas
  - using a 1-5 scale (very high to very low)
- their own suggestions for other high priorities for prevention
- their view as to how a notional £100 of council spending should be allocated between prevention and existing social care/specialist services
- their view as to how a notional £100 of council spending should be allocated between each of the ten spending areas.

The first of these can be considered as an unconstrained priority, since people could (if they wanted to) put a high priority on each of the ten areas. The allocation of the £100 constrains people to make difficult choices and is – as a result – a more accurate assessment of their priorities.

Their overall support for the idea of preventative spending was also explored and this is reported upon first (see section 5.3 below).

5.2 Overview

A very large majority of residents (93%) thought that it's a good idea for the Council to spend money on prevention. Attitudes on this topic were remarkably consistent amongst the various population groups.

When next asked why, many people used the expression "prevention is better than cure" and the majority referred to potential money-saving 'in the long run'.

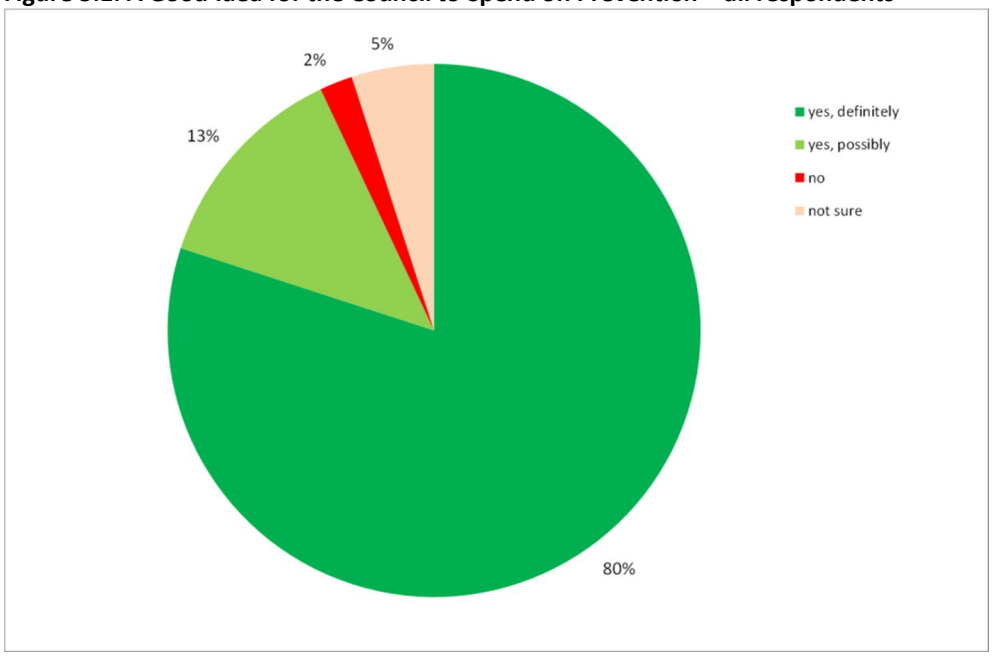
When residents were presented with the same list of ten possible action areas and asked to put a high or low priority on each, the top five (unconstrained) priorities were mostly the same as those where awareness was highest. Only one spending area (helping people to quit smoking) was a high priority for less than half of the population.

When asked to allocate a notional £100 between prevention and existing services, opinion was almost equally split between the two. Allocation of £100 between the ten potential spending areas showed that residents have three principal priorities: support for older people, helping those with mental health difficulties and support for carers. Almost a half of their allocation was for these three areas. Very little spending allocation was made on helping people to quit smoking or the prevention of sexually-transmitted infections.

5.3 Support for the Principle of Prevention

A very large majority of residents thought that it's a good idea for the Council to spend money on prevention ("*with the aim of reducing expenditure later by avoiding problems from happening*"). Four respondents in five said "yes, definitely" to this idea.

Figure 5.1: A Good Idea for the Council to Spend on Prevention – all respondents



Attitudes on this topic were remarkably consistent amongst the various population groups. The differences between the groups were tiny – no more than 5% separates the highest and lowest.

Figure 5.2: A Good Idea for the Council to Spend on Prevention – population groups

When next asked why they thought that, a wide range of responses were given. Many people said "prevention is better than cure" and, as may be seen, the majority referred to potential money-saving 'in the long run'. Examples included:

There's an old English saying prevention is better than cure, by spending money initially it means they can save more in the long run

Because it's best to tackle risks before the develop

Causes less problems

Because it avoids the problems from happening it's difficult to quantify though. It's difficult to get the credit for preventative action

If you prevent something then in the long run it cuts down on cost

Because of cost cutting, makes more sense

You need to spend on prevention to get results and solutions to problems

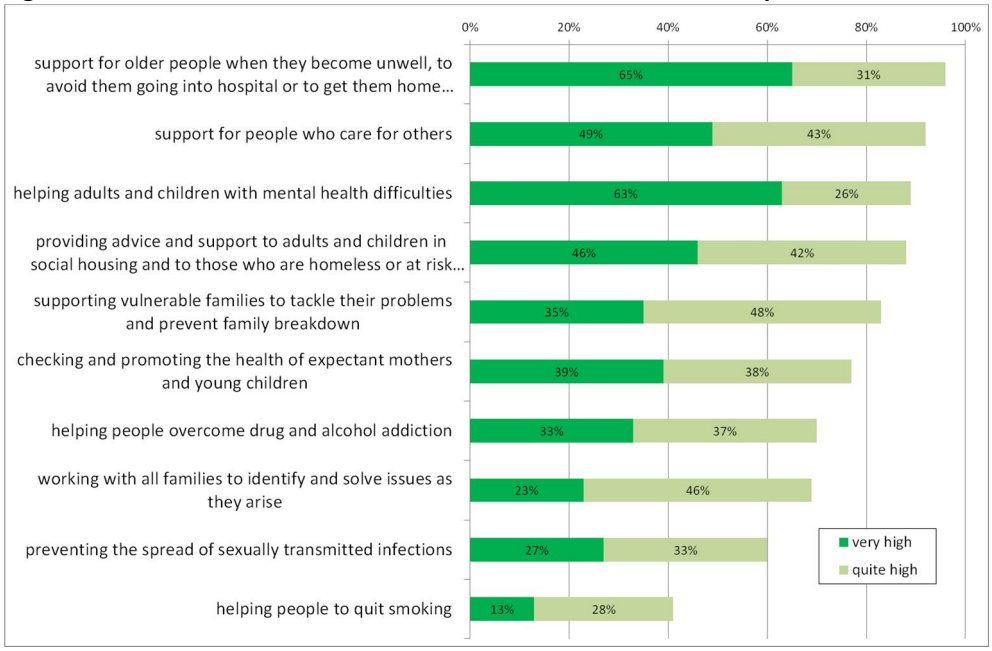
Figure 5.3: Why it's a Good Idea (or not) for the Council to Spend on Prevention

5.4 Unconstrained Priorities

The survey respondents were next given the same list of ten possible service areas for prevention and were asked to put a high or low priority against each. The next chart shows that the top five priorities were mostly the same as those where awareness was highest: support for older people (96%), support for carers (92%), help for those with mental health difficulties (89%) and advice/support for those in social housing or homeless (88%). The additional high-priority area that didn't feature so strongly in the awareness question ('supporting vulnerable families to tackle their problems and prevent family breakdown') was seen to be a high priority by 83%.

Only one spending area was considered to be a very or quite high priority by less than 50% of the population – spending on helping people to quit smoking.

Figure 5.4: Perceived Priorities for the Council on Prevention – all respondents[4]



When given the opportunity to say what other priorities they thought there might be, the majority had exhausted their ideas and only 40% were able to provide examples. There was support amongst residents for issues concerning education/schooling, health and children, with examples given that included:

Floods - Road congestion

Employment, get more employment for people so less problems

Providing education for young children, teenagers, places & facilities for them to reduce the chance of then being involved in problems on the street

Support for elderly people who are isolated and lonely they feel people don't care about them

Dementia & memory loss high priority

School truancy. Local services, libraries, Museums

Helping families with social issues. Not only low income families, everyone

Bus transport need improving, it will prevent old people getting isolated

Preventing terrorism

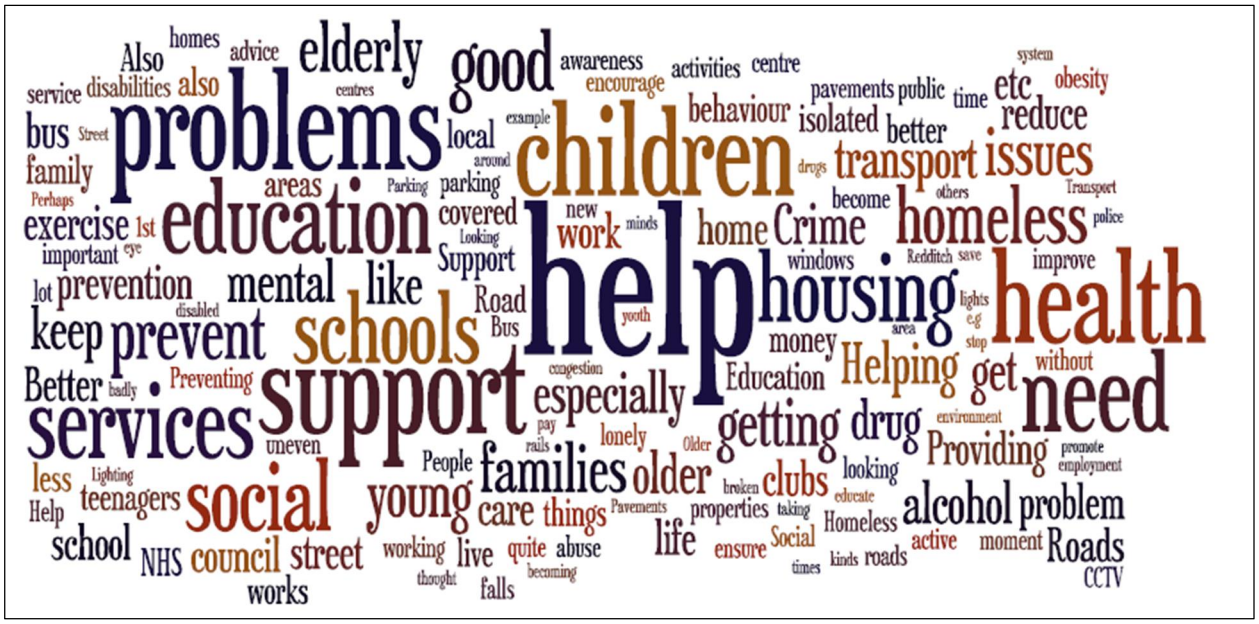
What about obesity, that's also a big health problem

[4] Population differences have been shown later for the constrained priority choices that people made, as this is a more accurate reflection of opinion.

Money management should be an issue, teach this in school, especially teenagers in schools, financial knowledge to help them in the future

Turn on local lights to prevent any break-ins, such as broken windows

Figure 5.5: Other Perceived Priorities



5.5 Allocation of Spending

In view of a concern that surveys of the general population tend to produce results that show that most services are high priorities, this study also included questions that forced people to make choices between potential areas of preventative spending. Respondents were given a notional £100 of council spending and were asked to allocate the £100:

i. between spending on existing social care and other specialist services **OR** spending on prevention
ii. between the ten potential services areas discussed earlier in this report.

