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Description automatically generated**Active Together Conference: Networking Sessions**

**ETHNICALLY DIVERSE COMMUNITIES**

* Removing umbrella terms
* Be open
* Language – pc prevents us getting things done
* Not making stereotypes or assumptions
* Understanding community needs
* Having representatives of communities in leadership roles
* Role model
* Incorporating religious holidays in activities
* Celebrating what we do well
* Hearing enough voices – leading to decisions
* Community at the heart of decision making
* Give the community a voice
* Tools to create real change eg. data, petitions as well as personal story
* Stop having meetings about it, more action
* Language and timing
* Visibility and recognition
* Educating generation
* Helping the family accept
* Understanding – making acronyms clear to participants – reducing assumptions around knowledge and others. Not placing all individuals from the same community in the same bracket.
* Access to information – extending our reach. Utilising word of mouth within communities. Going into the community.
* Open up conversations within communities to address barriers (particularly when trying to land a specific programme).
* Utilising ‘trusted voice’, build champions in communities, reflection and representation
* Being braver to ask questions and utilise community leaders and creating a more respectful environment. ‘Confident’ is a better word than braver. People who want to up their understanding by asking questions should be empowered to, and not feel shamed or like they will ‘get it wrong’. No bad intent.
* Engaging with trusted community leaders – implement into strategic planning
* Language ‘sport’ – ‘activity’, barriers like dress code
* However, should more emphasis be placed on sports organisations to reduce this stigma. How achievable does ‘sport’ feel for some EDC’s.
* PA by stealth – active living
* Knowledge of what counts.
* Making assumptions is too easy – listen more and learn and understand. How can we help people?
* Social elements to the sessions
* Physical activity and sport organisations going to EDC communities
* Doing something different in your policy – strategic risk
* Take the risk scaling up engagement
* Do a few things well first – do not try and do everything
* Everyone is good at what they do – give the resources to the people who know the community
* We are investing in the shiny stuff – voluntary sectors?
* Structural forms – that are not working (data) – EDC communities want to be out in the community doing what they know
* Paying the EDC communities, this voluntary job may be their primary income – confidence and skills
* Do organisations understand the community?
* Maintaining the relationship
* Partnership utilising (inviting EDC communities to organisations and the opposite way)
* Transport barriers
* Sharing resources
* ‘Getting to know my community’ regularly. Sessions with EDC communities engaging with organisations.
* Age group barriers – so many different organisations and services for different groups – age/gender
* Time of sessions – belonging/respect – attention to detail
* Opening up access/role models. So many different aspects, not to be looked at as a whole different aspect.
* Connectivity and collaboration/common ground
* Asking what we can be doing better? Learning from the community groups, getting it back to active teams (changing the format)
* LOPC – heads being all white males from all other outdoor centres (are aware of this and recognised). No role model from ED background. Find it hard to engage to apply for apprenticeship with the community.
* Language barriers
* EDC community education and encouraging others in their community. Started to work with groups such as LCFC. Encourage voluntary work.
* Some factors for organisations are out of their control. Opportunities are created y EDC communities but how can this re-occur
* Trusted voices – but what is next?
* Facilities ie. women’s only swim sessions – developing inactive structures
* Are planers considering adjustments required?
* Responsibility on partners and participants to open challenging conversations around how best to engage.
* Breaking down barriers with a trusted source – social activity before physical activity
* Frontline staff like receptionists have a really crucial role to create that inclusive environment and provide support – customer service
* Up accessibility ie. alternative languages
* Awareness of digital exclusion and other means of communication
* Wrap around care in one place
* Where is activity already happening in places or need ie. food banks and go in from there

**LOW SOCIO ECONOMIC GROUPS**

* Stigmas associated with low socio economic groups
* Networking with low socio economic group areas eg. food banks
* Having ‘motivating’ people within groups to encourage others
* Communities need to trust what we want to achieve educating people on various types of physical activity not just sport
* Tailoring costs to the people you work with
* Listen to what people from these groups want
* Need to understand their needs and not make assumption’s
* Lack of funding
* Struggling to afford equipment/uniform
* Accessibility and transport (keep it localised)
* Building social bonds
* Giving follow up advice
* Sessions need to be sustainable – how are we maintaining this?
* Educating people about the benefits of being active and there doesn’t need to be a cost
* School ‘leavers’ (16-19\_ not engaged
* Access to low cost activities – ideally free. ‘Informal’ groups not ‘sport’ specific
* The right offer – free at point of access and future pathways
* Other priorities/social influences/environments – sport/physical activity is low down!
* Stigma! It’s for the ‘poor kids’
* Discourages ‘social mobility’!
* Improve access to wellbeing – role of old youth service
* Work better with local trusted organisations who understand the needs of communities better
* Focus on vulnerabilities
* Patronising ‘messaging’/confusing or over complicated messaging eg. CMO guidelines
* Understand ‘barriers’ better – might not be perceived as ‘barriers’ to groups/individuals – whose barriers
* Relatable ‘role models’/LTOs to work with groups
* Negative opinions towards organisations – councils!
* Take your lanyards off! Be a person” Not a representative of your organisation!
* Have we got the capacity, resources, skills to do this?! Prioritise the needs of Prioritise the needs of Your neighbourhoods.
* Focus on prevention! Even pre-conception
* Don’t like the language: gets in the way, creates assumptions, hiding word poverty
* Physical activity wont get on the agenda
* Celebrate and work out why people are / could be linking with us
* Systems and services expect you to pay
* Realism of situation – different values, bespoke approach
* Free session but what about travel too?
* Is physical activity a choice? Poorer you are, the less choice you have
* Phone is a priority
* Choice is a privilege
* Underserved is better than hard to reach
* Activity down the priority list
* Community cafes and food banks – once engaged then how long to then approach to undertake physical activity

