Attitudes to Health in Hull 2007

An exploratory review

Annie Oldroyd
Research Consultant
SMSR LTD

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Steering Group Members and Support

Attitudes to Health Steering Group Members:

Sarah Jenkins (Chair)	Public Health, Hull Teaching PCT
Jo Stott	Public Health, Hull Teaching PCT
Robert Sheikh-Iddenden	Public Health, Hull Teaching PCT
Heather Kelly	Patient and Public Involvement Hull Teaching PCT
Ros Abbott	Hull Community Network
Annie Oldroyd	Research Consultant SMSR Ltd
Ian Mills	Research Director SMSR Ltd
Tony Douglas	Research Consultant SMSR Ltd

Support to the steering group was also provided by:

Other members of the team: Darren Hornby; Claire Jackson; Mark Brady and Janice Hames from SMSR, and Dr Andrew Taylor and Kate Birkenhead from Public Health Sciences, Hull Teaching PCT.

Foreword

Whilst many people living in Hull enjoy reasonably good health there is a significant number of people living in our communities who are at greater risk of disease and therefore do not achieve good health status.

Life expectancy in Hull remains below the national average and the major causes of death are from cancers and circulatory disease. It is well know that causes of ill-health and disease are often related to lifestyle behaviours and the choices made by individuals do not always have a positive impact on health.

If we are to improve health in Hull there is a need to better understand the communities which we serve.

As Director of Public Health for the city of Hull I feel there is a need to explore attitudes and perceptions of our population in relation to lifestyles and access to health services.

This report provides a first step in highlighting and identifying key issues which it is hoped will assist those working in Public Health and beyond in the planning and development of interventions which will deliver the desired improvements and have a positive impact on the health of our city.

Dr Wendy Richardson
Director of Public Health
Hull Teaching Primary Care Trust & Hull City Council

1 Introduction

On behalf of the Attitudes to Health Steering Group, I am pleased to present the findings of a programme of a qualitative study which has examined the attitudes and understanding of residents in targeted neighbourhood renewal wards in Hull in respect of health, health behaviours, risk taking and health service delivery.

Hull is one of the most deprived cities in the UK with areas of high deprivation and challenging social conditions. It is considered that complex patterns of health behaviours and lifestyles impact upon individuals to bring about a variety of adverse health outcomes. The Hull Neighbourhood Renewal Fund (NRF) strategy includes a number of programmes, which aim to reduce health inequalities and improve the health status and quality of life for people living in Hull and the study was underpinned by the delivery of the Neighbourhood Renewal Floor Target Action Plan.

In partnership with national and regional colleagues, the Local Strategic Partnership (now known as One Hull) proposed in August 2006 that the Neighbourhood Renewal Floor Target Action Plan for Health be refreshed to include a more targeted and focused approach to improving mortality rates. It was deemed important that the plan addressed a need for accelerated progress against the floor targets and achieved real, measurable health improvements for the population, a reduction in deaths caused by circulatory disease and cancer and increased overall life expectancy in the city.

A wealth of evidence was presented regarding the health status of the local population and in light of this the plan re-focused to target those in the mid-life (40-60) years; it was proposed that a study be undertaken to explore attitudes towards health within this age group with a particular focus on lifestyle choices, understanding of risk and access to primary care services and health screening.

The study was undertaken through a series of preliminary interviews with community liaison and health workers, a programme of focus groups across the Neighbourhood Renewal Wards followed by one to one interviews with participants and local professionals working in health and other local organisations. It was supported by a literature review, which was carried out simultaneously. The report presents the findings, draws conclusions and offers recommendations, which will hopefully assist a range of partners across the City to develop their own plans and interventions in the arena of personal health.

I would like to thank the steering group for their continued support, SMSR Ltd who carried out the study and more importantly those who were willing to participate and have made the study possible.

Sarah Jenkins
Public Health Programmes Lead
Steering Group Chair

SMSR Profile

The organisation that carried out the study, SMSR[1] is a locally based limited company, established for sixteen years and specialising in tailored research and review for both public and private sector clients.

SMSR's small, dedicated, graduate team works co-operatively with clients to design and develop both quantitative and qualitative investigations and studies that meet either the specific needs of an individual organisation or the generic requirements of a particular sector.

SMSR works primarily for public sector organisations including local and county councils, police authorities, health trusts, education departments and housing organisations. Their work includes: public consultation through telephone, postal and face to face survey; executive interview; mystery shipping and focused qualitative study, often to examine the results of quantitative research.

Qualitative study is at the heart of many research projects; it is often the element of investigation that provides the insight required to fully understand a topic, a situation or a problem. Though SMSR often includes a qualitative element to add value to quantitative research results, there are many situations where a qualitative approach is used in isolation.

Qualitative study is most useful when a target group is small or when the experience and practice of a few individuals is likely to have an impact or shed light on the behaviour of others. SMSR uses key members of the team and associate researchers from a variety of relevant backgrounds to recruit representative individuals and groups and develop semi-structured qualitative research studies with confidence.

Members of the project team can be contacted by telephone 01482 211200

SMSR
social and market strategic research

[1] Social Market Strategic Research

2 Executive Summary

2.1 Introduction

Hull has areas of high deprivation, challenging social conditions and complex patterns of health behaviours that result in adverse health outcomes. Programmes underpinned by the Hull Neighbourhood Renewal Fund (NRF) strategy aim to reduce health inequalities and improve the health status and quality of life for people living in Hull. The following study, which considered health behaviours and attitudes of 40 – 60 year olds in the target wards [2] was underpinned by the delivery of the Neighbourhood Renewal Floor Target Action Plan. The main report presents qualitative findings, draws conclusions and offers recommendations to assist partners across the city to develop plans and interventions in the arena of personal health.

2.2 Background and Context

Hull is a City with a population of approximately 245,000 people situated on the north bank of the River Humber in East Yorkshire. The city's boundaries are urban and it encompasses some of the most deprived wards both regionally and nationally. In Hull life expectancy is below the national average and there are higher rates of death from cancer and coronary heart disease than in other areas both regionally and nationally.

Key factors leading to preventable disease in the city are smoking, obesity and alcohol consumption. If general health and life expectancy in the city is to be improved, these factors must be addressed and this study[3] has sought a better understanding of how the population views the impact of their behaviours, their attitudes to health screening and how health service provision and education affects the health of individuals and the way they live their lives.

2.3 Qualitative Methodology

The study was conducted in seven stages

1. Promotion
2. Professional interviews (pre-focus groups)
3. Focus groups: A series of 12 focus groups was undertaken with 11 x 40-60 year old groups (8 mixed sex, 1 all female group, 1 all male group, 1 BME group) and a reflector group with community volunteers
4. Professional interviews (Post focus groups)
5. Focus group follow-ups
6. Reflector discussion
7. Report compilation and staged review of report development[4]

[2] See background and context in the main report

[3] It should be noted that the study was carried out during a period when the city was badly affected by flooding and at a time when the population first felt the impact of changes in smoking legislation.

[4] Findings were compared and contrasted with the results of the literature review

RESULTS AND FINDINGS

2.4. PROMOTION

Preliminary promotional information to the community sector and to primary care had limited success and though it generated some volunteers from the community there was no voluntary response from targeted practices. Practices were contacted by telephone after focus group work had been completed and a positive response was gained, which ensured that primary care personnel in the target areas had an opportunity to comment on the findings.

2.5 PROFESSIONAL INTERVIEWS (pre focus groups)

Preliminary interviews were undertaken using a semi-structured agenda with community workers/health-workers to provide insight into their perception of the local population's attitudes to health and behaviours that may affect long-term health. Perceptions of community health workers were used to inform the development of focus group agendas.

2.6 FOCUS GROUP FINDINGS

2.6.1 Illness and disease caused by lifestyle and life choices: Participants were able to identify a range of preventable diseases and conditions that they believed were attributable to lifestyle and behaviours. The diseases identified were consistent with those identified by community professionals

2.6.2 Factors affecting health: Groups identified the main factors, which had a negative affect on their own health and that of their family, friends and neighbours. The factors were consistent with those identified by community health professionals and included: smoking; alcohol; stress; poor environment; employment; unemployment; lack of money; poor diet; lack of exercise; lack of knowledge; lack of support and illegal drug use.

2.6.3 Attitudes to Risk and Changing Behaviour: The main personal situations and behaviours believed to constitute a risk to health included: where individuals lived and worked; alcohol intake and excessive drinking; smoking and inhaling the smoke of others; eating a poor diet and over-eating; failing to take exercise; long-working hours; taking illegal drugs and social isolation.

The report considers the findings under 6 main headings

- Theme 1 - Environmental
- Theme 2 - Socio-economic
- Theme 3 - Smoking, alcohol and illegal drugs
- Theme 4 - Diet and nutrition
- Theme 5 - Health screening and health-checks
- Theme 6 - Education and information

2.6.4 Theme 1: Attitudes to environmental factors (locality, housing, local shops and services, neighbours, isolation and work hazards); A similar range of environmental factors were identified by all groups.

- **The home:** Some individuals had anxiety related to the fabric of their homes but in most circumstances this was less important than other factors.
- **The neighbourhood:** The location and/or isolation of the neighbourhood, negative effect of bad neighbours, the behaviour of young people and others in the community and hazards in the locality were considered as detrimental to a feeling of health and well-being by many of those attending the groups.
- **Work and the environment:** In addition people were concerned about environmental hazards, deterioration in local services and the long-term effects of working in hazardous occupations.

2.6.5 Theme 2: Attitudes to socio-economic factors (employment, unemployment, poverty, locality, family responsibility, lifestyle and life chances)
Participants agreed that income levels, opportunities and personal responsibilities had a direct impact on health.

- **Income/employment**: All participants, across the target areas and within the special groups said that the gap between rich and poor was having a bad effect on the health of people in Hull and suggested that in some areas, securing a good income was impossible because of the negative associations of their post-codes.
- **Exercise and fitness:** Participants considered that income levels had a significant impact on how much exercise people were able to take
- **Family responsibility:** Family responsibilities were considered a major factor in personal health and the additional burden of long-term caring for disabled family members was identified as a cause of illness.

2.6.6 Theme 3: Attitudes to smoking, alcohol and illegal drugs
Participants across the target areas recognised smoking, heavy drinking and drug-taking as causes of illness and disease in the general population.

- **Smoking:** Though identified as a major contributory factor to ill-health in Hull, many focus participants who acknowledged the existence of a smoking culture were reluctant to admit that smoking would have a serious impact on their lives though they were well aware that smoking caused illness and disease.
    - There was a general feeling that more could be done to help people 'get off' cigarettes and that interventions had to be planned to suit the individual.
    - Participants gave a number of reasons behind the continued high incidence of smoking in the city, which included: the easy availability of illegal imports; the enjoyment derived from cigarettes; the benefits of reducing smoking (instead of stopping completely) and boredom.
    - The study found a wide variance in attitudes to the change in legislations; though welcomed by some, others considered it as a restriction in personal freedom and the cause of additional stress.

