Sixteen Hands

FINAL REPORT

NHS Sheffield

Improving the nutrition and oral health of vulnerable and at risk older people (aged 65+)

Stage Two Research and Final Recommendations

Contact

Philippa Lark
Sixteen Hands Ltd
Round Foundry Media Centre
Foundry Street
Leeds LS11 5QP

T: 0113 394 4365
E: philippa@sixteenhands.co.uk
W: sixteenhands.co.uk

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1. Executive summary

This project is divided into two stages. The first stage focused on gaining insight from the voluntary sector and HCPs, who have depth understanding and regular contact with the insight audience.

This second stage has focused on engaging with the insight audience itself, in two geographical areas as agreed with NHS Sheffield on 4 June – isolated older people in Totley and Dore and older members of the Pakistani community in Darnall.

This final report sets out the detailed findings of the Stage Two research, draws overall conclusions and makes recommendations for an approach to social marketing interventions based on the findings of both stages of work, related to our overall objective:

To change the shopping, cooking and eating habits of frail, housebound and vulnerable older People, in order to help them stay in good health.

Stage 2: Objectives

1. To understand the key factors that have a significant impact on the nutrition, oral and dental health of two communities – older, isolated people in Totley & Dore and older members of the Pakistani community in Darnall.

2. Establish the most appropriate and potentially effective channels for communicating with older people about their nutritional and oral health needs.

3. Understand the key issues and barriers to behavioural change.

4. Make recommendations on the scope of a social marketing programme with the objective of improving the nutritional and oral health of older people living Sheffield.

Key recommendations

- *Develop an integrated 'service pull' and 'customer push' strategy*
  – 'Service pull' – develop a scheme that will help people identify those at highest risk, which can be implemented through existing channels across the range of service providers (HCPs, carers, community organisations / voluntary / charity workers)
  – 'Customer push' – at a community level, educate 'meal providers' and older people about the importance of oral health and a healthy diet. Focus on how they can change what they do to improve diet and oral health. Make it fun and social to motivate.

- *Develop the intervention through a pilot study*
  – The barriers to behavioural change differ across different segments of older people. Therefore criteria for evaluation and success need to be tested and the 'optimum' intervention developed. Resources are also limited, so measuring effectiveness is key.

- *Review the current marketing of the Dental Helpline*
  – Whilst this is not a quantitative study of awareness levels of the Helpline, this project does raise questions about the effectiveness of the current activities publicising the Helpline to older people and to those who care for them.

Summary of findings – primary insight audiences

Themes	Audiences		Possible elements of the 'marketing mix'
	Totley and Dore	**BME**	
Current diet	Generally eating a healthy and balanced diet. Home cooking repertoire is varied and primarily made from scratch, very limited use or ready meals and good supply of fresh fish and vegetables. Some single men need help – they have little experience of food preparation or balanced diets – fry-ups or fish and chips are commonplace.	Still eating a very traditional diet of curry and chapatti. Wives do all cooking from scratch. No advice on how to make their own diet healthy. Would like their wives to know how to make a 'low fat' version.	Cookery school, sample menus, cooking tips for recently bereaved men. Community cookery classes for Pakistani women - demonstrate how to make 'low fat' but traditional Asian food.
Access	Have the means to purchase healthy food and access high quality, local food outlets. None are able to shop outside the village without help, although about half use scooters around the village. Most public transport is inaccessible. Tesco runs a bus but have to get a taxi back as can't carry the bags. Majority depend on family or carers to shop for them. No one accessing the internet for home.	Price is a real issue, especially cost of fresh fish and vegetables. Physical access to food is not an issue – wives purchase locally from Hallal butchers and Asian greengrocers.	Improvements to public transport. Increased support of community transport. Supermarket pick up and drop off. Nutritional information for carers – are they purchasing a healthy shopping bag?
Health awareness	Aware what a healthy diet comprises and 'five a day'. No mention of sugar intake or age related diabetes	Generally aware of the principle of a healthy diet but unwilling to change traditional menu. All very aware of the link between a diet high in sugar and diabetes. Many felt that there was some degree of inevitability and they would get it anyway due to genes.	Still some work to be done on age related diabetes – health-related advice needs to come from GP for BME groups.
Oral health	Most have a dentist, of which about half are NHS dentists. However many have to travel to get to their dentist and this is difficult. Less than half are go regularly and many have not visited in the last 10 years. Denture-wearers do not see the need. Ill-fitting dentures have an impact on diet.	All find it difficult to get an appointment and the experience is poor – especially for emergency treatments. Average wait is 1 – 2 months. They all felt that Darnall has a particular problem, as dentists are foreign, they can't understand them and find them quite arrogant.	Need to communicate availability / accessibility of NHS Dental Services more effectively and the importance of oral health, particularly for denture-wearers.