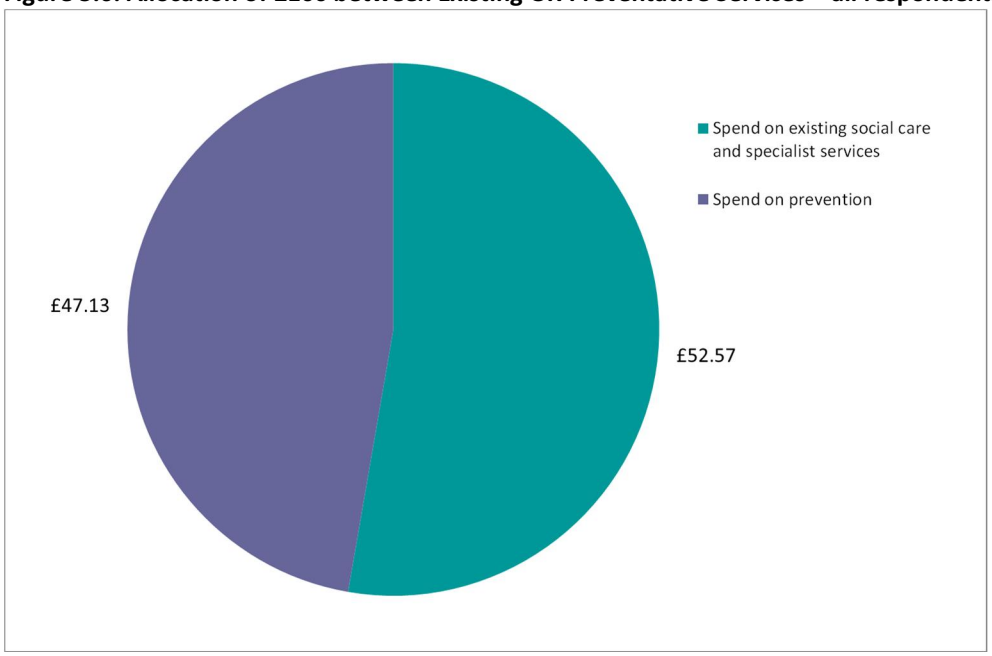
When examining these results it should be noted that everyone was given £100 to allocate, so there should be no income or affordability effects at play here[5].

In the first case (spending on prevention or existing services) opinion was almost equally split. The average level of spend on existing social care and other specialist services was £52.57 and on prevention the average spend was £47.13[6].

[5] When survey respondents are asked in surveys to 'vote' for increases or decreases in council tax (to pay for more or fewer services, for example), people on low incomes tend to answer differently than those on higher incomes. This study took a different approach, with people allocating a notional £100, so their answers should not be influenced by their own levels of income.

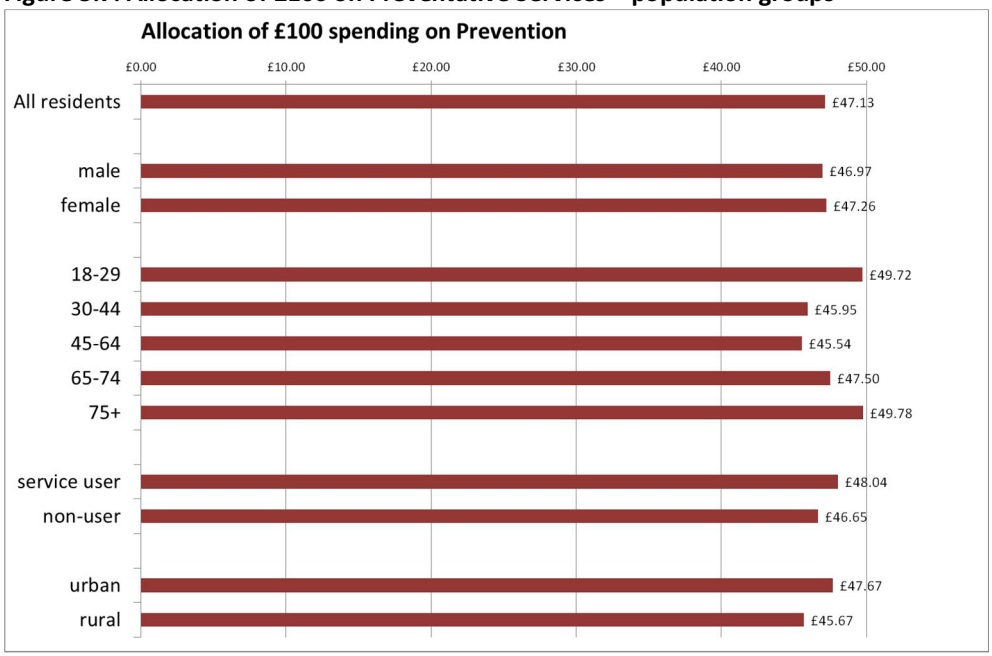
[6] Nine people were unable or unwilling to allocate the £100; 28 people spent nothing on prevention; 3 people did not allocate the full £100 – which is why the figures do not quite sum to £100.

Figure 5.6: Allocation of £100 between Existing OR Preventative Services – all respondents



The proportion of the notional £100 that different population groups allocated to prevention was remarkably similar, as this next chart shows. Men and women allocated almost exactly the same amount of money and no more than £4 or so separates the highest-allocating and lowest-allocating groups. Those allocating most were the under-30s and the over-75s, with slightly higher figures amongst service users and those living in urban areas.

Figure 5.7: Allocation of £100 on Preventative Services – population groups

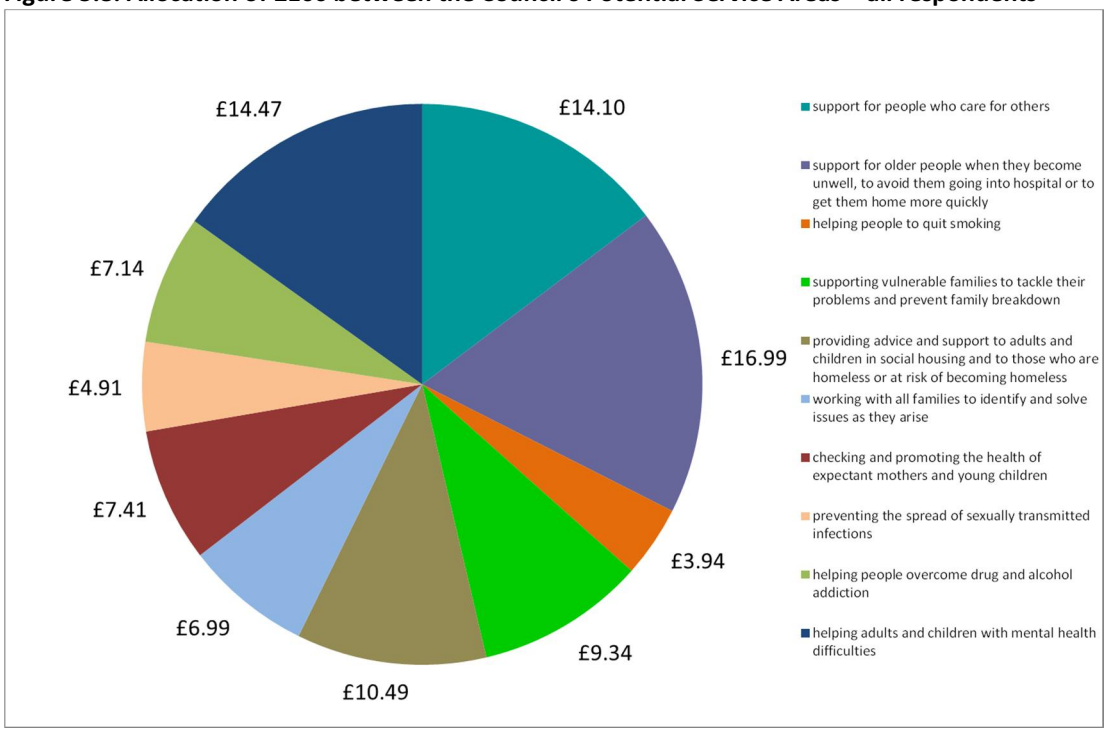


The allocation of the notional £100 between the ten possible service areas where the Council might allocate spending was interesting. Whilst (as can be seen below) the £100 was allocated, on average, across all service areas, there are three areas that stand out as having most priority

attached to them – they are: support for older people (£16.99), helping those with mental health difficulties (£14.47), and support for carers (£14.10)[7].

The lowest priorities, in terms of allocating spending, were helping people to quit smoking (£3.94) and the prevention of sexually-transmitted infections (£4.91).

Figure 5.8: Allocation of £100 between the Council's Potential Service Areas – all respondents



As was the case with awareness, the constrained choices between spending areas that residents made during this exercise showed significant similarities – and occasional differences – when the results of different population groups are examined.

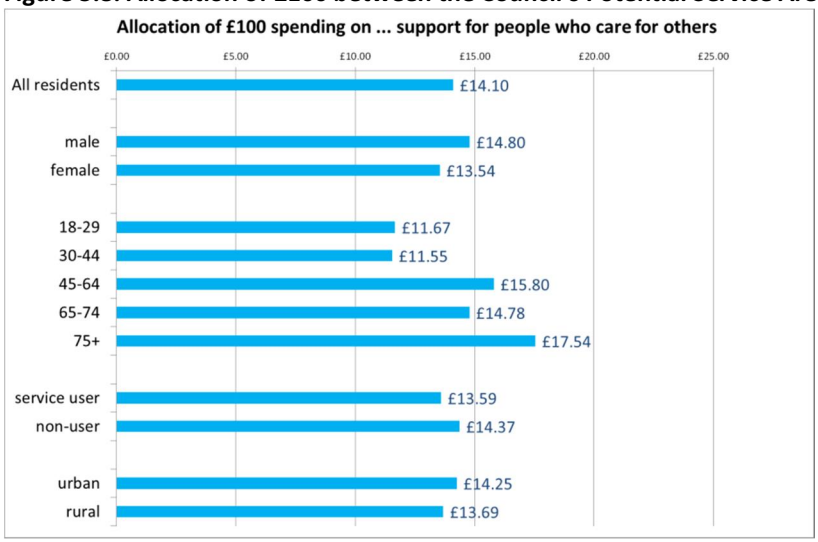
The different levels of 'spend' amongst the population groups (for the ten spending areas) are shown in the full set of thumbnail charts over the following pages. The key differences are:

- allocation of the £100 towards support for people who care for others was notably higher amongst those aged 45+ and was slightly higher amongst males
- a very similar pattern was evident in the allocations for support for older people, with a £10 difference between the under 30s and the over-75s. People who were not service users also allocated more (nearly £3 more than users)
- on help to quit smoking, allocations were very similar in absolute terms, with a slightly-higher allocation amongst those under 45 and amongst service users
- with regard to support for vulnerable families, the allocations were quite consistent amongst the population – slightly lower amongst the under-30s and amongst men

[7] As with the previous question, not everyone was able to carry out this task fully. Twelve people were unable to allocate spending at all, three spent nothing on prevention and 53 people did not allocate the full £100. This likewise explains why the averages shown in the chart do not total £100.

- allocation of preventative spending on those in need of social housing was also broadly similar across the groups
- the allocation of the £100 for 'working with all families' showed few differences between the segments of the population
- there was a major age difference when it came to the allocations for spending on the council's preventative work with expectant mothers and young children. The under-30s allocated more than £10, with the sums declining with age to the point that those 75+ allocated less than half this amount
- there were also age differences regarding spending on sexually-transmitted infections but the differences were not as great – the under-30s allocated £6.34 and the 75+ age group £3.39, with a similar decline with age. Spending amongst urban dwellers was also slightly higher
- allocations for drug and alcohol addiction were greatest amongst men (£7.85), under-30s (£8.86), service users (£7.71) and rural dwellers (£8.24)
- preventative allocations for mental health had less-obvious patterns. The highest allocations were amongst females (£15.34), those aged 65-74 (£17.12), non-users £14.79 and, again, rural dwellers £15.58).