- **Alcohol:** Though well-recognised as a cause of illness and death among family and friends alcohol was an accepted part of the culture that was unlikely to change.

- Participants admitted that binge-drinking was a common feature of social behaviour and that drunkenness was considered as a desirable outcome of a night out.
- Problem drinking was exacerbated by a number of things including: happy hours; extended opening of pubs and clubs; shots' and drinks' deals; student nights; the need for pub chains to make lots of money; landlords and shops serving people who were underage; adults helping teenagers to buy alcohol.

- **Illegal drugs:** Though some participants were able to identify some risks when prompted, health problems associated with drug-taking were not widely recognised and the problem was almost always related to the young users

2.6.7 Theme 4: Attitudes to diet and poor nutrition:

Though participants in all groups identified good nutrition as an important factor in remaining healthy and fit in middle age, discussion revealed a huge variance in attitude and behaviour.

- There was broad recognition of healthy and unhealthy food groups and an anxiety that related to an increasing lack of knowledge about food purchase and basic cookery skills, which had been lost because of the availability of processed foods, change in family lifestyle and lack of education in school.
- Blame for post-war change and deterioration in diet was levelled at the supermarkets, food manufacturers, advertising, low incomes and low availability of good food shops in some areas.

2.6.8 Theme 5: Attitudes to screening and access to primary care services:

Provision of good local health services and support from health professionals were seen as important to ensuring good health was maintained.

- Female participants had all been invited to attend for cervical screening and those over fifty had been invited for mammography. In most cases[5] women had attended regularly but was not the case for everyone and some women gave insight into poor attendance.
- Most people expressed satisfaction with their own GP and participants said that the attitude of health professionals had an impact on how people used services and how they responded to advice and guidance.
- Participants said that attendance at appointments was important and most maintained that they would not miss appointments deliberately.
- There was almost unanimous enthusiasm in all the groups about the idea of a 'Health MOT."
- Access to NHS dentistry and GP appointment systems were the most frequently identified problems.
- Some participants identified difficulty in accessing out of hours services.
- The geographical location of urgent care facilities was a problem for many people who had no car of their own and were dependent on inadequate public transport.

[5] Some (four or five across the groups) said that they did not attend any more as they had suffered with some gynaecological illness and had had hysterectomies and therefore had no cervix (so no risk).

2.6.9 Theme 7: Attitudes to health education and information: Opinions about health information and health education were mixed but for many the absence of the right guidance and support was seen as a contributory factor to the ill health of individuals.

- Most people considered that television was an effective way to get information out to the general public and the TV documentary was frequently identified as the most reliable source of information about health and health risks.
- Radio programmes, magazines, leaflets, slimming groups and health professionals also provided information and guidance that made a difference. Some participants said that only things that affected them personally made them think twice about their lifestyles.

2.7 REFLECTIONS ON FINDINGS

Following completion of the focus groups a series of consultations were carried out with groups and individuals. Findings from focus groups were presented as a series of statements and the reflector group considered them in the light of their own experience.

2.7.1 Reflector group (volunteers community sector)

There was broad agreement in the group that smoking, alcohol abuse and poor diet were the main contributory factors to the lowered life expectancy and higher incidence of preventable diseases and on the whole the group agreed with the reasons given by the focus groups for the impact of these factors on the health of the target population. The reflector group was generally sympathetic and recognised the predicament of focus group participants who lived some distance from primary care services in areas where public transport was insufficient to meet the needs of the population.

2.7.2 Professional interviews (practice personnel)

Health Centre and GP Practice staff participated in follow-up interviews, which also considered the main outcomes and themes of the study. Interviewees concurred with many of the factors, which focus group participants believed had an impact on the long-term health and acknowledge the wide range of environmental and socio-economic factors that were identified by the groups.

2.7.3 Range of preventable diseases: the interviewees confirmed the range of preventable illnesses and conditions identified by the focus groups.

2.7.4 Main causes of preventable disease: Interviewee opinions on the causes of disease also corresponded with those of the focus groups.

2.7.5 Attitudes to risk: Attitudes to the risks, health and lifestyle choices of the population varied enormously across the areas, with acknowledgements for the social predicaments of patients expressed most forcefully by nurses and practice managers.

2.7.6 Altering behaviour: A lack of health education was held to be responsible for some of the 'careless' attitudes to health, particularly the effects of smoking. Cultural change was considered to be necessary and education was considered as the most valuable intervention and contribution to altering attitudes and reducing risks.

2.7.7 **The reasons for poor nutrition**: Like participants of the focus groups, professionals interviewed had mixed view about why people ate a poor diet. There was some disagreement with the idea that people on low incomes were forced to eat an unhealthy diet. Again education was regarded as the essential component of any overall intervention to alter the nutrition of the population.

2.7.8 **Attitude of health workers to patients**: Interviewees had mixed views about the criticism of some focus group participants about the poor attitude of health workers to patients with some voicing agreement and some giving reasons for negative public perception.

2.7.9 **Appointments and access to care**: Questioned about access to primary care, interviewees expressed a range of different opinions with some expressing sympathy with patients' views and others providing insight into the difficulties of service providers.

2.7.10 **Screening / health checks / missed appointments**: Interviewees were asked to consider the problem of DNAs and general patient responses to screening and health-checks. Professionals reinforced the idea that missed appointments were a problem and voiced opinions about why DNAs might occur. Ensuring attendance for screening was recognised as a problem by some of the professionals interviewed but there was general agreement among nurses and practice manager that there would be a good 'turn-out' for routine screening. Some practices referred to successful experiences of routine health-check projects in the past.

2.7.11 **Education and information:** In general, health professionals favoured 'big' messages through TV and popular culture to deliver health information.

2.7.12 **Reflector interviews (individual focus group participants):** A series of one to one face-to-face interviews were conducted with volunteers from the focus groups. There were no new findings reported and the interviews served to confirm that the focus group discussions were valid in the eyes of individuals who participated.

3 Background and Context

Hull is a city with a population of approximately 245,000 people situated on the north bank of the River Humber in East Yorkshire. The city's boundaries are urban and it encompasses some of the most deprived wards both regionally and nationally. Based on the index of multiple deprivation, Hull ranks 9th most deprived out of 354 local authorities. One third of Hull's wards (8 out of 24) were ranked in the 5% most deprived nationally whilst half of all Hull's wards were ranked in the 10% most deprived.

Hull is one of 88 local authorities, which draws Neighbourhood Renewal Funding into the city. The funding is to assist in the delivery of the National Public Service Agreement (PSA) or floor targets.

Targets, which are specific to health, are about increasing life expectancy and reducing mortality from cancers and circulatory disease. There is now an agreed local Neighbourhood Renewal Floor Target Action Plan (FTAP) for health, which focuses on targeting primary and secondary interventions to those in the 40 – 60 year old age range and 'needs-focused' groups primarily those who are engaged with specialist addictions services and older people.

Whilst demonstrating the need to target a specific age-group there was also a geographical dimension to the targeting of interventions as set out by One Hull and based on ward rankings within the Indices of Multiple Deprivation.

Therefore the following wards were agreed as target areas within the city:

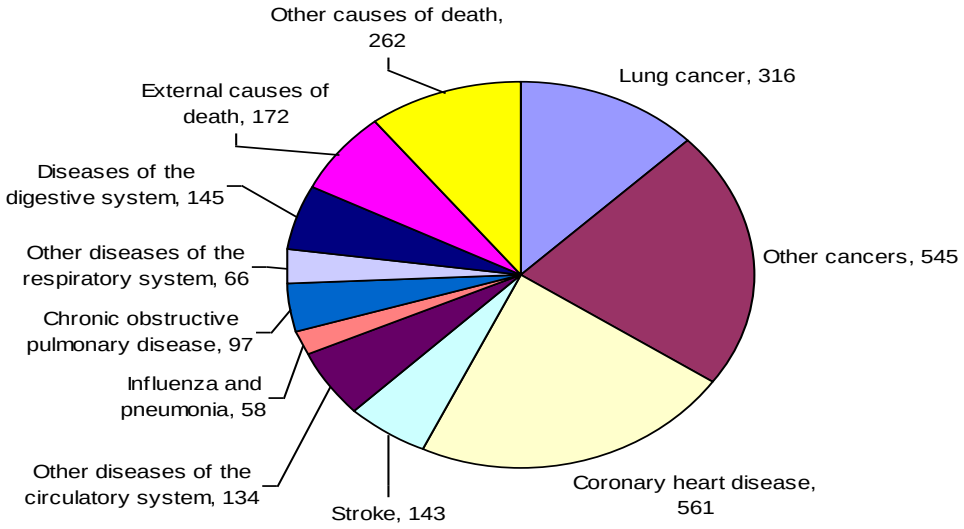
Myton	Orchard Park and Greenwood
St Andrews	Bransholme East
Newington	Bransholme West
Newland	Marfleet
Southcoates East	Longhill

In Hull life expectancy is below the national average and there are higher rates of death from cancer and coronary heart disease than in other areas both regionally and nationally.

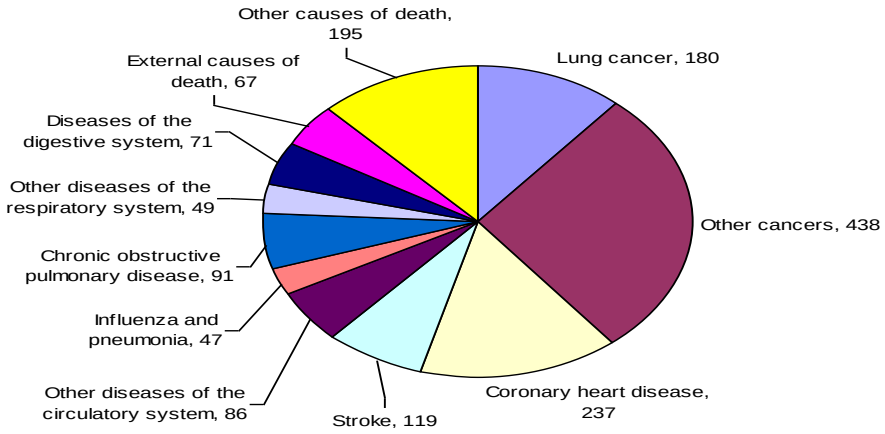
The pie charts below show the main causes of premature death for both men and women in Hull between 2001 and 2004[6].

[6] Further information on these statistics can be found at www.hullpublichealth.org

MAIN CAUSES OF DEATH FOR MEN AGED UNDER 75 YEARS (2001-2004)



MAIN CAUSES OF DEATH FOR WOMEN AGED UNDER 75 YEARS (2001-2004)



The pie charts show that the major killers are cancer and circulatory disease. This pattern of ill-health is consistent across the PCT localities and demonstrates the homogenous nature of ill-health in Hull communities and the challenge for public health. As well as primary prevention of ill-health and disease, secondary prevention in primary care is a major priority in terms of reducing inequalities, mortality and morbidity rates in relation to coronary heart disease and cancer.