	No recall of information on oral health but half have not visited the dentist in the last 10 years.	Lack of knowledge of those with dentures on good oral health. Understanding that you should see a dentist every 6 months, but objected to paying £15/16 a time just to be looked at. One man said he avoided the English dental system and had his teeth looked at every year when he went to Pakistan.	
Sphere of influence	Most don't read the 'Sheffield' paper but instead read Telegraph, Daily Mail, Express or Yorkshire Post. Do however read the very local press i.e. 'Dore to Door'. Notice board in village shop also useful. Around a third listen to BBC Radio Sheffield. Rarely take public transport so outdoor limited. Luncheon clubs main social interaction points, some members of Towns Women's Guild etc. All have carers and most have family, some contact with social service if they have had a hospital visits.	Any health messages/ initiatives must be delivered through the community network and / or GPs. Mosques would play a very important role in distributing information. Also felt that community centres, libraries, dentists, doctors and pharmacies would be good places. Very important that all messages would be delivered verbally as they feel that there is low reading and writing skills amongst their peer group.	Communication required at a micro community level i.e. community centres, lunch clubs, local community newsletters, places of worship etc. Very limited 'commercial' media opportunities.

Summary:

The older residents of Totley and Dore do not appear to have significant nutritional health problems, but access to dental services could be improved and for denture-wearers, this is affecting their diet. Whilst there is some evidence of very isolated older people who may be in need of support, this did not seem to be very prevalent. One exception in this community seems to be the need for widowers to receive help and advice about meals and diet. Findings from stage one would indicate that the more deprived communities of Sheffield have greater need.

In Darnall, the older members of the Pakistani population appear to be well looked after by their families and community. However, there is a real need to provide the women of these communities with practical and accessible help in preparing healthier meals at a realistic cost. In addition, access to dental services seems to be very poor.

Both communities expressed a strong desire for more community facilities, as the social interaction is a key motivator. This was also a key finding from stage one of this project. Commercial media opportunities are very limited across both segments.

2. Methodology

The second stage of the insight project was conducted using qualitative methods. In addition, some desk research has been done to augment the findings in order to make recommendations on developing a social marketing intervention structured to meet our overall objective.

One-on-one interviews and group discussions were held with the following people / organisations:

- Pakistan and Muslim Centre, Darnall – Mr Malik, Community Worker
- Asian Elderly Caring Society Lunch Club – 22 males, aged 60 plus (majority 70 plus)
- Open Door Luncheon Club, Totley and Dore – Maureen Cope, co-ordinator
- Open Door Luncheon Club, Totley and Dore – 15 attendees, male and female aged 80 plus, many with some disability and most aged over 90 years

Desk research

- POPPS Community Portraits, Darnall (Neighbourhoods & Community Care Directorate, Sheffield City Council)
- TGI analysis of media channels applied to an over 75's age profile
- The Dental Health of Adults in Yorkshire and the Humber 2008 (survey results)

Additional HCP interviews

- Meeting with Kate Jones and Zoe Marshman – Directors of Dental Public Health

3. Detailed findings

The findings are structured around the four objectives of this stage of work.

Objective 1: To understand the key factors that have a significant impact on the nutrition, oral and dental health of two communities – older, isolated people in Totley and Dore and older members of the Pakistani community in Darnall.

Totley and Dore

Current diet – participants were largely aware of the government's '5 a day' message and were generally eating a healthy diet with a good supply of fresh fish and vegetables. Many of the women interviewed were 'scratch' cooks and there was little evidence of usage of ready-made or convenience foods. However this was not necessarily the case for single men (see below).

Gender – some single men struggle with a healthy diet, although they may be aware of the importance of '5 a day'. They come from a generation whose wives provided the family's meals and so have little experience of food preparation. There is evidence that some of these men are overly reliant of fry-ups and fish and chips – in some cases there was a low level of understanding about what constitutes a balanced diet and why it's important.

Isolation (and pride) – Totley and Dore is an affluent area so there are no real issues with poverty. However, there is a feeling that some older residents may prefer to remain at home, rather than admit to needing support and help. All the participants had carers.

Resources and support – there are four lunch clubs in the area and it is estimated that about a third of members regularly attend one or more of them. However, local volunteers are aware of older people in the community who may be in need of support and help. If someone is identified they will try and make contact, but this is ad hoc. Moreover, there is a waiting list for the lunch clubs suggesting that the volunteers cannot keep up with the demand. There is also a lack of volunteers. The primary reason for attending is social.