Figure 5.8: Allocation of £100 between the Council's Potential Service Areas – population groups



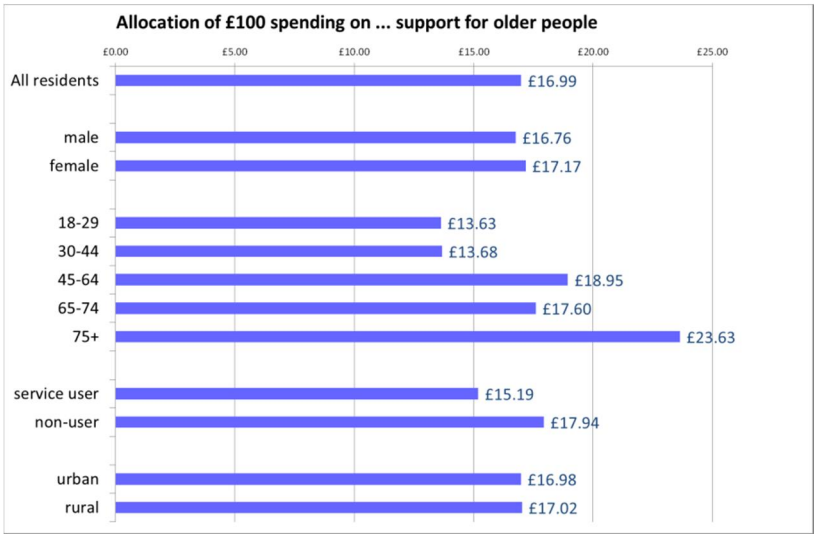
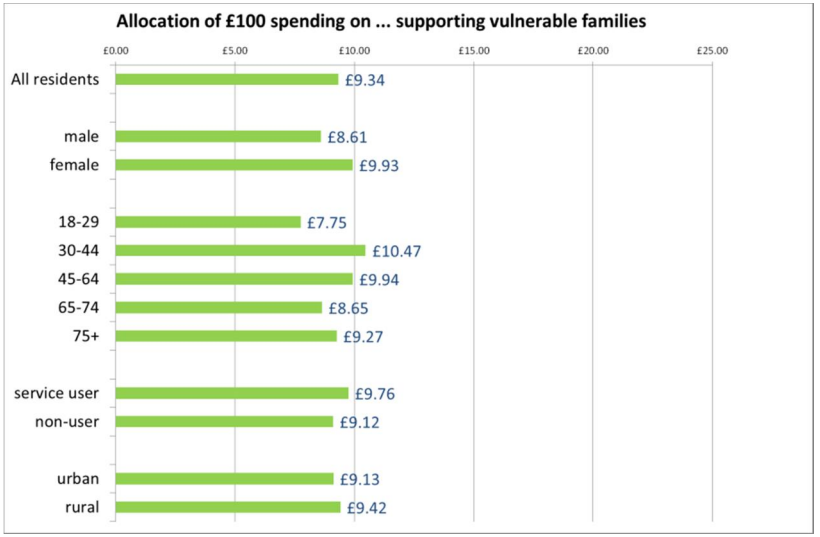
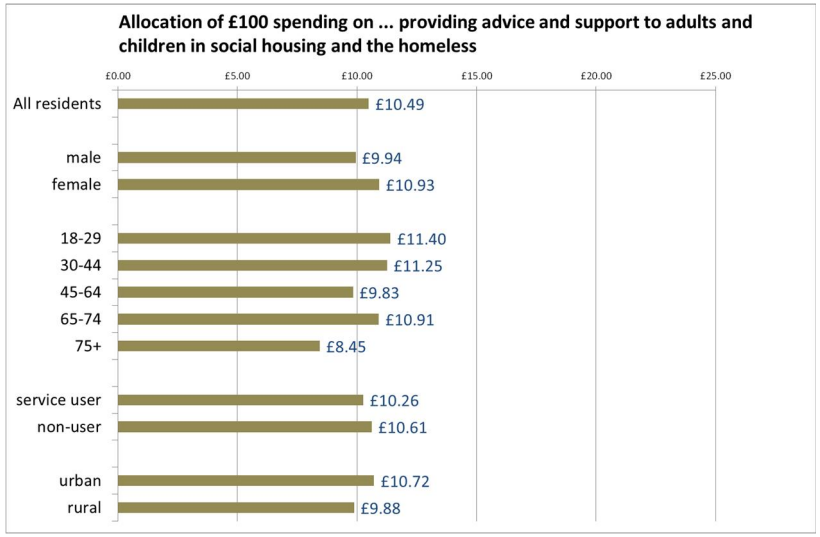


Figure 5.8: Allocation of £100 between the Council's Potential Service Areas – population groups (cont'd)





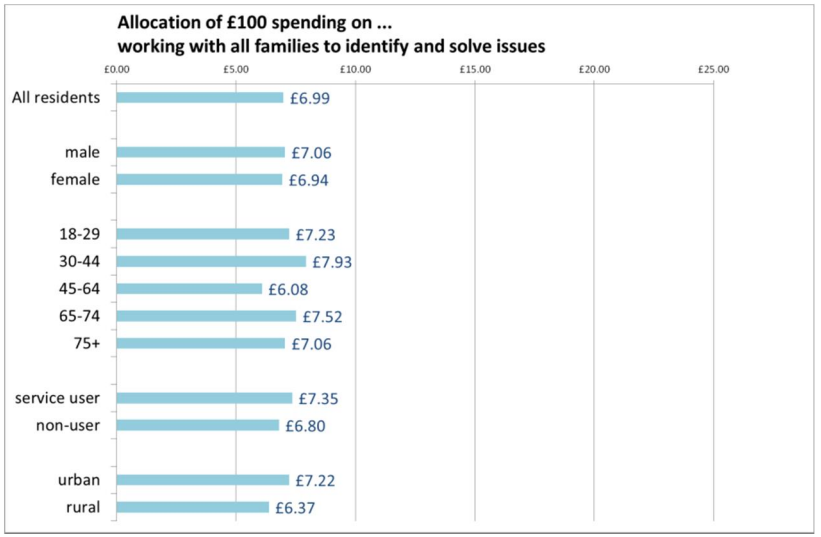
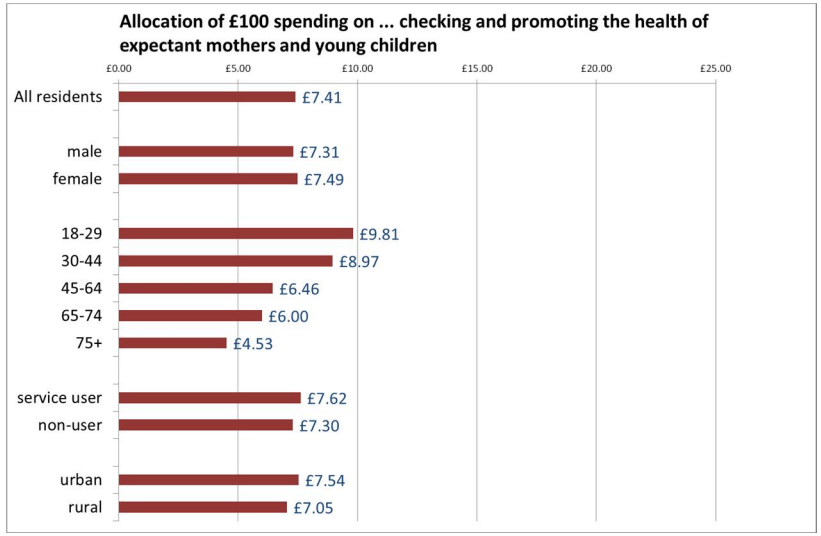
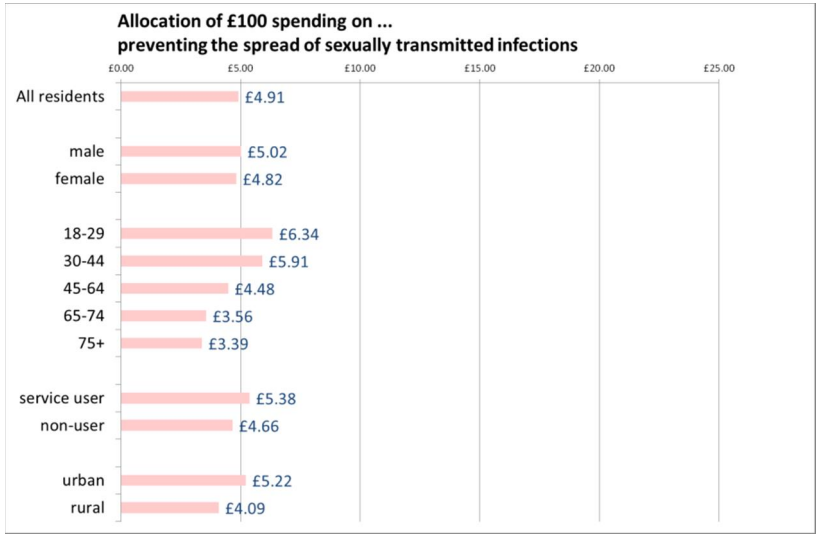
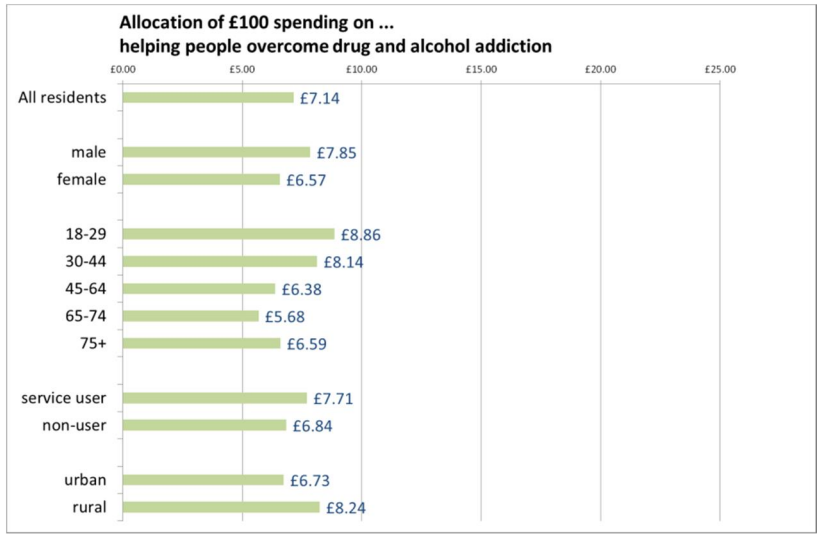
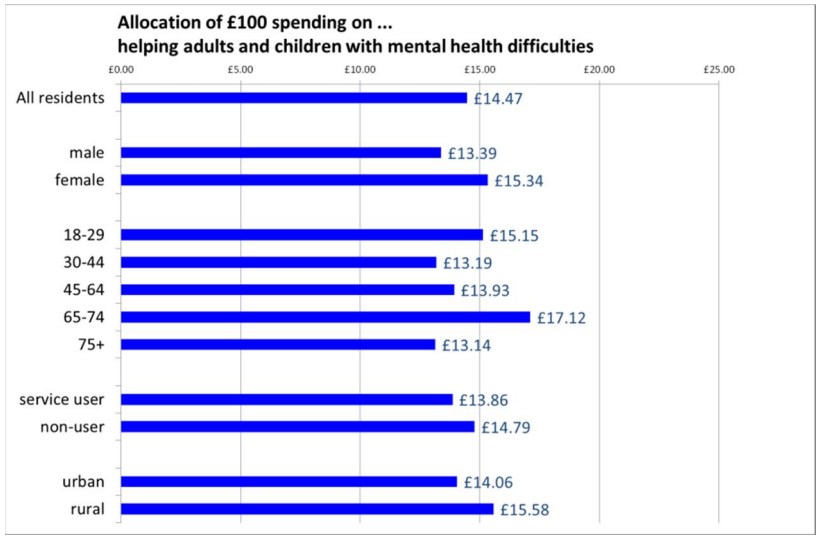


Figure 5.8: Allocation of £100 between the Council's Potential Service Areas – population groups (cont'd)









6. Demand Management

6.1 Introduction

The idea that the Council might take other actions that would reduce demand, or entail managing it differently, was introduced very carefully, given the potentially sensitive nature of the phrase "demand management". Respondents were shown a list of possible actions and given the following introduction:

> Demand for some council services, such as Social Care, is rising. Communities are changing and growing, so this demand is going to keep rising in the future. There are also pressures from changes to the law. At the same time, funding for the council is reducing; so the council is required to do more for local residents, but with less money.
>
> One of the ways the council could reduce demand is by focusing on prevention, which we have been discussing. As well as providing services that prevent demand, the council could be taking other actions to reduce demand or manage it differently.

They were then asked to allocate a priority for each action area, from very low to very high.

Questions were also asked:

i. to determine whether they thought it's a good idea for the council to manage demand for services in way such as these
ii. to understand what they thought the role of the council should be in terms of empowering communities and individuals to take more responsibility for reducing demand[8].

This chapter of the report also presents the findings to the early question in the interview "what, if anything, do you understand by the expression 'demand management'?".

6.2 Overview

There is a low level of understanding about the concept of 'demand management', as well as concerns about its connotations and implications.

A significant majority (87%) think that it's a good idea that the Council manages demand for its services in ways like the ones described.

Amongst seven possible options, one potential action area for demand management had most support – 'joined-up working (with the NHS, for example) to avoid duplication and waste'.