People with a high risk of developing coronary heart disease are not always identified and usually first present to health services in an emergency situation with myocardial infarction (heart attack). Though there is a lack of more robust evidence, anecdotal evidence suggests that men in particular are often reluctant to access primary care and symptoms of heart disease go unnoticed or are ignored until an emergency situation

occurs. Reasons are not understood but it is believed that there is a culture of male acceptance that chest pains at 60 are normal/part of getting older. Additionally, for both sexes, when there is a family history of heart disease expectations of health and life expectancy are often low.

In terms of cancer screening, though Hull PCT is meeting the overall target of 80% uptake for cervical screening in the city there are some practices that fall below this figure. Local anecdotal evidence suggests that women often fail to attend for colposcopy following an abnormal smear result and that those who fail to attend tend to live in the most deprived areas of the city[7].

Key factors leading to diseases such as heart disease or cancer (and subsequently premature death) are high levels of smoking, obesity and alcohol consumption. Hull has a high prevalence of smoking (50% in some areas of the city) and there are expectations that the trend for increased incidence of obesity will continue. Self-reported alcohol consumption has shown that significant numbers of people in the city are drinking to harmful and hazardous levels. If general health and life expectancy in the city is to be improved, these factors must be addressed and this study[8] has sought a better understanding of how the population views the impact of their behaviours and the choices they make and to discover how health service provision and education affects the health of individuals and the way they live their lives.

[7] The study revealed good attitudes both to cervical screening and colposcopy but the group were between 40 and 60 years and the literature review (Cervical screening and colposcopy Page 6) suggests that poor take-up and attendance at recall appointments is significantly lower in younger age groups. In light of this a focus group with young women considered the difference in attitudes and revealed lower levels of understanding about the importance of the screening and a higher reluctance to attend related to embarrassment. Further work with younger women would provide additional insight into how attitudes and behaviours could be changed.

[8] It should be noted that the study was carried out during a period when the city was badly affected by flooding and at a time when the initial impact of a change in smoking legislation was felt by the population.

4 Qualitative Methodology

4.1 The remit of the study was to investigate local attitudes and understanding of general health, gain insight into local knowledge of and local attitudes to preventable disease and to explore group and individual attitudes to behaviours that constitute a risk to health.

4.2 This study has been undertaken in order identify attitudes that may be generalised to the NRF target areas. To avoid the risk of labelling and stigmatising individual communities, the steering group decided to avoid relating comments to specific neighbourhoods.

4.3 In addition the study aimed to gain insight into general opinions and perceptions of primary healthcare services, to identify reasons for non-attendance for appointments including health screening and to investigate the attitudes of women, particularly in relation to cervical screening.

4.4 There was a requirement that the work with individual and focus group participants would provide a unique opportunity for learning for the study team, for the PCT and for participants of the study.

4.5 Members of the project steering group were consulted throughout the development of the study.

4.6 Lines of communication were established between key workers on the study team and between SMSR consultants and the project lead (Sarah Jenkins) within the PCT. A series of steering group meetings was planned, regular additional routes for ongoing consultation arranged and regular feedback agreed. The study and reporting was conducted in seven stages:

4.7 **Stage 1 PROMOTION**
Information outlining the study was sent, with a covering letter, to community groups across the three PCT localities in the target areas. Volunteers were requested to assist with the study. Letters were also sent to GP practices in the target areas to invite professional participation in the study.

4.8 **Stage 2 PROFESSIONAL INTERVIEWS (Pre focus groups)**
A series of preliminary interviews was undertaken with selected community/health professionals to provide insight into their perceptions of attitudes to health and health behaviours of people in the targeted 'Neighbourhood Renewal Wards.' The findings of these interviews informed the development of the focus group agendas for Stage 3.

4.9 **Stage 3 FOCUS GROUPS**
Using random telephone recruitment across the targeted areas, a series of 12 focus groups was undertaken with

- 11 x 40-60 year old groups
  (8 mixed sex, 1 all female group, 1 all male group, 1 BME group)
- 1 reflector group with community volunteers

4.9.1 A register of recruitment was made and retained by SMSR and recruits were assured that their contributions would be treated in confidence. The register was also used to provide a record of expense payments made to attendees to cover travel and care costs.

4.9.2 A letter from SMSR and a map of the location and details of focus group times confirmed acceptance of attendance and dates were enclosed.

4.9.3 A preliminary focus group was held using a draft agenda, compiled using information from preliminary interviews with community/health personnel. Early outcomes were discussed with members of the steering group at a scheduled meeting and minor additions and revisions were made to the agenda before the planned programme of focus groups was undertaken.[9]

4.9.4 Venues within each area were selected with regard to accessibility for recruits from the target ward and a trained facilitator conducted focus groups with a supporting scribe. Groups were provided with a clear framework for discussion and given background information about the reason for and aims of the study.[10]

4.9.5 Each group was scheduled to run for two hours and were conducted between 3.00 and 5.00 pm or between 6.00 and 8.00 pm.

4.9.6 Attendance was good for all groups with between 8 and 12 attendees for nearly all groups. Lowest attendance figures achieved were for the BME group where 7 of 10 recruited attended the discussion.

4.9.7 Though groups were recruited at random, it is necessary to recognise that people who agree to participate in this kind of study are usually people who have some confidence in their ability to contribute and/or an interest in the subject of the study. The study may not therefore fully represent the views, attitudes and experience of people who resisted the invitation to take part.

4.10 **Stage 4 PROFESSIONAL INTERVIEWS (Post focus groups)**
A series of one to one interviews with primary care personnel was undertaken to reflect on the outcomes of the focus groups. The interviews were based on a series of statements that provided a 'snapshot' of the main findings from the focus groups.

4.11 **Stage 5 FOCUS GROUP FOLLOW-UPS**
Follow-up interviews with male and female individuals who had taken part in focus group discussions was undertaken to confirm and add depth to information gathered during group discussion

4.12 **Stage 6 REFLECTOR DISCUSSION**
A reflector group with volunteer individuals from community groups was undertaken to inform the agenda for the stake holder event

[9] Delay in scheduling meant that some groups were facilitated after the introduction of the national legislation, which banned smoking inside public buildings.
[10] The schedule of focus group events was postponed because of bad weather, flooding and associated disruption in target areas and focus group work continued during July. Single sex groups were eventually completed in early August.

4.13 **Stage 7 REPORT COMPILATION**

The construction of the report was discussed with steering group members anda drafting process with staged reviews agreed.

4.13.1 In consultation with the report compiler, a decision was taken to present focus group findings under themed headings.

4.13.1 The steering group advised the identification of key learning points associated with the six themes.

4.13.2 The study findings were compared and contrasted with the results of the literature review supported by a literature review .

4.13.3 A requirement for verbatim commentary was stressed and a need for clarity and brevity.

4.13.4 It was required that a copy of the report and the associated literature review were made available on the Hull Public Health website.[11]

[11] www.hullpublichealth.org

RESULTS AND FINDINGS

5 PROMOTION

Though information and invitations to participate were sent out to local community groups and support organisations, only 12 individuals from these groups expressed an interest in participation. Their names were recorded on a contact database and they were contacted and asked whether they would be willing to take part in a reflector group when focus group work was complete and in the dissemination of the findings. Though selected GPs were invited to participate there were no responses to the invitations prior to study commencement.

Practices were contacted by telephone after focus group work had been completed and a positive response was gained from targeted practices, which ensured that health professionals in the target areas had an opportunity to comment on the findings.

6 PROFESSIONAL INTERVIEWS (Pre focus groups)

Preliminary interviews were undertaken using a semi-structured agenda with community workers/health-workers to provide an overview of attitudes to health and health behaviours of people in the targeted Neighbourhood Renewal Wards. A synopsis of discussion and comment appears below and the material gathered was used to inform the development of the main focus group agendas. Views reported are the personal views of those interviewed and are not representative of the views of particular organisations.

6.1 The issue of high mortality rates was discussed and interviewees had mixed views about life expectancy in Hull. One said that she had seen little evidence of shortened life expectancy while another believed that for men it might be as low as 64 and as low as 70 for women. There was an acceptance that women on the whole lived longer than men and only one of the interviewees believed that people in Hull had a life expectancy of 80+.

6.2 Without exception, all community-based workers interviewed expected their own life to be longer than the average of those in the community in which they worked. This was because interviewees felt that they knew more about healthy eating, the harmfulness of alcohol and cigarettes, the value of exercise and had higher levels of financial security.

6.3 All interviewees identified a wide range of preventable conditions[12], illnesses and diseases, which included chronic obesity, heart disease, hypertension, liver failure, diabetes, stroke, cancer[13] and sexually transmitted disease.

6.4 Other illnesses, considered to be less under the control of the individual, were illnesses related to mental health, which were often considered to be a result of quality of life and lack of hope or aspirations. There was however a link made by two of the professionals that some kinds of psychological disturbance were related to drug abuse.

6.5 Causes of illness were largely attributed to poor diet, smoking, alcohol, lack of money, drug related imbalance and unsafe sexual behaviour but additionally, all interviewees were convinced that the place you lived in had a direct impact on your health and life expectancy[14].

6.6 The impact of the local environment on health and life-span was related in part to the quality of housing in an area, but more strongly linked to a lack of opportunity and lifestyle choice in some areas, the absence of successful, 'aspirational' social peers. How an individual family lived, was heavily influenced by the lifestyle, which was prevalent in the locality and the occupants of the row of houses in which they lived.

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[12] The literature review carried out simultaneously considered smoking , obesity, physical activity and alcohol consumption.

[13] Department of Health (2005) estimated that Eastern Hull had the highest smoking prevalence in England and the highest lung cancer rate for the Yorkshire and Humber region (Literature review: Smoking, obesity, physical activity and alcohol Page 2)

[14] Literature review (Smoking, obesity, physical exercise and alcohol) Page 5 suggests that age, sex and housing conditions have a major effect on how people relate to health programmes; Page 9 identifies the link between obesity and deprivation. Page 15 identifies low exercise provision in deprived neighbourhoods in relation to low exercise levels.

6.7 Additionally, the negative reporting of the media had a detrimental effect on a whole neighbourhood or estate and one interviewee said that a national newspaper suggested that a street in Hull was the worst in England. The interviewee suggested that inhabitants of that particular street would reflect on the report and decide that they had no hope and would be '*sucked more easily'* into the habits and lives of those who lived closest to them

6.8 It was suggested that young people on estates on the periphery of Hull believed that they were *'chavs.'* This belief lowered their expectations and this meant that few regarded training and education as a feasible lifestyle choice.

6.9 It was suggested that many families who were dependant upon benefits lived on take-away meals, pizza and fizzy drinks and that even with knowledge individuals failed to take care of themselves[15].

6.10 In one of the areas it was suggested that some children locally had never touched or tasted carrots or peas and there was a problem, in that particular area, in respect of accessing good quality fresh food. It was part of the social norm to eat junk food and take part in regular 'binge' drinking.