Shopping / access to food – Totley and Dore is well supplied with high quality local food outlets. There are two fishmongers, a baker and a green grocer who delivers to the doorstep. Even though none of the participants were able to shop for themselves outside the village, the proximity of good quality local shops and the ability to pay for quality there meant access to good food was not too much of a problem. About half the respondents had scooters so were able to shop for themselves, the remainder were largely reliant on carers and / or family. Shopping outside Totley and Dore is not easy for the older population as public transport is inaccessible and they don't use the Tesco bus, as they can't carry the bags home. No one used the Internet, but felt that this might be important for the generation below them.

Dental care / oral health – most had a dentist and around half are on the books of an NHS dentist. However many have to travel to see their dentist, which means they are reliant on others to help them do so. Less then half go regularly and a significant number had not been for over 10 years. There was also evidence that ill-fitting dentures are having an impact on diet and for those with dentures, there was a lack of awareness of the importance of going to the dentist. No one recalled seeing information on oral health.

Pakistani community – Darnall

Current diet – curry and chapatti is the main diet of all the men in this group. They don't want to change their diet, but are interested in how their wives could make a healthier version of it. They were all aware that what they eat is fattening. They recalled no advice on how their diet could become healthier, despite being very much aware of the '5 a day' campaign. This is because they don't feel that the levels of benefits are sufficient to sustain this and that it would mean change to their traditional diet. However, all were very aware of the link between a poor diet, high in sugar, and diabetes. Many had a fatalistic attitude towards this, feeling that their genes would mean that it would be inevitable. Some saw it as a 'British' problem that doesn't exist in Pakistan.

Unprompted they commented that exercise should be discussed whenever diet is. They have a passion for swimming and sauna but felt that racial stereotyping was taking place at their local facilities as they all get asked repeatedly by staff to take a shower before bathing (which they do anyway).

They very firmly see the sauna as exercise. Feel it is cost prohibitive at £5.35 for a swim and sauna and feel that swimming should be heavily discounted for the over 50s (over 65 is too late to start).

Gender – the preparation of food is done by the women. The men were concerned that information about diet and healthy eating was not reaching their wives. In addition, they felt that provision for women was poor – funerals are looked forward to as they provide an opportunity to socialise. If a wife or female family member becomes ill, she can go for weeks without seeing anyone.

Affluence levels – all of the respondents felt that to eat healthily would be more expensive. They believe fresh vegetables and fish to be beyond their means. In addition, they felt that they live 'two lives' – supporting their families in the UK and back in Pakistan, where they are seen as relatively affluent.

Isolation – the men felt isolation not to be an issue in their community and could name the actual instances of an isolated individual (just two) and also how they had informed the 'authorities' but little had been done. However, they did express concern about the isolation of women (see Gender, above). Their close-knit community structure is the main reason that isolation is not seen as an issue. Their families care for the majority of older people – it is seen as a responsibility and a mark of respect. You would be disgraced if you didn't look after your older relatives. There was also a sense that social services, NHS etc, recognise this and use it to their advantage – "we don't need to support them as the family/community will". This is born out by comments from Dental Public Health, who felt that the ethnic minority groups have much better family networks to enable them to look after their health, even if they are adverse to traditional routes of clinical engagement.

However, there were real concerns that the next generation will not be so willing to provide the same level of support – that there is a cultural shift to the ways of the 'west'. This was manifest in concern for the future (next 10 – 15 years). All are worried by this problem and felt very pessimistic about the future.

Some individuals felt comforted by their desire to return to Pakistan, as they got older. However this was felt by many to be a pipe dream and they recognised the need to start preparing for reality.

Resources and support – they all felt the provision of day care centres to be inadequate and that these should play a very important role – they also felt specific provision is needed for women. The men would be happy to have culturally mixed centres, as long as their cultural needs were addressed. They commented that white Christians had pubs and social clubs, but there was no equivalent for their communities.

They are generally fed up with the NHS 'everyone matters' mantra – they take part in lots of consultation and never see anything change or the final reports and recommendations.

In addition, there was a belief that there was much more 'professional' help for people with physical disabilities than for lonely isolated people.

Shopping / access to food – they do not do the shopping as this is the job of the women and they are provided with food they like by their wives so. However, as noted in diet above, there is a strong perception healthy food – fresh vegetables and fish – is too expensive.

Dental care / oral health – All felt that access to the dentist is very poor. They find it difficult to get an appointment, especially for emergency treatments and that the average wait for an appointment is 1 - 2 months.