When asked what they thought the role of the Council should be in terms of empowering communities and individuals to take more responsibility for reducing their demand for Council services, there was a strong emphasis on 'information', 'encouragement' and 'involvement'.

[8] The issues concerning community and personal empowerment are quite complex, so the results to this one question should be treated as providing an indication of the views of residents.

There was also quite a strong belief that people should be taking more responsibility for themselves, either as individuals or as part of community action, together with a call for more volunteers or closer working by the council with the voluntary sector.

6.3 Perceptions of Demand Management

The County Council may not use the term 'demand management' in the context of the preventative agenda, but the expression was examined briefly early in the interview to see what connotations it has to local residents.

A majority (288 people, 54%) were unable to give an answer when asked about the phrase "demand management", most of these having no idea at all what the phrase means. It's also important to note that the phrase can be threatening to some people, for example:

Forced to do something

People demanding money from you by cowboy builders

It sounds ominous!

What the management want, as they want people to jump to their tune whether you like it or not

But as can be seen below, there is some understanding of the phrase. It can be correctly associated with council services and the need to match supply and demand, with people saying such things as:

County management reacting to the needs of people and circumstances

Managing demands the needs of the community

Managing the appetite for demand

Prioritise the things that have the highest demand get the money

To manage money better

Planning the resources to meet the demand

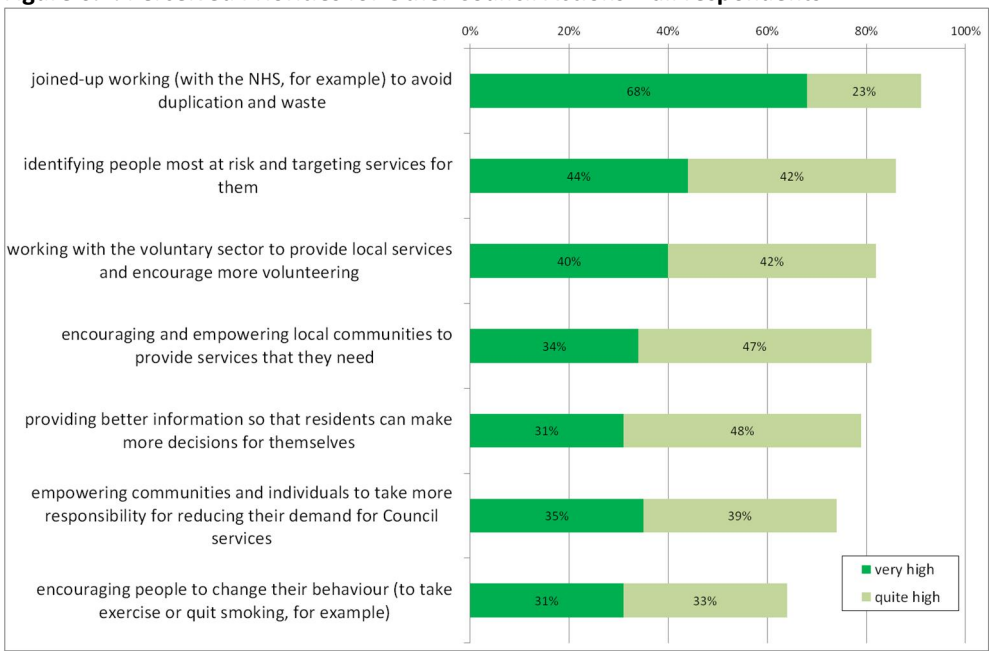
Figure 6.1: Understanding of the Phrase "Demand Management"

6.4 Priorities for Demand Management

Amongst the seven possible options presented to residents, there was one potential action area for demand management that had most support – 'joined-up working (with the NHS, for example) to avoid duplication and waste'. Ninety-one percent of survey respondents gave this a quite or very high priority rating.

The area with least support – and not surprisingly given the results in the previous chapter – was for encouraging people to change their behaviour (to take exercise or quit smoking, for example). Here, just 64% gave it a quite or very high priority rating, suggesting that there is higher support for people taking responsibility for managing their own demand but lower support for the council in trying to change behaviours.

Figure 6.2: Perceived Priorities for Other Council Actions – all respondents

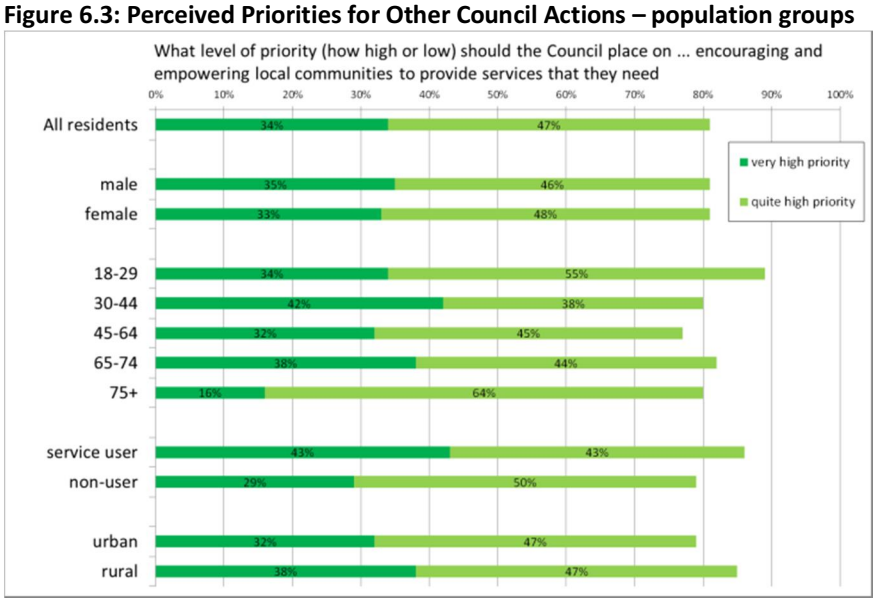


When the results to these questions are examined by the different population groups, there is a remarkable similarity in their views on most topics. The greatest differences were that:

- young people placed more emphasis on encouragement and empowerment – and also on the council providing better information
- the emphasis on joined-up working increases with age
- service users placed a slightly higher priority than non-users on encouragement and empowerment, on action to change behaviour, and on targeting at those most at risk
- rural dwellers put more emphasis than urban dwellers on encouraging and empowering communities to provide services.

The results are shown in the thumbnail charts that follow.

Figure 6.3: Perceived Priorities for Other Council Actions – population groups



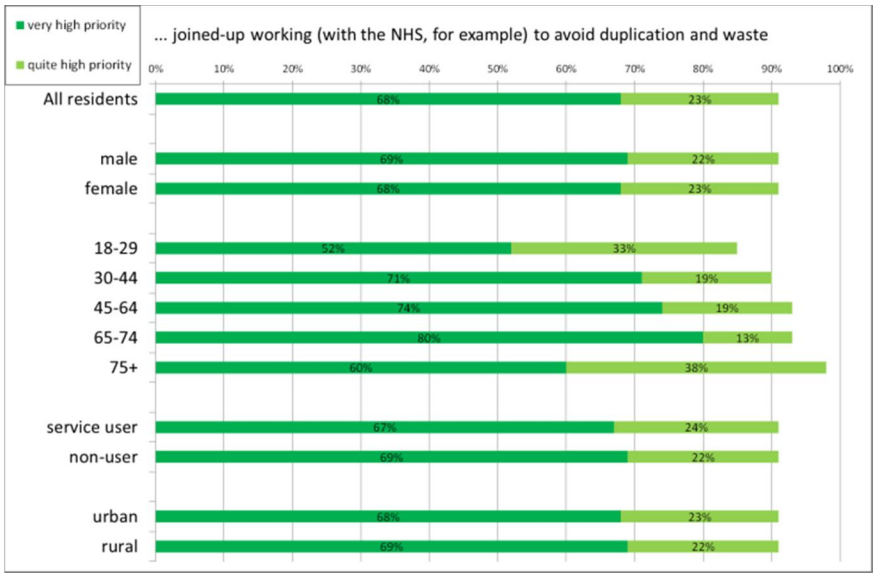
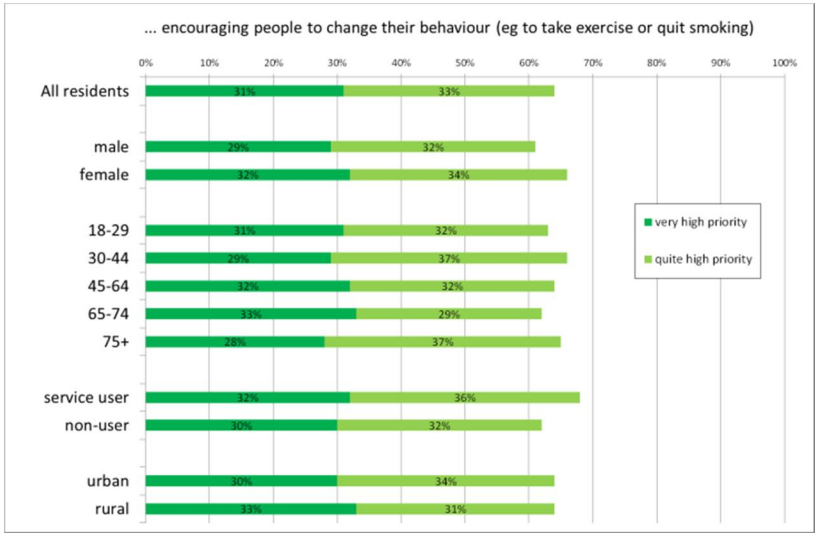
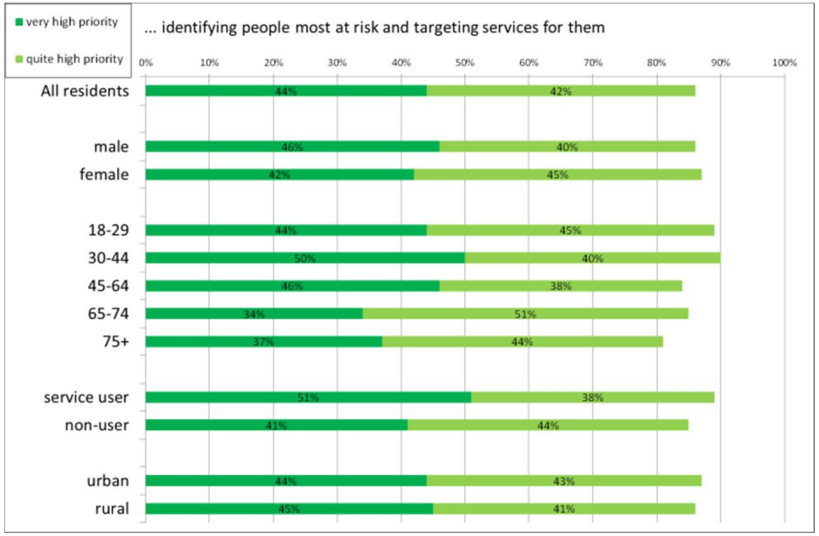


Figure 6.3: Perceived Priorities for Other Council Actions – population groups (cont'd)