6.11 Asked about how health and lifestyle could be improved, interviewees had many suggestions, which included[16]

- one to one support for smokers
- 'de-cooling' smoking for the young
- group activity for slimmers
- formal education in sexual safety
- advice through the media on nutrition/cookery and exercise
- outright bans on drinking alcoholic drinks in the street or parks.

6.12 Sexual health was considered by all interviewees to be a major problem and reference was made, not to their own risks but to risks that they considered were frequently taken by young people with a number of sexual partners.

6.13 Social isolation was regarded as a situation that had a negative influence on health and it was identified as a major factor in the limitation of life chances including social education, employment and choice of partners

[15] Literature review (Smoking, obesity, physical exercise and alcohol) Page 9.

[16] The PCT and its partners are delivering a range of public health programmes and interventions to address the health improvement requirements identified by the interviewees. Creative social marketing techniques are being used to make interventions more effective and more responsive to the needs of the target groups.

7 FOCUS GROUP FINDINGS

7.1 Illness and disease caused by lifestyle and life choices

Groups were asked to identify the negative health outcomes, which might result from the lives they lived and the choices that they made throughout their adulthood. Views and attitude reported are the personal views of participants and are not representative of the views of particular organisations or communities.

7.1.1 Participants in all groups were able to identify an extensive range of preventable diseases and conditions that they believed were attributable to lifestyle and behaviours. The illnesses[17] identified included (in alphabetical order):

- Alcoholism
- Arthritis
- Asthma
- Cancer
- Circulatory disorders
- Coronary heart disease
- Chronic back disorders
- Diabetes
- Eye problems
- Emphysema

7.2 Factors affecting health

All groups were asked to identify the main factors, which they believed had a negative affect on their own health and that of their family, friends and neighbours. Responses overall were consistent with the views of Community/Health interviewees. The main factors[18] identified were (in no particular order):

- Smoking *(heavily discussed and very topical)*
- Alcohol *(discussed as a health risk and a social risk)*
- Stress
- Poor environment
- Employment
- Unemployment
- Lack of money
- Poor diet *(discussed in relation to low income and lack of knowledge and education)*
- Lack of exercise
- Lack of knowledge
- Lack of support
- Drugs

[17] The illnesses and conditions identified by participants were consistent with those identified by professionals.

[18] The factors affecting health conditions identified by participants were consistent with those identified by professionals.

7.3 Attitudes to Risk and Changing Behaviour

In relation to the factors listed at 3.2 groups were also asked to consider the risks taken by themselves and their family friends and neighbours that contributed to the prevalence of conditions and illnesses that they had identified.

7.3.1 Participants identified a range of risk taking behaviours and lifestyle causes for preventable diseases and further discussion considered their attitudes to risks that they were prepared to take themselves. The main personal situations and behaviours that they believed constituted a risk[19] to health were identified (in no particular order) as:

- Where they lived
- Where they worked
- Alcohol intake and excessive drinking
- Smoking and inhaling the smoke of others
- Eating a poor diet and over-eating
- Failing to take exercise
- Long-working hours
- Taking illegal drugs
- Social isolation

7.3.2 The findings of the groups in terms of experience and attitude are therefore discussed below using a framework of six main themes

- Theme 1 - Environmental
- Theme 2 - Socio-economic
- Theme 3 - Smoking, alcohol and illegal drugs
- Theme 4 - Diet and nutrition
- Theme 5 - Health screening and health-checks
- Theme 6 - Education and information

7.3.3 In addition to the factors identified across the mixed sex 40 – 60 age group, participants in the black and minority ethnic (BME) group identified social exclusion and lack of interaction with the host population as a factor that does affect long-term health.

[19] Risks identified by participants were consistent with those identified by professionals

7.4 Theme 1

Attitudes to environmental factors (locality, housing, local shops and services, neighbours, isolation and work hazards)

On the whole, all groups identified a similar range of environmental factors that had an impact on their health and the health of their family, friends and neighbours.

7.4.1 **The home:** Some individuals had anxiety related to the fabric of their homes, particularly in respect of inherent dampness and lack of maintenance by landlords. In one area, the problem of heating older homes sufficiently (when prices were rising) was considered as a factor that would affect health, as people grew older. The fabric of the home however was less important to most people than other factors.

7.4.2 Residents in three groups said that because Hull was low-lying it was a naturally, 'damp' city.[20]

7.4.3 **The neighbourhood:** The location of the neighbourhood, negative effect of bad neighbours, the behaviour of young people and others in the community and hazards in the locality were considered as detrimental to a feeling of health and well-being by many of those attending the groups[21].

7.4.4 Members of a group on one of the peripheral estates said there should be more effective 'tenant monitoring.' They considered that 'problematic' families from other parts of the country were moved into houses but not 'checked' to see if they were acting responsibly and taking care of the property that they lived in. This had a negative impact on other people in the surrounding community, as interaction between tenants was either problematic or avoided because of fear of repercussions.

7.4.5 Continuing discussion focused on the impact on general health of neighbourhood conflict and associated stress and in that context, specific situations were discussed. Participants had strong views in relation to their own behaviour and that of their neighbours and it was clear that involvement in disputes with neighbours had a major impact on individual peace of mind.

7.4.6 Residents were particularly affected by the isolation of the Bransholme estate and its 'separateness' from the rest of the city

7.4.7 Services for the elderly and the disabled were said to have deteriorated in one area over recent years. People specifically expressed concern about the withdrawal of meals on wheels and the reduction of social contact as a result.

7.4.8 Some participants said that the local environments were badly affected by drug users littering the parks and open spaces with used needles and creating hazards for families and children

[20] Though the incidence of local flooding was recent, this comment was not associated with the impact of these events.

[21] The literature review(s) show throughout that socio-economic factors linked to economic and social deprivation have a negative impact on attitudes and behaviours.

7.4.9 Members of the black and minority ethnic group said that the lack of interaction with the host community was a cause of anxiety and that social acceptance was necessary to the maintenance of good health.

7.4.10 Participants in some areas[22] commented particularly on the impact of excessive traffic fumes in some of the main traffic routes within the city.

"I have smoked for years and suffer from emphysema but I am alright until go outside and then the traffic fumes make me breathless."

7.4.11 **Work hazards:** Some participants cited work hazards as a reason for the onset of disease. There were specific examples given which included petro-chemical fumes, dust from process and production and heavy work which eventually caused back and mobility problems. A lack of health and safety in previous occupations has resulted in exposure to a range of work hazards which participants felt had impacted on their health status in later life.

7.4.12 **Diseases attributed by groups to environmental factors:** Diseases considered to be related to environmental situations were said to be stress, lung diseases, coronary heart disease and high blood pressure. In some cases, group members tended to blame work hazards over and above lifestyle choices.

THEME 1 - KEY LEARNING POINTS

- *Management of neighbourhoods needs improvement and the issue of 'bad' neighbours needs further attention. Closer monitoring of tenants who have a negative impact on people in the vicinity and action to alter anti-social behaviour would have good health outcomes*
- *A lack of community cohesion and poor interaction between different groups were regarded as factors which affected health*
- *Occupation (or lack of occupation) and low incomes are often blamed for ill-health and unwise lifestyle choices are ignored*
- *Communication is best when it comes from 'people like us' as they are easier to relate to*
- *Clean-up programmes are required to ensure hazardous litter is removed from public areas*
- *People in the 40 – 60 age group are concerned about the impact of poor environments and communities on younger people*

[22] Participants in Newington and Newland were particularly affected by this problem

7.5 Theme 2

Attitudes to socio-economic factors (employment, unemployment, poverty, locality, family responsibility, lifestyle and life chances)

Participants across the target areas and within the BME group groups agreed unanimously that income levels, opportunities and responsibilities had a direct impact on health.

7.5.1 All participants, across the target areas and within the special groups said that the gap between rich and poor was having a bad effect on the health of people in Hull.

" If you are terrified to open every bill because you have no money, you get really stressed and then you make it worse by smoking or drinking[23] to make yourself feel better." (Male 40 – 60)

"If you know that everyone [24]has a better life than you, you get demoralized and then you get ill!" (Male 40 – 60)

"If you haven't got much money coming in you can't eat properly and then you get ill because you eat rubbish." (Female 40 – 60)

7.5.2 Some participants believed that their post-code was a barrier to them securing good regular work and has had an impact on their career prospects.

" It doesn't matter if you are good at something, once an employer knows you are from Bransholme or Orchard Park you don't stand a chance." (Male 40 – 60)

7.5.3 Discussion about unemployment was prolonged and there was a consensus about the long-term impact of unemployment on health in one group.

"If people don't have jobs they get depressed. Mental health problems lead to anti-social behaviour. Drug-taking and drinking a lot are more likely if you do not have anything to do or anywhere to go." (Male 40 – 60)

7.5.4 Members of the BME group described their experiences of hostility that had made them feel vulnerable and undermined community cohesion.

7.5.5 Employment status, level of income and where you lived was considered to have an impact on how much exercise you took. If you had to travel a long way to swim and had a low income you would not go regularly[25].

7.5.6 Participants across the groups said that organised exercise (in a gym or club) was usually too expensive and participants who did take regular

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[23] The literature review (Page 22: 5.4 Para 2) revealed that though binge drinking is common in many groups it is higher among the unemployed and alcohol abuse results in significantly higher hospital episodes, crime and reduced life expectancy

[24] The literature review(s) demonstrate throughout the negative impact of low income and social status.

[25] The literature review (Page 11: 3.4. Para 7) highlights the risk of sedentary lifestyles for young people which result in adult obesity.

exercise said that they walked or cycled everywhere because they did not have cars.

7.5.7 Family responsibilities were considered as a major factor in the health of the individual and the additional burden of caring for disabled family members was identified as a cause of ill health.

"I have looked after my younger sister [learning disabled] for 21 years and also had to care for my mother who got Alzheimers. I get a bit of financial support now but I had to fight for years to get some help and the worry of it all affects your health." (Female 40 – 60)

"I grew up with an alcoholic mother and an abusive father. He didn't live with us but he was a bad man and made us miserable. My mother was an alcoholic and died when she was in her forties. I have never had a drink but I cannot stop smoking as it would make me too stressed." (Male 40 – 60)

7.5.8 **Diseases attributed by groups to socio-economic factors**: Participants said that conditions and illnesses like stress, depression, lung diseases, high blood pressure and liver disease were caused by poverty and social and family pressures

THEME 2 - KEY LEARNING POINTS

- *Low incomes and poor attitudes to risk taking behaviours are linked in the minds of the target group*
- *Family experiences have both positive and negative impacts on lifestyle choices*
- *Close to home events might be good opportunities for education and intervention*
- *Employers in the area may be disregarding a source of labour because of local perceptions and prejudice*
- *Concern for young people related to aspiration and life chances often outweighed concern for themselves and people in their own age group*

7.6 Theme 3

Attitudes to smoking, alcohol and illegal drugs

Participants across the target areas recognised smoking, heavy drinking and drug-taking as causes of illness and disease in the general population.