They all felt that Darnall has a particular problem with dentists because they are all foreign and they can't understand them and they find them quite arrogant.

The general perception was that you should see a dentist every 6 months, but objected to paying £15/16 a time just to be looked at.

One man said he avoided the English dental system and had his teeth looked at every year when he went to Pakistan.

They also felt similarly about access to GPs – that it takes too long and that they found the receptionists most unhelpful. Their biggest frustration was the difficulty of actually getting through to make an appointment. They preferred the system of a few years ago when you could just go in of a morning and wait (maybe an hour) to see someone.

For both GP's and dentists they feel that supply hasn't kept up with demand in Darnall, as the population has exploded (due to immigrants – both eastern European and Asian)

Objective 2: Establish the most appropriate and potentially effective channels for communicating with older people about their nutritional and oral health needs.

Pakistani men – Darnall

Any health messages/initiatives must be delivered through the existing community network, in which Mosques play a very important role for the dissemination of information. They also felt that community centres are important (despite the need for more of them – especially for women), libraries, dentists, doctors and pharmacies would be good places for information. They also said that it would be important that all messages should be delivered verbally as they feel there are low reading and writing skills amongst their peer group. Important information about health (e.g. diabetes) needs to be delivered by GPs as only they have the respect and authority.

Isolated older people – Totley and Dore

The vast majority do not read the 'Sheffield' paper as they find it too depressing. They generally read the Telegraph, Daily Mail, Express or Yorkshire Post. They do however read the very local press i.e. 'Dore to Door'. They also find the notice board in village shop useful (around half are mobile around the village). Some listen to BBC Radio Sheffield (around a third) and they rarely take public transport, as it is not accessible. The luncheon clubs are their main social interaction points although some are members of other organisations such as the Towns Women's Guild. All have carers, the majority still see family, and some have contact with social services, especially if they have had hospital visits.

Provision of information about dental health

None of the target audiences had seen or heard any information about dental health or access to dental care. There appear to be a number of reasons for this.

Changes to the dental contract in 2006 have made it less financially rewarding to visit homes. In addition, the kits dentists need for in home treatment are very specialised. This is exacerbated by the fact that people who live in their own home very often want to keep their own dentist, but only some have dentists that are prepared to do home visits.

The oral health promotion team's role is to train the carers in care homes – aimed to be an annual training in 70% of the homes. This means that those living at home alone seem to be falling through a gap of information and (judging by their self-confessed infrequent visits to the dentist), service provision. This is also reflected by the fact that older people are the least regular attenders of dentists and difficulty getting to a dentist is sited as the problem.

Awareness of NHS Dental Helpline

This is now operating and as there is capacity in the system, there is (in theory) no need for anybody to be without a dentist. However, we believe that capacity in the system does not necessary mean dental services are accessible and we believe that this, combined with poor awareness of the importance of dental health – in particular denture wearers – is a key issue for our target audiences.

Campaigns to promote the helpline are running in pharmacies, libraries and the local paper, as well as on Age Concern's website. This activity has resulted in increased calls to the line. However, none of the individuals accessed in this study were aware of the Helpline, despite

Dental Public Health stating that they have an express aim to promote the Helpline specifically to the older audience and their carers. It must be noted that this is a small sample so this may not be representative of the wider older population in Sheffield.

Media analysis (TGI – Target Group Index surveys)

Media consumption – over 75s

- Higher than average TV consumption, particularly day time and early evening
- High newspaper readership with two thirds reading one every day
- Telegraph, Mail, Express and Mirror index well
- High local free sheets consumption
- Low magazine consumption
- Internet very poor
- Lower than average radio consumption but BBC radio average.
- With the exceptions of bus interiors, lower than average exposure to outdoor and ambient media

Implications – due to their age, isolation and cultural considerations, our target audiences consume limited commercial media. When we take into account the very tightly defined geographical areas we are targeting, the potential cost-effectiveness of the channels our audience consume has to be questioned. The possible exception to this is the local press, but in terms of changing behaviour (as opposed to awareness of a healthy diet) this has limited scope as a 'solus' media channel. In addition, we would also question the effectiveness of the channels currently being employed to communicate the Dental Helpline to older audiences. For example, promoting the helpline on the Age Concern website is unlikely to reach the target audiences themselves as they do not use the Internet.

Importance of carers

For many older people carers potentially play a very important role in helping meet our objectives. They are a 'channel' for information and they shop and cook for the people for whom they care. The importance of carers has been recognised by the Dental Public Health team and interviews with HCPs and other stakeholders during Phase 1 also demonstrated their importance. Carers can be professional or can be voluntary / family members.