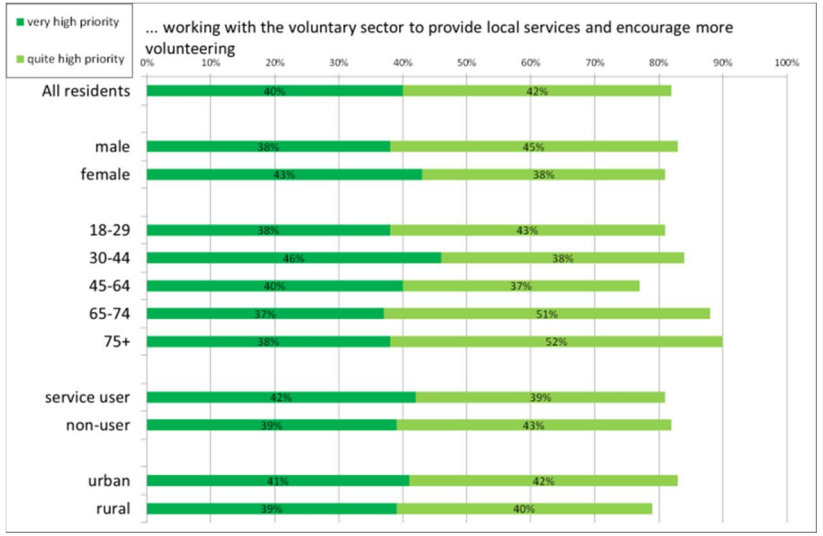
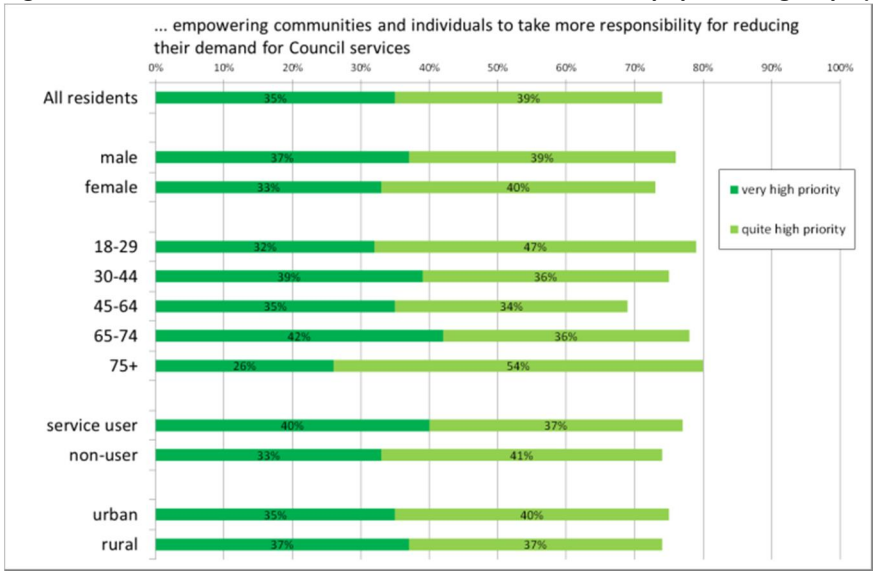


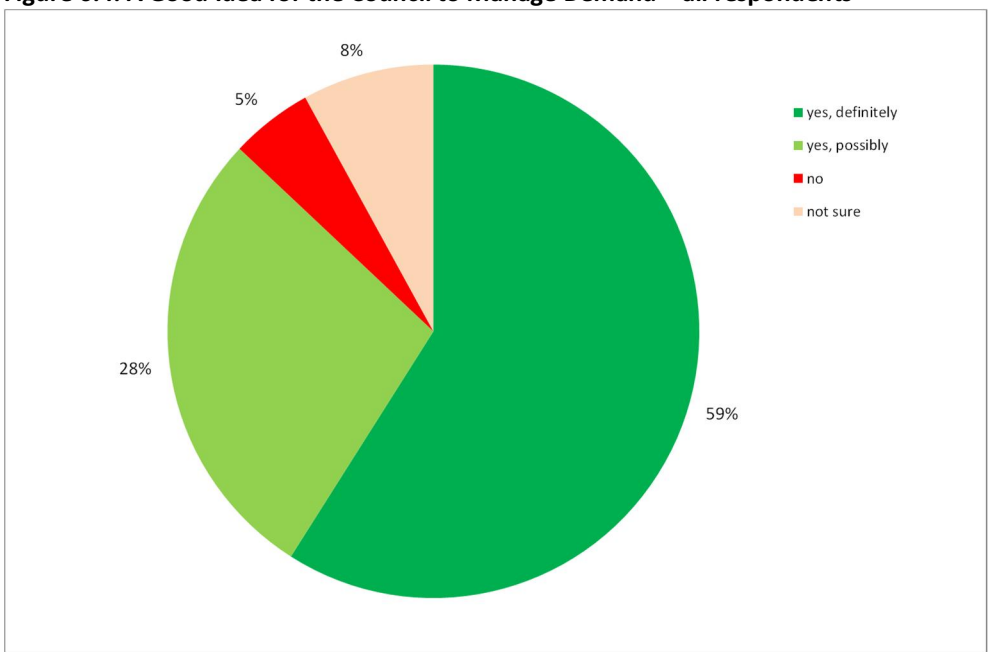
Figure 6.3: Perceived Priorities for Other Council Actions – population groups (cont'd)



6.5 Support for Demand Management

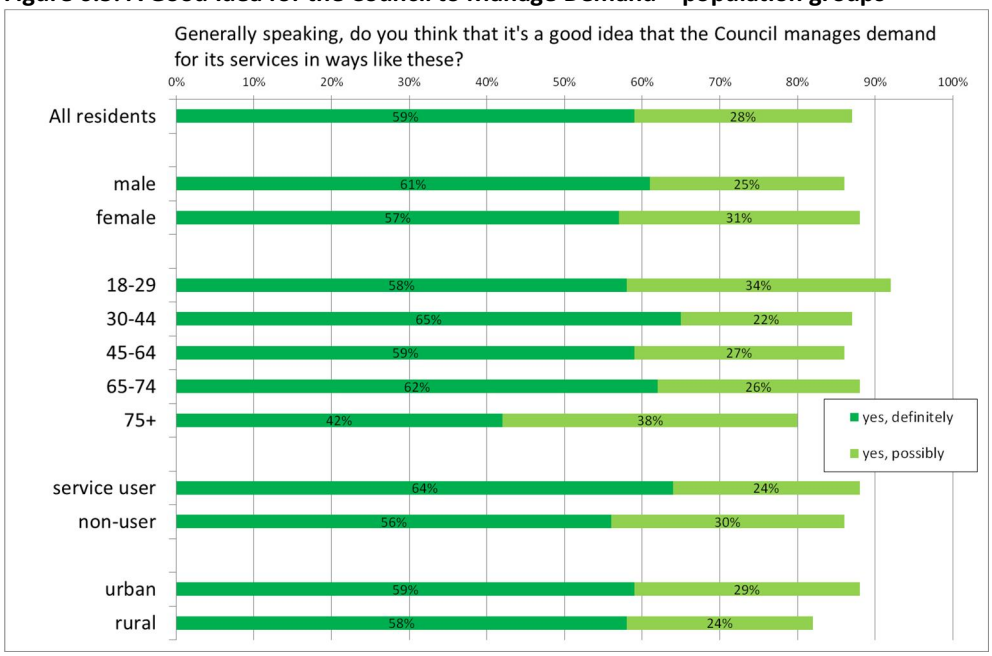
Generally speaking, a significant majority think that it's a good idea that the Council manages demand for its services in ways like these. Nearly six in ten people said 'yes, definitely' to this, with a further 28% agreeing, but less positively.

Figure 6.4: A Good Idea for the Council to Manage Demand – all respondents



Once again, the view amongst the different populations groups is fairly consistent on this question. There is a hint in the results that suggest that support declines with age but, otherwise, the differences are very small.

Figure 6.5: A Good Idea for the Council to Manage Demand – population groups



6.6 Empowering Communities and Individuals to take Responsibility

Finally, respondents were asked what they thought the role of the Council should be in terms of empowering communities and individuals to take more responsibility for reducing their demand for Council services. This open-ended question produced many varied answers, with the broad emphasis of opinion shown in the following word cloud.

As may be seen, there is a strong emphasis on 'information' and 'encouragement' and 'involvement'. On more detailed examination, there is quite a strong belief that people should be taking more responsibility for themselves, either as individuals or as part of community action. There was also a call for more volunteers or closer working with the voluntary sector. Quotes included such examples as:

Encouragement, publishing & educating people to make sure they know what to do & how to do it

Encourage the public to help to plan, they can do for selves

If people were encouraged to use prevention than cure would reduce the councils demand

Information is the key thing to everything

Give information and financial support to them

People should take responsibility for their own lives and not expect others to do things for them

I think there should be a big push for people to make their own decisions and to stop forcing the council to haemorrhage money on unnecessary things

I think they should give the public more opportunity to become involved in their decisions

However, it's also true that a small minority were against such ideas – strongly believing, for example, that the council is responsible for provision, not local residents. Examples here included:

Less volunteering, more workers

What do we pay council tax for if we're not supposed to demand services?

I don't think that is the council's role

I don't believe those that are untrained should run lives of other people. If you are not careful you can end up with volunteers whose views are not representative of rest of community

I think they should take responsibility for what needs doing and not try and shift the liability to someone else

Don't agree with this. Council should pay and do these services themselves not empowering communities

Figure 6.6: Perceived Role of the Council in Empowering Communities and Individuals

7. Conclusions and Recommendations

The research has provided clear and positive findings in most of the subject areas that were examined in the survey. They suggest that the council can begin to take action in the ways examined in the research with the knowledge that it will have broad support amongst the population of Worcestershire.

It is important to note that this degree of support is widespread amongst the different resident sub-groups that exist within the county. In many cases the opinions expressed by different groups were very similar and perhaps differed only in the degree of opinion, not in the broad direction.

There is a strong level of support for council spending on prevention and this level of support is such that residents, when asked, would themselves allocate the same proportion of the budget on preventative services as they would on existing social care. This might be impractical, but it does illustrate the extent of the support for preventative spending – and, from the comments that people make, the idea of spending now to save money later is a widely-held point of view.

Whilst people allocated, on average, across the spectrum of spending possibilities presented to them, there are just a few key priorities that they have for spending on prevention – and they concern perhaps some of the most vulnerable in the population:

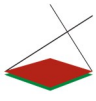
- support for older people
- support for carers
- help for those with mental health difficulties.

There is plenty of evidence to suggest that the phrase "demand management" should not be used in public discourse – it has too many negative and threatening connotations to local people. But there is strong support amongst Worcestershire residents for the idea of the council managing demand for its services in the ways that were described to them. Almost all of the seven potential areas examined in the survey were supported, with one area having support from almost the entire sample of residents – that of having joined-up working, for example with the NHS.

There are some initial indications from this research that suggest that residents would be open to ideas around community and personal empowerment, providing the circumstances were right. Such circumstances include adequate information, as well as encouragement.

So, overall, there is ample evidence from this survey of residents to suggest that the council will get widespread support when it comes to making policy on prevention, demand management and community responsibility. Support will not be total, as there are sections of the population that are against these ideas and, no doubt, some of this opposition will be heartfelt.

The degree of support may well be dependent upon the way in which the concepts are introduced to the population. The research very carefully introduced the concepts using simple and clear language, so a similar approach would seem to be a prerequisite. The report supports this suggestion by showing that the language and concepts used by residents themselves can



also be simple. There would seem to be some scope, therefore, for a carefully-designed communications campaign, to raise awareness and to explain the philosophy behind prevention to residents in the county. There would also appear to be scope for careful control of all council communication on the topics of prevention and demand management to ensure that the message is delivered consistently and in a readily-understandable manner.

The degree of support may also depend on the emphasis that the council places on which people in society will benefit most from preventative spending – vulnerable people are clearly very important, but this research suggests that people with habits such as smoking should not be the focus of spending and, as such, preventative spending on groups such as smokers (no matter how justified economically) would probably be resisted by Worcestershire residents.

There are two further issues to consider here:

i) it is important to note that some of the topics were explored only briefly in the interview – and this particularly applies to the issues around community empowerment. This is a complex topic and one that deserves dedicated qualitative social research to understand fully – the results from a single open-ended question at the end of a long interview can only give an indication of opinion on this matter

ii) the concepts concerning prevention and demand management were largely explored in positive terms, without explaining that there may be losers as well as winners. People allocated funds between services, but may not have fully realised that their smaller allocations might mean cuts in services. Their support might depend, therefore, on positive framing.

Appendix A : Study Method

Appendix A: Study Method

A.1 Overview

The survey was carried out by means of face-to-face interviews with residents of Worcestershire in six towns across the county, one town/city per Borough/District. The locations agreed with council officers were:

- Great Malvern
- Worcester
- Evesham
- Kidderminster
- Redditch; and
- Bromsgrove.

The aim was to achieve more than 500 interviews amongst people who were residents of the county of Worcestershire.

A.2 Choice of Approach

The research was required to address a series of topics that were both complex and potentially sensitive and, in view of this, it was decided that the subject matter was unsuitable for telephone, postal or online methods. An in-home face-to-face survey might have been ideal but, given the timescales available, it too was an impractical approach. It is for these reasons that the study team proposed carrying out the research by means of a series of hall tests – where local residents were recruited on street, with face-to-face interviewing taking place in a nearby venue. There were two hall tests in each District/Borough.