7.6.1 **Smoking:** Though identified as a major contributory factor to ill-health in Hull by all professionals interviewed many of the focus group participants were reluctant to admit that smoking would have (or already had) a serious impact on their lives.

> *"I have emphysema and it is quite bad but I don't think it is just the fags. I have done jobs where I have breathed in oil fumes, starch in a sweet factory and that's done most of the damage." (Female 40 – 60)*

7.6.2 Participants acknowledged that the area(s) they lived in[26] had a 'smoking' culture and though they were well aware that smoking caused illness and disease, limited lifespan and/or had a long-term detrimental effect on quality of life for both individual smokers and their families, there was widespread defence of the right to smoke, even from non-smokers.

7.6.3 Discussion among participants across the groups revealed a wide variance in attitudes and though some welcomed the smoking ban wholeheartedly others said that the change in legislation was unfair and that was an 'impingement' on their rights. Restrictions on smoking in hospital grounds was considered by one person to be a possible factor in making a stressful situation much worse.

7.6.4 There was a general feeling that more could be done to help people 'get off' cigarettes and a belief that the solution to each smoker's problem had to be approached differently as will-power varied from individuals and reasons for stopping were not always the same.[27] Patches and gum worked for some people, hypnosis worked for others; cutting down until you were ready to do it properly was also considered to be a successful route to stopping for individuals who had achieved cessation for some years[28].

7.6.5 Many people felt that they had achieved sufficient benefit from reducing the number of cigarettes they smoked and therefore did not feel that stopping completely was a real priority. Other reasons for continuing to smoke were provided by both male and female participants.

> *"Smoking is my only pleasure." (Female 40 – 60)*
> *"I don't have a job and smoking helps with boredom." (Female 40 – 60)*
> *"I don't know what to do with my hands when I am out if I don't smoke." (Male 40 – 60)*
> *"Tried to stop but the gum is disgusting." (Male 40 – 60)*

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[26] The literature search (Page 2: 2.2 give details of high smoking prevalence in Hull and tabulates smoking rates and details of Hull lung cancer rates which are in some areas almost twice the national average.

[27] Groups were informed about the availability of the smoking cessation programme and information was distributed to participants who were interested in the information leaflets made available by the PCT. The PCT continues to provide cessation support in a variety of ways.

[28] Literature search 2.2 supports the premise that a 'one size fits all ' approach to cessation is inadequate

7.6.6 Access to cheap cigarettes, widely available because 'you can get them off the docks' was believed to encourage people to smoke[29], as it did not cost them as much as it did in other parts of the country.

7.6.7 Several people said that the biggest advantage to stopping smoking was saving money but many others had made attempts to stop smoking for other reasons.

"I've cut down because I don't want to smoke in front of the 'grand-bain.' I am trying to stop as she doesn't want me to die." (Female 40 – 60)

7.6.8 People felt that they were well-informed about the health impact of smoking but rationalised their own choices and behaviour to justify their continued smoking[30].

"My auntie was 92 when she died. She never had a day's illness and she smoked ever since she was 14." (Female 40 – 60)

"My dad died of lung cancer and I have already been ill but I still haven't made up my mind to stop." (Male 40 – 60)

"I know it is dangerous. I reduced the amount I smoked after I woke up one night unable to breathe – but I still want to smoke – so I do." (Female 40 – 60)

"I know it's doing me no good but the more people go on about it the more I smoke. Talking about it now makes me want a fag." (Female 40 – 60)

"I stopped smoking for two weeks after I had a heart attack. Once the visitors had stopped coming I started to smoke again. Boredom!" (Male 40 – 60)

"I'll stop after my first cardiac arrest!" (Male 40-60)

7.6.9 **Alcohol:** Though recognised as a cause of illness and death among family and friends in all groups, for most participants alcohol was apparently a fixed aspect of their lives that was unlikely to change[31].

7.6.10 Across the groups, with the exception of the BME group, excessive drinking was an accepted (though not universally popular) part of the local lifestyle, even for those who did not drink themselves.

7.6.11 There was prolonged discussion in some groups about the growing problems of alcohol consumption among young people and some participants considered that this was partly because of the increased choice of products. Many people considered that alcohol played a major part in the increase in sexual activity among very young people.

7.6.12 Though 'binge drinking' was considered to be a major problem for young people, many participants across the 40 – 60 age group said that they were 'binge drinkers' too[32] but their 'bingeing' was usually related to the

[29] Smuggled (cheap) cigarettes are a problem in many areas of the country.
[30] The literature search (2.2) suggests that GPs need to raise the issue of smoking during consultations and that flexible support may encourage 'deprived' smokers to quit.
[31] The literature search 5.3 suggests that nationally 38% of men and 16% of women between 16 – and 64 have an alcohol use disorder.
[32] Literature search (5.4 Para 1) suggested that heavy drinking occurs between 4% and 9% more frequently in lower socio-economic men than in men in professional occupations.

weekend[33] and maybe only once every couple of weeks. Consumption was often linked to the availability of money.

"I have too much to drink when I can afford it. If I had more money I would go out and get drunk more often." (Male 40 – 60)

7.6.13 Though some participants said that they did not drink at all and others said that they drank moderately 'binge drinking' was admitted as a common feature of social behaviour and was reported to be a regular feature of a night-out at the weekend. One man suggested that there had been a cultural change and that in recent years people had started having a few drinks at home before they went out so that the 'night-out' would be less expensive

"Being drunk is what is important. It used to be 'go out and have a beer with your mates for a game of dominoes or darts' and now it is 'get tanked up at home and go out and get very, very drunk' and it isn't just young people who behave like this." (Male 40 – 60)

7.6.14 Those who disapproved of excessive drinking said that there were plenty of things that could be done to change the habits of the population and that action should be taken in this respect. Across the groups, participants said that the problem was exacerbated by a number of things including:

- happy hours
- extended opening of pubs and clubs
- shots' and drinks' deals
- student nights
- the need for pub chains to make lots of money
- landlords and shops serving people who were underage
- adults helping teenagers to buy alcohol.

7.6.15 Some smokers in the group[34] said that alcohol had become more acceptable to society than smoking.

"Even though binge drinking causes fights, car accidents, violence[35] at home and behaviour that generally hurts other people the people that have to stand on the street in the cold are the smokers." (Female 40 – 60)

7.6.16 The childhood experience of some people had prevented them from drinking and where parents had died or been incapable frequently because of drink, some participants felt fearful of any intake of alcohol.

"My dad drank two bottles of rum every day. Seeing him in that state has stopped me doing it." (Male 40 – 60)

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[33] The literature search (5.4. Para 2) suggests that the proportion of people binge-drinking is higher for unemployed groups.

[34] Smokers in some groups were resentful about the change in the smoking law and felt that they were being victimised.

[35] The literature search suggests (5.8) that there were 1.2 million violent incidents related to alcohol consumption and that a third of 360,000 reported incidents of domestic violence were linked to alcohol and that Hull has a reported violent crime rate of almost 40% compared to 20% across the country.

7.6.17 **Diseases attributed by groups to excessive alcohol consumption:** Participants identified liver and kidney disease, high blood pressure, heart disease and mental illness like paranoia.

7.6.18 **Illegal drugs:** Though some participants were able to identify some risks when prompted, health problems related to drug-taking were not widely recognised and the problem was almost always related to the young users

7.6.19 Participants in some groups suggested that there was a drug dealer on every street.

"*You can always get 'weed' from a local dealer and they can always get hold of something stronger if they're asked." (Male 40 – 60)*

7.6.20 **Diseases attributed by groups to use of illegal drugs:** Few people associated drug taking with disease but a few said that drugs were often at the root of mental illness.

THEME 3 - KEY LEARNING POINTS

- *Other exposures are blamed for smoking related diseases by smokers who do not want to give up*
- *Family experiences with smoking related disease have both positive and negative impacts on lifestyle choices*
- *Close to home events might be good opportunities for education and intervention*
- *Cutting down on cigarettes is seen as a positive way of reducing risk*
- *Target group is well-informed but can provide a range of reasons for continuing to smoke*
- *Smokers see themselves as victims of the new law which penalises them socially*
- *Crisis is often the only catalyst for stopping*
- *Smoking is often part of an individual's coping mechanisms and there is a fear associated with its removal*
- *Smoking is one of very few pleasures for some people in the target groups*
- *Alcohol and sexual risk taking are linked but fears of the target age group are largely for younger people*
- *Alcohol is seen as an important contributory factor in the growth of antisocial behaviour in younger age groups*

7.7 Theme 4

Attitudes to diet and poor nutrition

Though participants in all groups identified good nutrition as an important factor in remaining healthy and fit in middle age, discussion related to eating a healthy diet was wide-ranging and revealed a huge variance in attitude and behaviour.

7.7.1 There was broad recognition of the guidance to eat '5 a day'[36] and many older participants said that they ate healthily and cooked a lot of their own food[37]. In one group of 10 people however, only three individuals said that they were in the habit of '*cooking food from scratch'* and many thought that the ability to cook or even to choose what to cook was becoming less and less common. Several participants expressed concern about the diet of younger people and there was a suggestion, (also made by a health trainer[38]) that young people (under 40) often did not know how to cook the simplest of meals.

"We learned from our mothers or in lessons at school. Some people never saw food being cooked at home and schools only provide theory not practical teaching."

7.7.2 Individuals across the groups identified the 'dangerous' elements of a poor diet as salt, fat and sugar. Some said that 'chemicals' added to food were the most dangerous thing and many considered that food was 'healthier' fifty or sixty years ago before food was put in packets and preserved and frozen. A lack of knowledge, the rise of supermarkets, glamorous advertising and availability of convenience foods were held to be the main reasons for a decline in health.

"This sort of advertising started when I was a teenager. We didn't have enough money to buy a lot of it but my mum started us off with frozen meat pies and Vesta curries. When I go a job and had a bit of money of my own I bought things that I had seen on the telly but never tried at home. You thought you were doing something good." (Female 40 – 60)

7.7.3 In a number of areas, participants said that access to high quality meat and fruit and vegetables was restricted and the range of shops on estates was limited and said that the inability to afford good fresh food as a problem. A number in each group considered that fruit and vegetables were too expensive and several believed that it was impossible to eat well on a small income.

"I don't eat properly. I would rather feed the kids than eat myself but I cannot afford to put a hot meal on the table every day and this has a 'knock-on effect' for everyone. I feel constantly sick and moody and I take it out on the kids." (Female 40 – 60)

7.7.4 Access to fresh fruit and vegetables and to good butchers was not a problem in all areas and participants in one group agreed that there was a good variety of retail outlets in their area.

" In this area (Newland) the impact of immigration on the availability of good food has been really positive and the range of food at affordable prices has expanded."

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[36] The literature search (3.4 Para 6) suggests that in respect of fruit and vegetables higher social groups were most likely to make changes to increase consumption and lower social groups were most likely to reduce consumption of fried food.

[37] In the BME group, all participants said that they cooked fresh food on an almost daily basis

[38] "Many young people do not recognise common vegetables and have certainly never seen them cooked."