**LONG TERM HEALTH CONDITIONS**

* How do we prioritise and can we prioritise?
* Life changing
* Differences in when people put themselves in this category
* Do we need more training on what a long term health condition is?
* What is it?
* Does it create a barrier?
* Everyone’s experience is different
* Perception – this can be from a young age ‘pyjama syndrome’
* Is this the first step – understanding themselves
* Support
* Invisible – sometimes we aren’t aware that people need the support
* Difference between prevention of these and support/opportunities for those living with the conditions
* Is this the terminology we should use?
* How do patients have a good experience?
* Why is there inconsistency in knowledge? Health professionals.
* How do you make it important to every practitioner not just those who value physical activity
* Holistic approach not just condition focused
* 4RRS – additional roles but information is generally clinical position eg. physio, paramedics. Non clinical to the social subscribers/holistic
* How do we increase the understanding of social prescribing
* Social subscribers need to understand their community and the services available
* Using GP surgeries ore widely, offering more opportunities
* Can GP surgeries use technology more effectively
* Automated systems challenging to some communities
* Active Practices – not many GPs buying in: why, who do we increase update
* Promotion of successes - impact, 5 core priorities
* People need to feel understood
* Sector understanding
* More opportunities for LTHC and condition specific, not currently local. Coach and leisure providing understanding.
* Public understanding – consensus statement, still high level, needs to be more publicised. WAU doing a job but need more action less talk
* DWP work – 50% have home LTHC. How can we help get back into workplaces
* Marketing is growing – how are we going to keep up with demand
* Stereotyping – learning everyone is different, how can we bring in activities
* Mental health issues on rise – using sport to bridge gap. Creating social opportunities. Not lots of qualified professionals need
* ‘New’ concept – gap in understanding, prevention.
* Mental health/mental wellbeing
* Supporting coaches/instructors with ways to interact
* Have we got capacity to deal with all areas (LTHC/EDC/LSEG) how do we decide? Locality report?
* Waiting lists – fear of ‘sitting’ on list. Messaging/comms. Mental aspects, not being provided support
* How can coaches break down these barriers? More education. Adaptive and inclusive – small things that matter. Breaking down the fees for coaches to engage.
* Provide confidence to participant
* Instructors that live with conditions. Champions – workforce representatives. Go and ask people how we can help.
* Get feedback from participants. Build relationships with participants
* M&E – reporting needs to be broader perspective. More stories. Qualitative data. Conflict with funding requirements.

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| **ACTOR** | **BEHAVIOURS** |
| NHS, Local Government, Planners, Housing, targeted conversations through LTC | Stop stereotyping, personalisation, ask what is needed/when and how/where/with who. ‘Can Do’ approach, just need to try. Difference can be hard to measure. Don’t discuss progress in terms of success/failure or ask what the goal etc is for that person (back to personalisation),measurement of success or failure should be determined by user. |
| Social care, secondary care staff/clinicians, point of diagnosis. Commissioners, NHS & local government. Education – understanding the benefits. Planning – building nice places to be active.  GP’s/health professional, giving the right information. Social prescribing  Physio – pre/post op care – signposting to continue physical activity. | See physical activity as their business  Talk about the bigger picture, more holistic. 1 prevent.  All of us – peer support is so important  Measure what matters to people – nice environment. Access to trees.  Encouragement |
| Community members  Leisure centres  United Leicester  Professional sports clubs  Sports groups  Social groups  Too much policy | Share ideas  Joint programmes  Referrals  Policy reviews  Co-design  Awareness  Signposting  Funding |
| Physical activity development officer  Leisure providers  Volunteers  Social prescribers  Social groups (either)  GP’s and practice managers  School teachers  Facilities  Culture | Communication  Accessibility – improving access to options. GP’s being more aware  Improving awareness of benefits of physical activity  More promotion – champions  Cost  Language changed from physical activity to movement  Encourage physical activity in a younger cohort |