A.3 Sample

People were selected for interview according to a quota sample that was agreed with council officers. The quotas were set to match the known population characteristics of the County. The quotas were separate for each District/Borough and are shown overleaf. Quotas for age, gender and rurality were firm – clear targets that the interviewers should achieve. The other quotas were for guidance, to try and obtain as good a mix of people as possible.

Care was taken, particularly in towns near the county border (eg in Malvern), to ensure that only residents of Worcestershire were recruited for interview.

Table 1: Agreed Quotas

	n=	96	96	96	96	96	96
		Bromsgrove	**Evesham**	**Kidderminster**	**Malvern**	**Redditch**	**Worcester**
Age	18-29	14	14	14	14	19	24
	30-44	24	19	24	19	24	24
	45-64	34	34	34	34	34	29
	65-74	14	14	14	14	10	10
	75+	10	14	10	14	10	10
Gender	male	48	48	48	48	48	48
	female	48	48	48	48	48	48
Rurality	urban	77	38	77	48	96	96
	rural	19	58	19	48	0	0
Employment	full/part-time	62	62	62	62	62	62
	other	34	34	34	34	34	34
Ethnicity	white British	91	91	91	91	82	86
	other	5	5	5	5	14	10
Household							
Disability	yes	14	14	19	19	14	14
	no	82	82	77	77	82	82

A.4 Interviews Achieved

In total, 532 interviews were achieved and available for analysis.

Table 2: Quota Outcome	**576**		**532**	
Quota	**Target Interviews**	**%**	**Interviews Achieved**	**%**
18-29	**101**	**18%**	**106**	**20%**
30-44	**134**	**23%**	**105**	**20%**
45-64	**197**	**34%**	**193**	**36%**
65-74	**77**	**13%**	**84**	**16%**
75+	**67**	**12%**	**44**	**8%**
male	**288**	**50%**	**239**	**45%**
female	**288**	**50%**	**293**	**55%**
urban	**429**	**75%**	**387**	**73%**
rural	**147**	**26%**	**145**	**27%**
employed full/part-time	**374**	**65%**	**272**	**51%**
other	**202**	**35%**	**260**	**49%**
ethnicity: white British	**533**	**93%**	**494**	**93%**
other	**43**	**8%**	**38**	**7%**
household disability: yes	**96**	**17%**	**148**	**28%**
no	**480**	**83%**	**384**	**72%**

As can be seen, a very good spread was achieved across each quota category, with many quotas at or near target. There are also ample numbers within each cell of the quota matrix, implying robust weighting of the results (see section A.8 below).

A.5 Recruitment

Recruitment of respondents took place on street in the six town/city centres. A copy of the recruitment questionnaire is attached in Appendix C.

People who matched the quota and who were willing to be interviewed were invited into a nearby venue where the interview took place. The form of words used to invite people was: "*we are conducting a survey on behalf of Worcestershire County Council. Because the subject matter is confidential, we would like to invite you into a nearby hall to take part in the survey in privacy*".

The venues were as follows:

- Great Malvern, Lyttleton Well
- Worcester, St Andrew's Church Hall
- Evesham, Community Contact Centre
- Kidderminster, Town Hall Music Room
- Redditch, St Stephens Church and Emmanuel Centre.

The lack of a suitable venue in Bromsgrove meant that a creative solution had to be found – the market manager allowed us to interview under an awning in the High Street.

All fieldwork took place according to the principles of the MRS Code of Conduct.

A.6 Fieldwork

A total of 48 fieldworker shifts were carried out, with four fieldworkers interviewing on each day (two days fieldwork per location). Each shift was six hours in duration and took place between 10am and 4pm. The aim was for each interviewer to achieve 12 interviews per day (two per hour). The fieldwork dates were as follows:

- Malvern: Sat 21st and Thu 26th November
- Worcester: Mon 16th and Tue 17th November
- Evesham: Tue 1st and Fri 4th December
- Kidderminster: Wed 25th November and Thu 3rd December
- Redditch: Thu 19th November and Wed 2nd December
- Bromsgrove: Tue 24th and Sat 28th November.

As can be seen, there were eight shifts carried out on Saturdays.

A.7 Questionnaire

The interview took about 15-20 minutes to administer and covered the following topic areas:

- personal involvement (eg as a user) of services
- awareness of the Council's role in preventative activities
  - unprompted and prompted, generally
  - for each spending area in turn, prompted
- introduction to the 'benefits' from prevention
  - eg information about how spending can save expenditure in the long run
  - whether the Council should spend money on preventative activities, in general
- priorities for spending within a list of preventative measures
- the balance between spending on specialist/social care services and prevention
  - a money- allocation exercise
- priorities for spending within a list of preventative measures
  - another money-allocation exercise
- introduction to the idea of 'other actions'
  - eg information about citizen-led services
- the Council's role in managing demand for services, including the idea of local empowerment
- respondent and household demographics
  - age, gender, employment status, SEG, ethnicity
  - household size and composition

A copy of the agreed final questionnaire is attached as Appendix D. The show material that was used to help people respond to the survey is shown in Appendix E.

A.8 Data Processing

Following completion of each day's fieldwork, the questionnaires were checked and coded, before entering onto a database ready for checking, weighting and analysis.

The analysis contained in this draft final report is based on weighted data. Rim weighting was used (see below) to ensure that the sample fully matched the profile of the population of Worcestershire, in terms of age, gender, District/Borough and rurality.

RIM Weighting

Rim weighting is one of several weighting methods for adjusting the final sample of a survey so that it matches the characteristics of the target population – in this case, the general population of Worcestershire.

This need arises frequently in market research where the response to a survey among certain segments of the population is not 'correct' and so leads to a dataset that is not representative of known population characteristics. For example, if we know that the target population is split evenly among gender lines, yet we find that 65% of the survey responses are from women, we may need to use weighting during the analysis to allow for the skewed response pattern.

Rim weighting is an especially valuable addition to the researcher's toolbox. The "rim" in rim weighting comes from the acronym for **R**andom **I**terative **M**ethod. This may sound complex, but it's a good way of ensuring that the data matches the population in a variety of ways – not just gender, but also any number of other traits. The technique allows the analyst to adjust multiple characteristics in a dataset all at the same time in a way that ultimately keeps the different characteristics proportionate as a whole. Rim weighting allows the researcher to weight many characteristics at the same time, by using an algorithm that adjusts each variable as little as possible. The ultimate result is a weighted data that closely matches the target population across all the pre-defined dimensions.

In the case of this study, the raw survey data has been weighted to ensure that it matches the population characteristics of Worcestershire in terms of gender, age, location (District) and rurality.

On the question of rurality, the questionnaire gathered two pieces of information that could be used to define whether the respondent lived in a rural or urban area: a) their own assessment of whether their home was located in a rural area or in a town/city (Q3 of the recruitment questionnaire), and b) their detailed postcode, also gathered during the recruitment interview. The latter can be used to define rurality through use of the ONS Postcode Directory to identify if a postcode is urban or rural.

In actual fact the use of the respondent's postcode proved to be a difficult route. This was because a number of people refused to provide their postcode, gave only the first few characters of their postcode, or gave a postcode that was plausible but actually wrong (ie one that doesn't exist). In these cases it was obviously impossible to match postcode data with the ONS postcode directory. The loss of information was sufficient (32 cases in total) that the alternative approach – that of using the respondent's own definition of whether they lived in a rural or urban area – was used instead. However, this self-definition data has been weighted to the known urban/rural population numbers in the county, according to the ONS definitions of urban and rural.

The weights applied to each case in the datafile are unique, being a combination (iteration) of the adjustments to four separate variables: age, gender, District and rurality. The following table gives an indication of the scale of the weights applied by showing the adjustments for each of the four variables concerned.

Variable	Value	Weight
Gender	Male Female	1.11 0.91
Age	18-29 30-44 45-64 65-74 75+	0.91 1.16 0.94 0.82 1.45
District	Bromsgrove Wychavon Wyre Forest Malvern Hills Redditch Worcester	1.05 1.23 0.92 0.81 0.91 1.07
Rurality	Rural Urban	0.92 1.03

A.9 Confidence Limits

Judging whether the different results contained in this report are statistically different (and not just a function of chance) is not straightforward, but some guidance can be given to help with the task. Placing limits of confidence around an answer depends on three critical pieces of information:

i) the number of interviews that fall within any sample or subsample of the survey
ii) the result itself – how high or low in percentage terms
iii) whether the analysis in question examines different answers from the same sample or whether two different samples are being examined and compared.

Same Sample

The overall sample size achieved in the survey was 532 interviews. With this level of response, we can be 95% confident that, when examining the answers given by the whole sample to different questions, the results are accurate to within the following limits:

observed result	accuracy
10%	+/- 3.6%
20%	+/- 4.8%
30%	+/- 5.5%
40%	+/- 5.9%
50%	+/- 6.0%
60%	+/- 5.9%
70%	+/- 5.5%
80%	+/- 4.8%
90%	+/- 3.6%

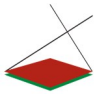
In other words, if the answer to one question is 80% and to another 90%, then we can be confident that the 10 percentage point difference is a significant one (because 10% is greater than 4.8% or 3.6%). But if the answer to the second question was 83%, a difference of 3 percentage points, then the difference would not be statistically significant.

Different Samples

The issues when comparing the results to any question from one part of the sample (eg males) with another (eg females) is slightly more complex. In these cases, the number of responses to the question is critical, as is the level of the observed result. The following tables provide some broad guidance, but the differences should really be examined through a significance-testing model.

Segment	Males … 95% confidence limits	Females … 95% confidence limits
Males (n=239)	10% or 90% … +/-5.4% 20% or 80% … +/-7.1% 30% or 70% … +/- 8.2% 40% or 60% … +/- 8.7% 50% … +/-8.9%	10% or 90% … +/-5.1% 20% or 80% … +/-6.8% 30% or 70% … +/- 7.8% 40% or 60% … +/- 8.4% 50% … +/-8.5%
Females (n=293)	10% or 90% … +/-5.1% 20% or 80% … +/-6.8% 30% or 70% … +/- 7.8% 40% or 60% … +/- 8.4% 50% … +/-8.5%	10% or 90% … +/-4.9% 20% or 80% … +/-6.5% 30% or 70% … +/- 7.4% 40% or 60% … +/- 7.9% 50% … +/-8.1%

Segment	Urban … 95% confidence limits	Rural … 95% confidence limits
Urban (n=387)	10% or 90% … +/-4.2% 20% or 80% … +/-5.7% 30% or 70% … +/- 6.5% 40% or 60% … +/- 6.9% 50% … +/-7.1%	10% or 90% … +/-5.7% 20% or 80% … +/-7.5% 30% or 70% … +/- 8.6% 40% or 60% … +/- 9.2% 50% … +/-9.4%
Rural (n=145)	10% or 90% … +/-5.7% 20% or 80% … +/-7.5% 30% or 70% … +/- 8.6% 40% or 60% … +/- 9.2% 50% … +/-9.4%	10% or 90% … +/-6.8% 20% or 80% … +/-9.1% 30% or 70% … +/- 10.4% 40% or 60% … +/- 11.1% 50% … +/-11.3%



Appendix B : Resident Profile Details

Appendix B: Respondent Profile

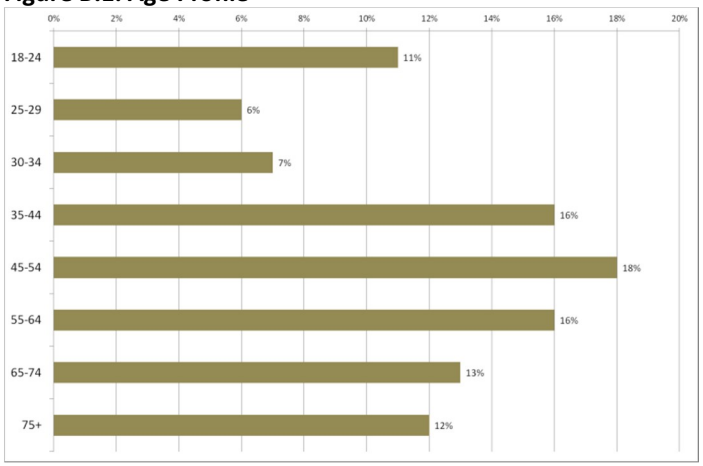
B.1 Introduction

The profile of respondents who took part in the survey is shown in this appendix. The percentages in each of the figures relate to the weighted sample (see the previous appendix for details).