7.7.5 **Diseases attributed by the groups to poor nutrition:** diabetes, coronary heart disease, high blood pressure, obesity and arthritis.

THEME 4 - KEY LEARNING POINTS

- *There has been a loss of skills and knowledge across several generations in relation to home cooking*
- *Family practice of preparing meals no longer exists in many homes*
- *Many see low income as a barrier to eating healthily*
- *People do not know how to cook on a budget*
- *Processed food and supermarkets seen as the source of the problem*
- *People influenced heavily by advertising*
- *Older people are concerned about who will teach the young*

7.8 Theme 5

Attitudes to screening and access to primary care services

Participants were questioned about their attitudes to the provision of routine screening programmes and access to primary care services.

7.8.1 In all groups, female participants confirmed that they had all been invited to attend for cervical screening and those over fifty had been invited for mammography. As the literature review revealed differences in attitude to and attendance for screening, which depended on age and relationship status, an additional group of young women was invited to talk about their own feelings and behaviour in respect of the screening service.[39]

7.8.2 Attitudes to the cervical and breast screening programmes were discussed and participants were asked about personal attendance[40] for the services that were on offer and about reasons behind failure to attend for initial appointments or follow-ups. In most cases[41] women in the target age group said that had attended regularly (as often as they had been called)[42] but though they had attended and believed that opportunities for health checks should not be missed this was not the case for everyone and some women gave insight into poor attendance.

"I had cervical cancer, which was caught early because of screening but my sister won't go in case she finds out something is wrong."

[39] Discussion with younger women revealed differences in attitude: higher levels of embarrassment and fear and less understanding of the association between sexual activity and cervical cancer. Further work with younger age groups is required.

[40] The literature review (Cervical screening and colposcopy):4.3 Communication and Information suggests that attendance for cervical screening is better in older age groups. Nearly 60% of women in the younger age group 25 – 34 who had never attended said it was because they were embarrassed and uncomfortable about attending.

[41] Some (four or five across the groups) said that they did not attend any more as they had suffered with some gynaecological illness and had had hysterectomies and therefore had no cervix (so no risk).

[42] The literature review (Cervical Screening and Colposcopy) reinforces this result and (Page 4: 4.1 Para 8) suggests (Millet 2002) that uptake of screening is highest among married and separated women and (Adab 2003) in older age groups.

"Women avoid breast–screening because it is unpleasant. Either someone tells them about it and how much it hurts or they go once and don't want to have it done again."

"Waiting for the results[43] *is worse than the examination and being recalled is really scary."*

7.8.3 Two of the participants in the all female group said that screening had 'saved their lives. ' Mammography had revealed cancer in its early stages and both women had had a mastectomy, subsequent radiotherapy and drug treatment.

"I had a lump. I got speedy treatment when there was a real problem. I cannot complain at all."

7.8.4 Despite treatment for a malignant tumour, one of the women had continued to smoke and another said that she had been for a 'lung scan.' The scan demonstrated that her lungs were in poorer condition than would generally be expected in a woman of her age.

"It showed my lungs were [appeared to be] 10 years older than me. I'm 42. I've smoked since I was 16 (sometimes 60 a day) so I didn't think it was too bad. I expected it to be worse."

The news did not stop the woman smoking but she did reduce the number of cigarettes she smoked and she considered that this would help.

7.8.5 The provision of health services and support from health professionals were seen as important to ensuring good health was maintained and participants suggested that if services were poor and patients had no faith in the service then people were less likely to attend and health and well-being deteriorated as a result.

7.8.6 Some participants identified factors that made individuals reluctant to use services. One participant said that the language doctors used was sometimes a barrier to communication:

"If you do not understand the terms that the doctor has been taught it makes it difficult to explain things or to understand what the doctor is telling you."

7.8.7 Another participant commented that despite public information available in hospitals and surgeries about MRSA, doctors made examinations and often failed (to be seen) to wash their hands.

7.8.8 Groups were told that a high incidence in Hull of people missing GP and hospital appointments caused problems for both staff and patients and asked to comment on the reasons for the problem.

[43] The prolonged 'wait' for results, for both types of screening, was repeatedly seen as more difficult than attending for the appointment

7.8.9 Most of those who attended the focus groups said that they did not miss appointments and many could not understand why people failed to turn up when it was so difficult to get an appointment in the first place. Others however gave some possible reasons for non-attendance.

"I might forget because of my condition but the surgery rings now to remind me that I should be on my way."

"Doctor's hours are inconvenient and you might miss one because you are at work and you don't catch the bus on time."

7.8.10 Two, male participants admitted that they had missed appointments on a couple of occasions. They said that this was largely because they failed to make appointments at a convenient time.

"Sometimes you try to make an appointment because you are worried or because you don't feel well and the only appointment is for three days away for the following week. You take the appointment because you cannot get an alternative and then you might feel better on the day of the appointment or maybe you're working a few miles away and it might be impossible to get back at the right time. It takes so long to get through on the phone you can't be bothered to try all morning just to cancel it.

7.8.11 There was a suggestion from two of the groups that if appointment reminders and cancellations could be done by text message then a lot of the problems would be solved easily.

7.8.12 One man suggested that people who missed appointments should be charged by health centres in the same way as they are by dental practices.

7.8.13 Participants were asked whether they thought people in their area used health services wisely in terms of booking appointments and following advice

7.8.14 Discussion in some groups considered whether people were responsible about the medicines they were prescribed and most participants said that they were conscientious about taking medicines and completed courses of tablets as instructed. A number of people however said that if they considered that the doctor had not listened to them properly and issued a prescription they might ignore the direction to take medicine and not have the prescription made up.

7.8.15 One female participant said that she would probably ignore a problem for about six months before she went to a doctor as she did not like attending the surgery. She said that she had dealt with what she thought was a recurring 'water' infection for four years before she went to the GP. She found out that she was suffering with gallstones.

"I couldn't be bothered to go. Did not want to bother them."

7.8.16 There was almost unanimous enthusiasm in all the groups about the idea of a 'Health MOT" and participants were convinced that this would be an excellent development on the service. One man suggested that if an MOT

service was on offer it would be useful if men were encouraged to 'go with a friend.' He considered that this would make some people more likely to go.

7.8.17 Two participants (both male) were resistant to any sort of screening and one said that he had ignored a recent invitation to be included in a screening programme for bowel cancer.

"I got a bowel cancer test through the post. I think it was part of an experiment. I did not send it back. I do not want to know."

"I wouldn't ever go for screening, whatever it was for as I don't want to know. It is too scary!"

7.8.18 Participants were asked whether any of the services they needed were difficult to access.

7.8.19 Access to GP appointments was the most frequently identified problem and though, on the whole, participants were largely satisfied with GP services (once they had access) there were many difficulties reported in relation to booking of appointments, particularly in respect of early morning telephone contact with surgeries and health centres.

7.8.20 It was clear that for a minority of people who participated in the group discussion, their own attitude to health was affected by the attitude of health professionals to them. Some people felt that doctors failed to treat them as individuals and a number of participants felt that the introduction of a PC to the doctor's desk had created a barrier between the doctor and patient, reduced eye contact and inhibited proper communication.

7.8.21 Some described the dismissive attitude of doctors and one woman said that her GP refused to discuss her grandchild's health with her teenage daughter (the mother) and she always had to attend the surgery with mother and child if the child was unwell.

7.8.22 A number of participants said that if they left a surgery feeling that they had been a nuisance and that their complaint was treated as trivial, it made them reluctant to return and seek help and advice. One woman commented that a health visitor had once spoken to her as though she was stupid. It had an effect that was permanent and had prevented her from seeking help and advice from health visitors and nurses ever since.

7.8.23 One participant pointed out that in the evening, the closest casualty department was two bus-rides away and others agreed that if you needed urgent care in the area it was often difficult to access. The geographical location of urgent care facilities was a problem for many people who had no car of their own and were dependent on inadequate public transport.

7.8.24 There were a number of people across the groups who said that dietary advice[44] and support for weight loss was difficult to find unless you went to Weight Watchers or a similar organisation and there was a specific anxiety related to advice on diets for children.

7.8.25 Support for patients with mental health problems was considered to be in short supply and there was a request from several individuals for earlier access to psychiatric assessment

7.8.26 The greatest problem however, which was identified in relation to access to services was associated with dental care. Many participants said that access to national health dental services had become increasingly difficult in recent years. In some areas however, the situation had improved in recent months with the opening of new practices and the arrival of dentists from other countries.

THEME 5 - KEY LEARNING POINTS

- *People do not always understand what the doctor tells them*
- *Technology in doctors' surgeries has created a communication barrier*
- *Fear of screening is often related to fear of outcomes*
- *Older women are more likely to attend for screening than young women*
- *Messages from 'people like us' are best*
- *Doctors should check understanding of patients*
- *Use of new information technologies need explanation*
- *Patient understanding of the health service limitations needs improvement*
- *Communication for health professional could be improved*
- *Patients do not always take responsibility for their lack of understanding*
- *Transport to health services is a problem for low income families*

[44] The literature review (smoking, obesity, physical activity and alcohol) Page 12: 3.5 suggests that attitudes of health professionals to overweight people (Harvey 2001) are either neutral or negative and that negative attitudes increased with the level of obesity observed. Brandsma (2005) concluded that health professionals working with overweight people needed good interpersonal and motivational skills and that GPs (p13) have little enthusiasm for weight management

7.9 Theme 7

Attitudes to education and information

Opinions about information and education were mixed but for many the absence of the right guidance and support was seen as a contributory factor to the ill health of individuals

7.9.1 Most people considered that television was an effective way to get information out to the general public and on the whole. The TV documentary was regarded as being the most reliable source of information about health and health risks. Participants said that they watched a variety of things that provided information about health but not all the messages were good ones. .

"The programme about hydrogenated fats was really good. It made me look at labels so that I wasn't buying things that had HFs in them." (Female 40 – 60)

"Programmes on obesity make you more aware of over-eating and the need for exercise."

"Adverts about drinking are good. They show people what sort of things happen when you are 'leathered'." (Male 40 – 60)

"The smoking advert with the mother dying of cancer was good. That made you think!" (Female 40 – 60)

"Soaps are a good way to get messages across but they don't it enough. Bad people generally drink and smoke more than nice people but on the whole, people on soaps don't die of everyday diseases. It would be good if they did." (Female 40 – 60)

7.9.2 Programmes that some participants believed were designed to scare the public were not considered to be particularly useful

"Some things on the telly stop people paying attention. Health scares on the news like salmonella or BSE or bird-flu or wine is good for you one day and it isn't the next. They don't do any good because people end up not knowing what to believe at all." (Male 40 – 60)

7.9.3 It was suggested that reading leaflets and magazines might result in a temporary change in behaviour and but only things that affected you personally really made you think twice.