B.2 Gender and Age

One half of the weighted sample was male, one half female. The full age distribution is as shown below.

Figure B.1: Age Profile



B.3 Household Composition

One in five respondents (21%) had dependent children living with them at home.

Amongst those with children living at home, the 6-10-year-old age group was most evident. Over a half (52%) had children of this age (see overleaf).

Just over one in ten respondents (11%) was a carer for someone living with them – ie they gave special help to an adult who is sick, has a disability or is an older person. A further 14% gave care for a person in another household (these figures exclude professional carers).

One in three respondents (34%) could be considered as being a 'service user' – in that they, or a person in their immediate household, used or benefited from the council's services (11 services were used to define this). The most frequently-mentioned service was "help with mental health difficulties" which accounted for 10% of the sample of residents.

A quarter of residents (24%) said they had a disability.

Figure B.2: Age of Children

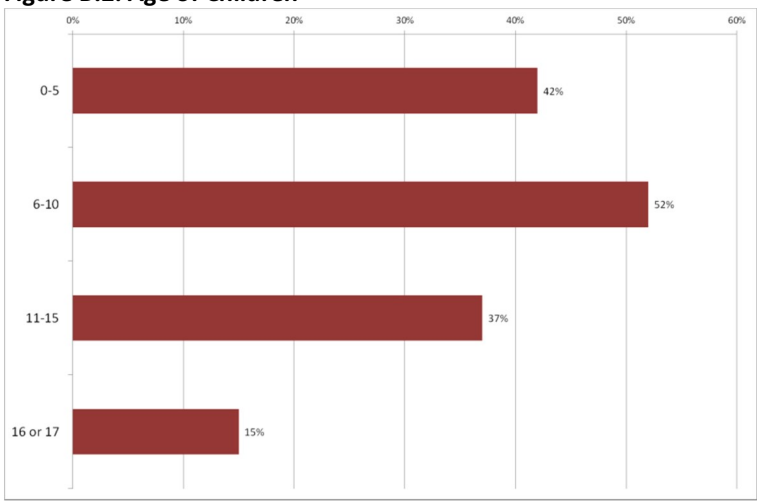


Figure B.3: Carers

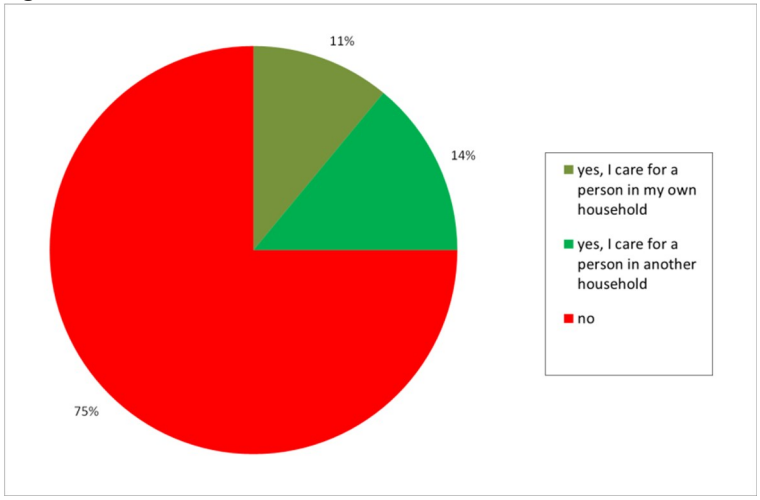


Figure B.4: Use of Council Services

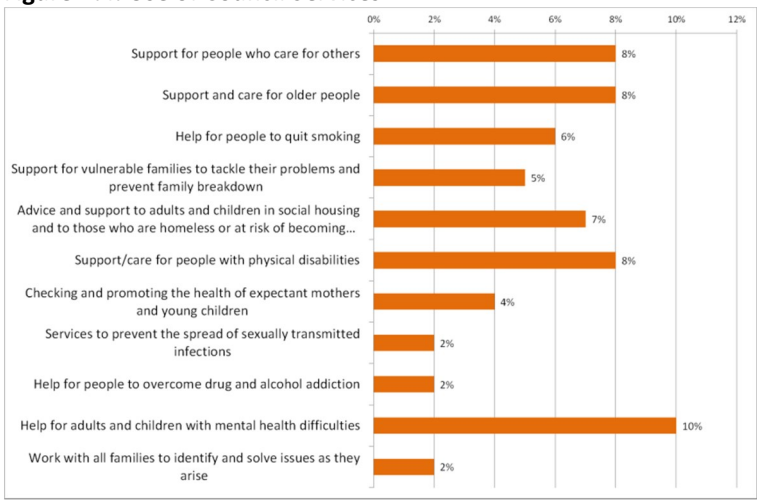
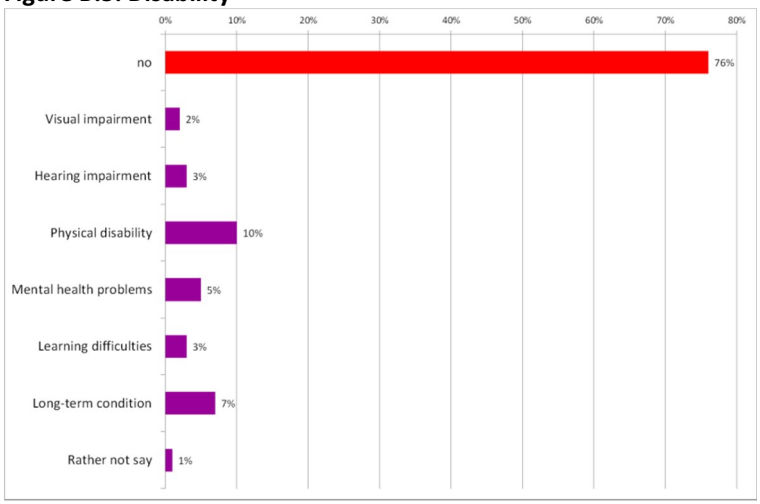


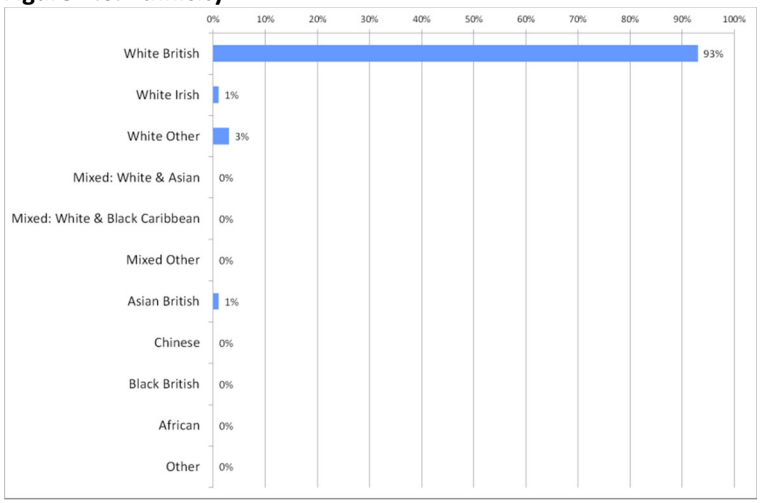
Figure B.5: Disability



B.4 Ethnicity and Working Status

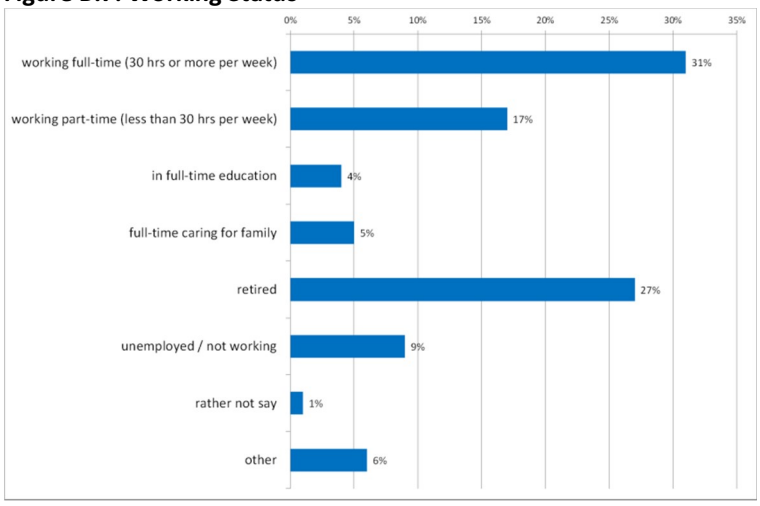
Thirteen in every fourteen residents (93%) said that their ethnicity was "white British". The few other ethnicities are shown in the following chart. Those shown as 0% actually reflect at least someone with that ethnicity, but the numbers are too small to be calculated as a percentage.

Figure B.6: Ethnicity

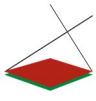


Nearly a half of the sample were in work, with the majority of these being in full-time employment. Retired residents comprised just over a quarter of the sample.

Figure B.7: Working Status



Appendix C : Recruitment Questionnaire



Worcestershire County Council Survey

theresearchbox

Good morning/afternoon. My name is ..... and I am carrying out a survey on behalf of Worcestershire County Council about the council's services in the county. Would you mind answering some questions? The interview will take about 10-15 minutes. All the answers that you give will be strictly confidential. Thank you.

Q1. First, I would like to ask a few questions to check that we have the right mix of people.

Do you live in the county of Worcestershire?

yes	☐ 1	**CONTINUE**
no	☐ 2	**CLOSE**

Q2. What is your home postcode? (eg GL51 9AG)

☐☐☐☐☐☐☐☐

Q3. Is your home in a rural area (including villages), or is it in a town/city?

rural area/village	☐ 1	**CHECK QUOTA**
town/city	☐ 2	**CHECK QUOTA**

Q8. **RECORD** Gender

male	☐ 1	**CHECK QUOTA**
female	☐ 2	**CHECK QUOTA**

Q4. How old are you?

18-29	☐ 1	**CHECK QUOTA**
30-44	☐ 2	**CHECK QUOTA**
45-64	☐ 3	**CHECK QUOTA**
65-74	☐ 4	**CHECK QUOTA**
75+	☐ 5	**CHECK QUOTA**

Q5. What is your working status?

working full or part time	☐ 1	**CHECK QUOTA GUIDANCE**
other	☐ 2	**CHECK QUOTA GUIDANCE**

Q6. What is your ethnic origin?

White British	☐ 1	**CHECK QUOTA GUIDANCE**
other	☐ 2	**CHECK QUOTA GUIDANCE**

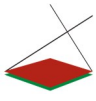
Q7. Do you, or any member of your family that you live with, have a disability?

yes	☐ 1	**CHECK QUOTA GUIDANCE**
no	☐ 2	**CHECK QUOTA GUIDANCE**

CHECK QUOTAS. ASK RESPONDENT TO ACCOMPANY YOU TO THE HALL FOR FULL INTERVIEW.

ATTACH THIS RECRUITMENT QUESTIONNAIRE TO THE FULL SURVEY.

Appendix D : Survey Questionnaire



Worcestershire Prevention Survey

theresearchbox

Thank you for agreeing to take part in this survey, which is being carried out on behalf of Worcestershire County Council. Can I just stress that all the answers that you give will be kept strictly confidential.

Q1. First, can I ask which of these services that the County Council provides you (or members of your immediate household) have personally used or benefitted from in the last 12 months?
SHOWCARD A

- Support for people who care for others..... ☐ 01
- Primary school education..... ☐ 02
- Support and care for older people ..... ☐ 03
- Libraries ..... ☐ 04
- Help for people to quit smoking..... ☐ 05
- Country parks..... ☐ 06
- Support for vulnerable families to tackle their problems and prevent family breakdown..... ☐ 07
- Childrens arts and music ..... ☐ 08
- Advice and support to adults and children in social housing and to those who are homeless or at risk of becoming homeless ☐ 09
- Support/care for people with physical disabilities..... ☐ 10
- Transport from home to school or college ☐ 11
- Checking and promoting the health of expectant mothers and young children..... ☐ 12
- Registrar & coroner services..... ☐ 13
- Services to prevent the spread of sexually transmitted infections..... ☐ 14
- Household recycling sites ..... ☐ 15
- Help for people to overcome drug and alcohol addiction..... ☐ 16
- Consumer protection and trading standards ..... ☐ 17
- Help for adults and children with mental health difficulties..... ☐ 18
- Museums..... ☐ 19
- Work with all families to identify and solve issues as they arise ..... ☐ 20

Q2. What, if anything, do you understand by the expression "**Demand Management**"?

Prevention

Q3. Now, can I ask if you understand what is meant by these phrases? **READ OUT**

	yes, definitely	yes, possibly	no	don't know
a stitch in time saves nine.....	☐ 1	☐ 2	☐ 3	☐ 4
prevention is better than cure.....	☐ 1	☐ 2	☐ 3	☐ 4

Q4 The phrase "prevention is better than cure" means that it is better to stop something bad from happening now than it is to deal with the problem after it has happened.

Can you give me an example of how you might spend money on **preventing** something from happening, rather than curing a problem after it has happened?

Q5. Are you aware that the Council spends money on prevention - with the aim of reducing expenditure later by avoiding problems from happening?

yes, definitely ☐ 1
yes, possibly ☐ 2
no ☐ 3
not sure ☐ 4

Q6 Can you give me any examples of how the Council might spend its money on **preventing** things from happening, rather than curing problems after they have happened?

Q7. Preventative services help people maintain their independence and can prevent or delay the need for more intensive services in the future. They also help people get the most out of life.

Which of these areas do you think the Council spends money on **prevention**? **SHOWCARD B**

	yes, definitely	yes, possibly	no	don't know
support for people who care for others	☐ 1	☐ 2	☐ 3	☐ 4
support for older people when they become unwell, to avoid them going into hospital or to get them home more quickly	☐ 1	☐ 2	☐ 3	☐ 4
helping people to quit smoking	☐ 1	☐ 2	☐ 3	☐ 4
supporting vulnerable families to tackle their problems and prevent family breakdown	☐ 1	☐ 2	☐ 3	☐ 4
providing advice and support to adults and children in social housing and to those who are homeless or at risk of becoming homeless	☐ 1	☐ 2	☐ 3	☐ 4
working with all families to identify and solve issues as they arise	☐ 1	☐ 2	☐ 3	☐ 4
checking and promoting the health of expectant mothers and young children	☐ 1	☐ 2	☐ 3	☐ 4
preventing the spread of sexually transmitted infections	☐ 1	☐ 2	☐ 3	☐ 4
helping people overcome drug and alcohol addiction	☐ 1	☐ 2	☐ 3	☐ 4
helping adults and children with mental health difficulties	☐ 1	☐ 2	☐ 3	☐ 4

Q8. Do you think that it's a good idea that the Council spends money on prevention - with the aim of reducing expenditure later by avoiding problems from happening?

yes, definitely ☐ 1
yes, possibly ☐ 2
no ☐ 3
not sure ☐ 4

Q9 Why do you say that?

Q10. What level of priority (how high or low) should the Council place on **prevention** in these service areas? **SHOWCARD B**

	very high	quite high	neither	quite low	very low
	1	2	3	4	5
support for people who care for others	☐	☐	☐	☐	☐
support for older people when they become unwell, to avoid them going into hospital or to get them home more quickly.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
helping people to quit smoking....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
supporting vulnerable families to tackle their problems and prevent family breakdown	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
providing advice and support to adults and children in social housing and to those who are homeless or at risk of becoming homeless.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
working with all families to identify and solve issues as they arise	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
checking and promoting the health of expectant mothers and young children.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
preventing the spread of sexually transmitted infections	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
helping people overcome drug and alcohol addiction	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
helping adults and children with mental health difficulties.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Q11. Are there any other areas that you think should be a high priority for the Council in terms of **prevention**?

For every £100 that Worcestershire County Council spends, it can be spent on either i) existing social care and specialist services or ii) on <u>prevention.</u> Where do you think that this money should be spent? Please allocate the £100 against these two service areas. You don't have to allocate the full £100 if you don't want to. SHOWCARD C

Q12. Spending on existing social care and other specialist services

Spending on prevention

For every £100 that Worcestershire County Council spends wholly on Prevention, where do you think that this money should be spent?

SHOWCARD D. Please allocate the £100 against this list of services. You don't have to allocate the full £100 if you don't want to.

Q13.	Support for people who care for others	
	Support for older people when they become unwell, to avoid them going into hospital or to get them home more quickly	
	Helping people to quit smoking	
	Supporting vulnerable families to tackle their problems and prevent family breakdown	
	Providing advice and support to adults and children in social housing and to those who are homeless or at risk of becoming homeless	
	Working with all families to identify and solve issues as they arise	
	Checking and promoting the health of expectant mothers and young children	
	Preventing the spread of sexually transmitted infections	
	Helping people overcome drug and alcohol addiction	
	Helping adults and children with mental health difficulties	

CHECK THAT THE TOTAL DOES NOT EXCEED £100.

Other Actions

Demand for some council services, such as Social Care, is rising. Communities are changing and growing, so this demand is going to keep rising in the future. There are also pressures from changes to the law. At the same time, funding for the council is reducing; so the council is required to do more for local residents, but with less money.

One of the ways the Council could reduce demand is by focusing on prevention, which we have been discussing. As well as providing services that prevent demand, the council could be taking other actions to reduce demand or manage it differently.

Q14. What level of priority (how high or low) should the Council place on the following actions to help manage demand for its services? **SHOWCARD E.**

	very high	quite high	neither	quite low	very low
	1	2	3	4	5
encouraging and empowering local communities to provide services that they need...	☐	☐	☐	☐	☐
joined-up working (with the NHS, for example) to avoid duplication and waste	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
encouraging people to change their behaviour (to take exercise or quit smoking, for example)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
providing better information so that residents can make more decisions for themselves	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
identifying people most at risk and targeting services for them	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
working with the voluntary sector to provide local services and encourage more volunteering	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
empowering communities and individuals to take more responsibility for reducing their demand for Council services	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Q15. Generally speaking, do you think that it's a good idea that the Council manages demand for its services in ways like these?

yes, definitely ☐ 1 — no ☐ 3

yes, possibly ☐ 2 — not sure ☐ 4

Q16. What do you think the role of the Council should be in terms of empowering communities and individuals to take more responsibility for reducing their demand for Council services?

Profile Questions

Q17. Finally, can I ask some more detailed questions about yourself? First, how old are you?

18-24 ☐ 1 — 55-64 ☐ 6

25-29 ☐ 2 — 65-74 ☐ 7

30-34 ☐ 3 — 75+ ☐ 8

35-44 ☐ 4 — refused ☐ 9

45-54 ☐ 5

Q18. Do you have dependent children living with you at home?

yes ☐ 1 — rather not say ☐ 3

no ☐ 2

Q19. **IF YES:** In which age groups are your children? **CODE ALL THAT APPLY**

0-5 ☐ 1 — 11-15 ☐ 3

6-10 ☐ 2 — 16 or 17 ☐ 4

Q20. Do you look after, or give special help to an adult who is sick, has a disability, or is an older person other than in a professional capacity? **IF YES, PROBE WHERE**

- yes, I care for a person in my own household ☐ 1
- yes, I care for a person in another household ☐ 2
- no ☐ 3
- rather not say ☐ 4

Q21. Are you .... **READ OUT. CODE <u>PRINCIPAL</u> ACTIVITY ONLY**

- working full-time (30 hrs or more per week) ☐ 1
- working part-time (less than 30 hrs per week) ☐ 2
- in full-time education ☐ 3
- full-time caring for family ☐ 4
- retired ☐ 5
- unemployed / not working ☐ 6
- rather not say ☐ 7
- other ☐ 8

what other?

Q22. Do you consider yourself to have a disability? **PROBE AND CODE ALL THAT APPLY**

- no ☐ 1
- Visual impairment ☐ 2
- Hearing impairment ☐ 3
- Physical disability ☐ 4
- Mental health problems ☐ 5
- Learning difficulties ☐ 6
- Long-term condition ☐ 7
- Rather not say ☐ 8

Q23. To which of the following ethnic groups do you consider you belong? **SHOWCARD F**

- White British ☐ 01
- White Irish ☐ 02
- White Other ☐ 03
- Indian ☐ 04
- Pakistani ☐ 05
- Asian Other ☐ 06
- Mixed: White & Asian ☐ 07
- Mixed: White & Black African ☐ 08
- Mixed: White & Black Caribbean ☐ 09
- Mixed Other ☐ 10
- Asian British ☐ 11
- Bangladeshi ☐ 12
- Chinese ☐ 13
- Black British ☐ 14
- African ☐ 15
- Caribbean ☐ 16
- Rather not say ☐ 17
- Other ☐ 18

Q24. Request respondent telephone number (for back-checking)

THANK RESPONDENT AND CLOSE. ATTACH THE RECRUITMENT QUESTIONNAIRE.
THEN RECORD THE FOLLOWING DETAILS:

Q25. Location

- Bromsgrove ☐ 1
- Evesham ☐ 2
- Kidderminster ☐ 3
- Malvern ☐ 4
- Redditch ☐ 5
- Worcester ☐ 6

Q26. Date of Interview (eg 01-11-15)

Q27. Time of Interview (24 hour clock)

Q28. Duration of Interview (minutes)

Q29. Name of interviewer

Q30. I confirm that I have carried out this interview in accordance with the MRS Code of Conduct ...
SIGN:

Appendix E : Interview Show Material

SHOWCARD A

1. Support for people who care for others
2. Primary school education
3. Support and care for older people
4. Libraries
5. Help for people to quit smoking
6. Country parks
7. Support for vulnerable families to tackle their problems and prevent family breakdown
8. Children's arts and music
9. Advice and support to adults and children in social housing and to those who are homeless or at risk of becoming homeless
10. Support/care for people with physical disabilities
11. Transport from home to school or college
12. Checking and promoting the health of expectant mothers and young children
13. Registrar & coroner services
14. Services to prevent the spread of sexually transmitted infections
15. Household recycling sites
16. Help for people to overcome drug and alcohol addiction
17. Consumer protection and trading standards
18. Help for adults and children with mental health difficulties
19. Museums
20. Work with all families to identify and solve issues as they arise

SHOWCARD B

- Support for people who care for others
- Support for older people when they become unwell, to avoid them going into hospital or to get them home more quickly
- Helping people to quit smoking
- Supporting vulnerable families to tackle their problems and prevent family breakdown
- Providing advice and support to adults and children in social housing and to those who are homeless or at risk of becoming homeless
- Working with all families to identify and solve issues as they arise
- Checking and promoting the health of expectant mothers and young children
- Preventing the spread of sexually transmitted infections
- Preventing the spread of sexually transmitted infections
- Helping adults and children with mental health difficulties

SHOWCARD C

1. Spending on existing social care and other specialist services

2. Spending on prevention

SHOWCARD D

1. Support for people who care for others
2. Support for older people when they become unwell, to avoid them going into hospital or to get them home more quickly
3. Helping people to quit smoking
4. Supporting vulnerable families to tackle their problems and prevent family breakdown
5. Providing advice and support to adults and children in social housing and to those who are homeless or at risk of becoming homeless
6. Working with all families to identify and solve issues as they arise
7. Checking and promoting the health of expectant mothers and young children
8. Preventing the spread of sexually transmitted infections
9. Preventing the spread of sexually transmitted infections
10. Helping adults and children with mental health difficulties

SHOWCARD E

- encouraging and empowering local communities to provide services that they need
- joined-up working (with the NHS, for example) to avoid duplication and waste
- encouraging people to change their behaviour (to take exercise or quit smoking, for example)
- providing better information so that residents can make more decisions for themselves
- identifying people most at risk and targeting services for them
- working with the voluntary sector to provide local services and encourage more volunteering
- empowering communities and individuals to take more responsibility for reducing their demand for Council services

SHOWCARD F

1. White British
2. White Irish
3. White Other
4. Indian
5. Pakistani
6. Asian Other
7. Mixed: White & Asian
8. Mixed: White & Black African
9. Mixed: White & Black Caribbean
10. Mixed Other
11. Asian British
12. Bangladeshi
13. Chinese
14. Black British
15. African
16. Caribbean