7.9.4 Other individual preferences for vehicles of communication included Radio 4, newspapers and magazines. For several participants, leaflets in public places were considered to be useful and several people said that cookery programmes, food labels and Weight-watcher sessions had been helpful to them. Morning chat shows, where health professionals gave advice on healthy eating had an impact on people across the groups.

7.9.5 Opinions were mixed in relation to the effectiveness of health messages provided by health professionals locally. Some people had changed their

behaviour after advice had been given at the health centre but others had been discouraged by previous experience.

"I don't go to the GP or the nurse for advice as they are not helpful or polite. If someone has a superior attitude you ignore the message."

" I altered my diet according to advice given after I had a cholesterol check."

7.9.6 One participant pointed out that there was insufficient help and advice for parents who were bringing up obese children and other people agreed that this difficulty was on the increase and additional education was required.

7.9.7 In the all male group some participants agreed that education about money management (budgeting) would be of benefit to many young people who failed to plan expenditure or resulting debt.

THEME 6 - KEY LEARNING POINTS

- *Good health messages can come in many guises*
- *Condescending attitudes undermine good health messages*
- *Advice and education on managing budgets would help some people*
- *Results of health checks can alter behaviour*
- *More guidance on diet and feeding children is required*
- *Mixed media messages create confusion and lack of confidence*

8 REFLECTIONS ON FINDINGS

Following completion of the focus groups a series of consultations were carried out with groups and individuals. The findings from the focus groups were presented to them as a series of statements and they were asked to consider them in the light of their own experience and knowledge.

8.1 Reflector group (volunteers community sector)

Over a dozen (15) individuals had responded to a letter (sent to community groups), which had invited them to take part in the study. A number of attendees represented special interest groups including and carers' association, a local neighbourhood forum, a group for eating disorders and a swimming club for the disabled.

8.1.1 There was broad agreement in the group that smoking, alcohol abuse and poor diet were the main contributory factors to the lowered life expectancy and higher incidence of preventable diseases in the city but some of those attending argued that the statistics were misleading. They suggested that

- high rates of 'young' migration from the city resulted in an older population than other cities so increased mortality was inevitable
- the disproportionate nature of Hull's inner city population meant that it should only be compared to similar cities[45]
- a lot of the population was still on 'shift work' and so social activity was inevitably more pub orientated than in other cities
- a lack of 'knowledge' about health contributed to the situation
- poor wage levels had an impact on health
- lack of ability to manage money was a contributory factor.

8.1.2 Participants of the reflector group agreed that people in Hull took risks with their health even though they were well aware of the possible consequences. They said that people took risks related to diet, smoking and alcohol for a variety of reasons, which included

- apathy – the reason that people did not cook was because they could not be bothered to cook. Healthy food was actually cheaper than processed food but took more energy and planning to prepare
- availability of fast food – Hull offered a lot of fast food through takeaways and food production companies and 'fast food' was now the staple diet
- lack of education - about cooking and purchasing good food
- access - to cheap cigarettes
- peer pressure – particularly from other young people who smoke and drink
- relaxation in legislation – extended pub opening times
- local culture – fishing industry culture established pattern of hard work and no access to leisure with short periods of heavy drinking and smoking

[45] Middlesborough was suggested as a city with which Hull might be fairly compared

- unemployment – people with no work smoke more frequently than those who go out to work
- happy hours – the offer of cheap alcohol encourages people to drink more particularly if you are unhappy in the situation in which you live

8.1.3 In general terms participants of the reflector group thought that Hull (residents) had little pride in itself and that living in Hull, in some areas in particular, had a negative impact on health. They agreed wholeheartedly with the findings from the focus groups that the neighbourhood (and neighbours) could have an effect on personal and family ambition and on stress levels.

8.1.4 The breakdown of families and the loss of extended family support was considered to have had a severe impact on how people managed their own lives and how they responded to health risks and lifestyle choices. The existence of role models: people who know how to cook; people who are good parents; people who acknowledged the value of education and training; is a necessity if the apathetic attitude of the population towards their long-term health is to be altered.

8.1.5 The reflector group was generally sympathetic with focus group participants who lived some distance from primary care services in areas where public transport was insufficient to meet the needs of the population. Linked to this general observation, one contributor said, that in the area that he represented, the existence of several homes for the elderly, the influx of refugees and the number of residents in local supported living hostel/flat accommodation meant that primary care services were insufficient for the needs of the population. The health centre was inconveniently situated, poorly served by the local bus service and difficult to access, particularly for older people, and this meant that some people failed to attend for review appointments and often did not go to the doctor when they were ill.

8.1.6 The group agreed that the management of GP access had to be more focused on the needs of the patient both in terms of appointment bookings and attention and respect for patient needs. One reflector group participant commented specifically on the time it took his GP to enter correct coding information to his PC and the impact this had on the quality of the consultation.

8.1.7 Service gaps identified by focus groups were agreed by reflector group participants although the participants suggested that the PCT was 'listening' more than it had appeared to do in the past and services were improving.[46] One participant said that carers needed for support from primary care and another said that there was no local service for people with eating disorders.

8.1.8 The reflector group participants thought that improvement in services could be achieved by increasing the number of health centres, addressing

[46] Specialist dentistry services had become available recently

primary care 'black spots,[47]' building the self-esteem of the population, improving education and access to information, teaching parenting skills to fathers as well as mothers, providing education on diet, cookery and fitness and encouraging different services to 'speak' to one another.

8.2 Professional interviews (practice personnel)

Health Centre and GP Practice staff participated in follow-up interviews, which also considered the main outcomes and themes of the study. Discussions were based on consideration of a series of statements and associated questions. Interviewees included Practice Managers, Practice Nurses and GPs

8.2.1 **Main factors that affect health**: Interviewees concurred with many of the factors which focus group participants believed had an impact on the long-term health and acknowledge the wide range of environmental and socio-economic factors that were identified by the groups.

- Several interviewees identified low income as a factor and practice managers identified housing, employment, and a lack of hope for the future as possible contributors to poor health.
- One of the GPs interviewed however said that he thought his patients lacked awareness of the factors that impacted upon their long-term health. He suggested that the state had to take more responsibility for health education and that this should be approached at a 'generational' level.

8.2.2 **Range of preventable diseases**: The range of preventable illnesses and conditions identified by the focus groups was confirmed by the interviewees who provided a comprehensive list which included

- Obesity
- chronic obstructive pulmonary disease
- heart disease
- circulation problems
- cancer.
- Only one interviewee (a practice manager) mentioned depression as a preventable illness.

8.2.3 **Main causes of preventable disease:** Interviewee opinions on the causes of disease corresponded with those of the focus groups

- Smoking was the main cause of preventable disease
- There was an acknowledgement that people knew the dangers and some patients were anxious to let health professionals know that they 'did not smoke in front of the kids.'
- Three of the interviewees identified obesity as key cause of illness and suggested that people were increasingly overweight because they lacked knowledge.

8.2.4 **Attitudes to risk:** Attitudes to risk, health and lifestyle choices varied enormously across the areas.

- A nurse said that though some people were proactive in making a difference others maintained that smoking and alcohol were the only things that made life worth living.

[47] Some areas were less well served than others in Hull

- A practice manager suggested that a change in attitude should start with the younger age group so that they were discouraged from developing a pattern of risky behaviour. She recommended hard messages through mass media channels and a more open dialogue and social involvement between health professionals and families, which would reduce levels of anti-social behaviour and problems with drink and drugs.
- Others interviewed said that the more affluent an area, the better the exercise levels and the more healthy the diet.
- It was suggested by one interviewee that the target age group made very little use of knowledge provided as they lacked motivation and purpose
- Another said that the reason for this was the complete hopelessness of (their) the situation. She said that they had nothing else to live for and if everyone was in a mess, why should they resist having a bit of fun, be it sex, smoking, drinking or drugs.

8.2.5 **Altering behaviour:** A lack of education was held to be responsible for some of the 'careless' attitudes to health, particularly the effects of smoking.

- Education was needed from an early stage in life and it had to be everywhere. Cardiac road-shows and anti-smoking campaigns and events in supermarket car parks were suggested[48].
- A nurse said that smoking cessation classes were not sufficient and that doctors were reluctant to prescribe cessation aids as they cost too much money[49]. She considered that GPs needed further education and had to realise that patients needed back-up and ongoing support if they were to be successful.
- A GP championed the approach to smoking in Hull and said that the smoking cessation service was good right across the city. At his practice they used behaviour modification, counselling and drugs. He said that patients complained that they could not get exactly what they wanted but it was pointless to prescribe 'indiscriminately' and the situation could be difficult if a patient had seen or heard about a new drug that was not yet authorised.
- Other professionals confirmed said that smoking cessation was promoted constantly, even over the telephone and agreed with focus group contributors that willpower was the main determinant in success and one to one support could be extremely valuable.
- One practice had introduced big screens in the foyer to make health messages more noticeable.

8.2.6 Interviewees agreed that changing attitudes and lifestyle had to be done slowly in areas where there was little future aspiration and where people lived for the present

- A GP said that he was 'disappointed' that people did not use their knowledge to improve their situations. He suggested that most of his patients were 'happy' to 'live like this' and there was nothing more that could be done. He said that his patients gave many excuses for their

[48] The literature search (smoking, obesity, physical activity and alcohol) Page 5: 2.2 Smoking prevalence; suggests (Roddy 2006) observed a general lack of awareness and knowledge of smoking cessation services

[49] A number of initiatives are taking place in the community and this observation may demonstrate a lack of awareness among doctors and nurses of the range of interventions that are available

behaviour and that a sense of responsibility was lacking. They had 'no jobs, no motivation and nor role models.

- One of the practice managers said that behaviour would only be altered by the availability of more employment and training opportunities to give people hope for the future. She asked whether there was any need to be fit and live to a ripe old age if you had nothing to look forward to.

8.2.7 **The reasons for poor nutrition**: Like participants of the focus groups, professionals interviews had mixed view about why people ate a poor diet.

- Both nurses and practice managers interviewed said that it was ignorance, not low incomes that resulted in people eating badly although it was often perceived as a financial problem.
- A GP said that education was the key to good nutrition; he refuted the idea that financial difficulties were a factor but affirmed that social conditioning was difficult to undo.
- Interviewees said that health professionals were giving out the right information but the '2 for 1' offers at supermarkets and celebrities[50] promoting processed food from low-price supermarkets were more persuasive messages.
- Many agreed that the majority of young people did not know how to roast meat or make a simple stew and some agreed with focus group participants that diets had declined because families no longer ate together.
- Interviewees pointed that there was no domestic science available in school any more and education had to practical not theoretical.
- On the whole, the shopper in the area is looking for quick, easy things to eat

8.2.8 Attitude of health workers to patients: Interviewees had mixed views about the criticism of some focus group participants about the poor attitude of health workers to patients

- A nurse agreed that GPs and nurses sometimes failed to respect the level of understanding of their patients because of communication difficulties. She said that people in the health service were often from different social groups and did not always fully understand the people they were dealing with or the cultural situations and social problems they faced. There was a need for better training and education internally.
- A GP said that he had heard of people criticising the attitude of health-workers to patients and said that poor attitudes were common in all work-places and that they were a facet of human nature. It should be something that is addressed in each practice and the need for change taken on board internally.
- A practice manager agreed that some reception staff were really 'bad' but suggested that patients often acted as though they were in a high street supermarket[51] and wanted instant 'check-out' services. She pointed out that patients had high expectations and when they hear of a new drug such as a new smoking drug or a slimming pill they come in demanding or expecting it when it has not even been licensed.
- Another practice manager defended her peers. She said generally people were shown respect but often they approached the service when they were

[50] Kerry Katona and Iceland were referred to by the speaker
[51] Kwiksave was referred to by the speaker

in a ‘poor frame of mind’ and on a ‘short fuse;’ they wanted ‘to feel better’ and saw practice personnel as a barrier. The perception of the “gate keeper” she said was often gained in a practice where the personnel were simply ‘following doctors orders.’ She thought that the public lacked knowledge about people’s roles and responsibilities but did not know how to resolve this problem.

- Another interviewee said that doctors and nurses became impatient with ‘time-wasters’ as they had a negative impact on those that really needed attention. She agreed however that part of the problem could be addressed by good staff training.

8.2.9 **Appointments and access to care**: Questioned about access to primary care, interviewees expressed a range of different opinions.

- Nurses agreed that sometimes it was difficult for patients to get GP appointments and suggested that the expansion of triage systems would help to resolve the situation.
- A number of interviewees said that that there were still ‘a lot of the old school receptionists’ who tend to protect the doctors and have no real thought for the patient’ and a cultural change was required to ensure that this situation did not continue.
- A practice manager said that though she had some sympathy for the patients’ views there was a workload / capacity issue of which patients were usually unaware. Annual patient surveys demonstrate that in particular practices there were no real problems but even in the best practices constraints on the service are caused by a lack of resources and the necessary management of many inappropriate calls that require handling and appropriate redirection.
- One of the GPs accepted that telephone access was a problem. He said that he was generally unhappy with the situation but explained that although the practice could install another 10 lines they could not appoint 10 members of staff to deal with the calls. He sympathised with patients who wanted to talk to him immediately but said that he was always prepared to call a patient back.
- Interviewees said that many improvements were being made and one practice had already invested in additional lines. There were suggestions that a central, less personal system would probably resolve some of the issues raised in the focus groups.

8.2.10 **Screening / health checks / missed appointments**: Interviewees were asked to consider the problem of DNAs and general patient responses to screening and healthchecks

- Interviewees did not accept that problems with telephone access were connected to an increase in DNAs
- A nurse suggested that there was a correlation between appointment attendance and the weather.
- A GP reported that DNAs were a big problem and was most concerned about the amount of nurses’ time that was wasted. He said that this was a bigger loss than the doctor’s time as nurses often scheduled 25 minutes for an appointment. He suggested that on most occasions there was no genuine reason for failure to attend and very few people were courteous enough to ring up and cancel.

8.2.11 With reference to attendance for screening, one of the GPs said that getting people to attend was a problem.

- The practice 'pestered' people to attend for 'smears' but patients did not want to be pestered. He thought that there was limit to how much a GP should intervene but considered that one to ones with the practice nurse would help get the right messages across to the public.
- One of the nurses interviewed thought that patients did not take all screening appointments seriously and she pointed out that there was a high incidence of DNAs for asthma reviews and she suggested that nurses could predict who would fail to attend.
- Her opinion was supported by a practice manager from another area who said that asthmatics were offered good support but only came to surgery when they were 'badly.'
- There was an opinion held by some interviewees that some patients continue to abuse the health service and that surgeries often ring patients to find out why they failed to attend. Most people just say that they forgot.
- One practice was sending letters to repeat offenders that carried a warning

8.2.12 There was general agreement among nurses and practice manager that there would be a good 'turn-out' for routine screening and practices had once tried them out in the past (eg. well-man clincs).

- Nurses and practice managers pointed out that some of the chemists offer routine checks for diabetics and that practices took referrals from this source.
- A practice manager said that at her surgery there was an initiative to get all over 40s in for blood tests.
- A GP however was not enthusiastic about routine screening. He observed that it was a 'pointless exercise' and regular screening would increase difficulties. Cholesterol checks should only be done in the morning and are inaccurate if done at the wrong time or if the patient has insufficient information. Abnormal/raised blood pressure checks would have to be repeated frequently. This rechecking happens after general checks at appointments and work-load would be increased further in the future.

8.2.13 **Education and information:** In general, health professionals favoured 'big' messages through TV and popular culture to deliver health information.

- There was general agreement that 'soaps' were an influential medium for health guidance and a nurse remembered 'when Alma Baldwin missed a smear test and was diagnosed and died of cervical cancer.' She said that the practice had an 'influx of patients asking for a test.'
- Others agreed that some TV was 'very powerful' and could be use more to get messages out about teen pregnancy, STDs, obesity and smoking levels.
- Adverts for slimming products were considered to be less useful as the message needs to be relevant to the target group and people locally are more likely to relate to Coronation Street's Janice Battersby who dropped to a size 10 while appearing on the soap.

- Expensive women's magazines were regarded as too expensive and if it was 'a toss up between a few magazines and a packet of fags' there was no contest.
- Three of the interviewees believed that big TV campaigns were the ones that had real impact; a GP and referred specifically to the HIV/Aids campaign that had 'awoken the nation' to risk very quickly and a practice manager referred to a strong story-line in EastEnders that had supported the campaign messages.
- Large screens and hard-hitting videos were the answer for one practice manager.
- There was a need identified for patient education to reduce the number of unnecessary, time-wasting visits to the doctors. A nurse suggested that an improvement of knowledge of common remedies and use of pharmacy services would reduce the pressure on practice staff and allow more time for people who were ill.

8.3 Reflector interviews (individual focus group particpants)

A series of one to one face-to-face interviews were conducted with volunteers from the focus groups. There were no new findings reported and the interviews served to confirm that the focus group discussions were valid in the eyes of individuals who participated.

9 CONCLUSIONS

9.1 Understanding and attitudes to personal responsibility

The study revealed that the majority of people who agreed to take part in the study had high levels of understanding in respect of personal health. They demonstrated broad knowledge of the factors that contributed to disease and reduced life expectancy and were able to identify a wide range of preventable illnesses and conditions and relate them to specific causes.

Despite high levels of understanding, there was a noticeable reluctance from many individuals to take full responsibility for control and management of personal risk. Many participants accepted the risks of smoking, drinking and poor diet as elements of the local culture and a number of participants suggested that, despite the abundance of health messages, it was events 'close to home' and personal health crises that made them think seriously about changing their behaviour.

- There was a clear tendency to identify and hold responsible a variety of other factors that caused (or at least contributed towards) high incidences of smoking related illnesses. Other identified causes for illness and disease (accepted widely as attributable to smoking) included environmental and occupational pollutants, high levels of stress, local culture, availability of cheap cigarettes and a lack of choice in terms of cessation treatments and support.

- Illness and conditions (including obesity and diabetes) that are generally associated with poor choice of diet were considered as inevitable consequences of situations people faced. These included the inability to afford and/or source fresh fruit and vegetables, the lack of skill and/or time required to prepare food properly and the impact of advertising, availability of convenience foods and the proliferation of fast-food outlets

- Alcohol abuse was related to social problems by many members of the groups but accepted as a permanent feature of the local culture. Participants agreed that the problems were increasing, particularly in younger age groups and exacerbated by the availability and aggressive retailing of cheap drinks. Few people seemed likely to reduce their intake because of health risks.

- Though information, through the media and through health channels was clearly increasing knowledge and understanding there was an indication that personal experience and family tragedy had more impact (both negative and positive) on health behaviour. There was a clear requirement for personal and community education and timely intervention to strengthen the messages and one to one support to help change attitudes to risk and encourage a more responsible approach to personal health.

9.2 Access and attitude to services

The majority of people who agreed to take part claimed a responsible attitude to their use of health services and, across the target age group, reported a good uptake of screening services and a low incidence of non-attendance for health appointments. It is necessary to consider in this respect that though recruitment to the groups was random the likelihood of recruiting the disinterested and the irresponsible is low and therefore the findings of the study, in respect of missed appointments should be treated with caution.

9.3 Additional outcomes

Though not a focus of the study, the participants in all groups expressed high levels of concern about the health risks of young people and in many circumstances they considered that these were of more importance than the risks they ran themselves. Areas of concern for young people expressed across the groups included problems related to

- sexual behaviour: STDs; diminishing gene pool; under-age pregnancies; lack of sex education
- diet: inability to shop and/or cook; inability to budget; lack of knowledge
- alcohol: teenage drunkenness; ASB; links to sexual activity

10 RECOMMENDATIONS

10.1 Theme 1 – Environmental: As outcomes of the study suggest that tenant monitoring and care of the local environment are issues that are important to local people, it is recommended that this should be explored further with local authority area teams.

10.2 Theme 2 – Socio-economic: It is recommended that via One Hull Partnership arrangements local perceptions of postcode discriminations in relation to employment should be explored.

10.3 Theme 5 – Health screening and health-checks: The study revealed little about the high incidence of missed appointments and it is recommended that additional work is carried out and that this is targeted specifically at individuals with a history of non-attendance for health screening programmes and/or recalls. It is recommended that:

- Follow-up work should concentrate on non-attenders for colposcopy and breast screening recalls.
- A particular focus should be on targeted young women (25-35) who have demonstrated unreliable patterns of attendance for cervical screening. Further study should consider:
  - Reasons for high risk sexual behaviour.
  - Levels of understanding of risk.
  - Reasons for low/non-attendance for screening.
  - Reasons for non-attendance at follow-ups.

10.3.1 Primary care: It is recommended that:

- Using the knowledge of locally based health care professionals, further action is planned to reduce the frequency of missed GP appointments in primary care situations.

10.4 Theme 6 – Education and information: It is suggested that education remains the most important element in changing attitudes and behaviours and that the manner in which health information and guidance is delivered should be regularly reviewed and its efficacy monitored. In light of the study it is recommended that:

- Investment in the development of positive community role models is extended and that the impetus is for individual and community education is channeled through a 'people like us' approach.

- Local groups[52] (a public health one stop shop approach) are established to ensure development of understanding about health, nutrition and practical teaching of basic cookery. These should be made widely available in the localities and a framework for inter-generational learning about weight management, budgeting, shopping, cookery innovation and exercise programmes should be developed and managed in the localities.

[52] Programmes already in place are being developed and managed by PCT provider services.

- Consideration is given to opportunities for working with patients and their families at crisis points in the lives of individuals and that opportunities for multi-agency interventions are considered.

- Additional education of patients should be designed to improve understanding and use of primary care services. This education should seek to alter the belief that the intrusion of new technologies is detrimental to the relationship between patient and doctor and to ensure a broader understanding of the use of the computer screen during consultations, the role of the GP outside the doctor's surgery and a greater insight into how primary care services are managed and delivered.