Objective 3: Understand the key issues and barriers to behavioural change.

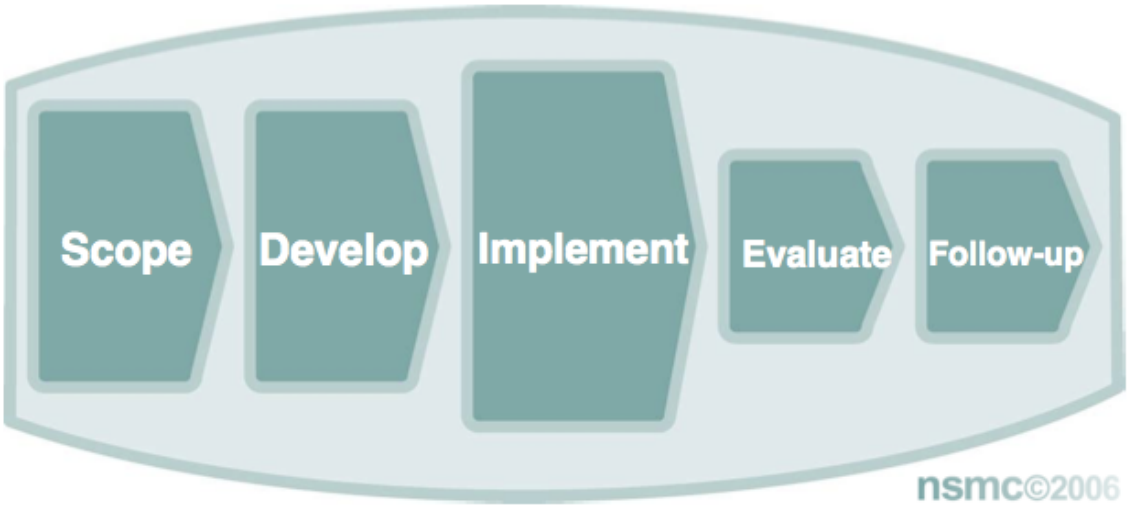
The findings from Stages 1 and 2 of this project indicate that the key barriers to effecting behavioural change to be the following:

Barrier	*BME Darnall*	*Totley and Dore*	*'Most vulnerable'*
1. Socially isolated with very limited opportunities for intervention		✓	✓
2. Identification of those most at risk – due to lack of common criteria for assessing risk, fragmented service across providers and limited cross-referrals between HCPs	✓	✓	✓
3. Lack of knowledge and understanding of nutritional health / balanced diet	✓		✓
4. Lack of knowledge and understanding of importance of dental health, especially denture-wearers	✓	✓	✓
5. Complex health issues (e.g. diabetes, alcohol dependency, mental health problems)	✓		✓
6. Limited access to 'commercial' communications channels and media	✓	✓	✓
7. Poor access to dental services / care (or perception of inaccessibility and lack of knowledge of availability)	✓	✓	✓
8. Poor access to healthy food – fresh vegetables and fish due to price, availability, understanding of need	✓		✓
9. Education / literacy / language barriers	✓		✓
10. Cultural issues – rely on HCPs for advice, in particular GPs or trusted community / voluntary organisations	✓		✓
11. Gender specific barriers	✓	✓	
12. Willingness / resources from HCPs, voluntary sector and carers to provide information, educate and help change behaviour	✓	✓	✓

Objective 4: Make recommendations on the scope of a social marketing programme with the objective of improving the nutritional and oral health of older people living Sheffield.

The recommendations from this project are based on the recommended activities for 'Stage 1: Scope' of the NSMC Total Planning Process model.

NSMC TPP model



Stage 1: "Really seeking to understand the consumer"

Key aspects for success:

- Examining and defining the presenting issue(s) with key stakeholders/partners involved.
- Reviewing and assessing potential 'customer' or 'audience' focus and rationale.
- Focusing attention on specific behaviours (and groups of behaviours) to establish initial behavioural goals.
- Developing a proposition – working out ideas and options for how to move from current behaviour to desired behaviour

Business objectives:

- Increase awareness amongst the target group of what food they need to buy and eat to maintain a healthy diet and good oral health
- Increase the number of older people in the target group who buy, cook and eat healthier foods
- Carers of people in the target group to buy and cook healthier foods for the people they care for

The aim for this insight project is:

- To identify ways to engage with vulnerable and hard-to-reach older people

Key audience insights:

- The underlying motivating factor is the basic human need for community and social interaction – we can use this to increase awareness via community and social locations.
- Where there is a will, there is a way. 'Meal providers' – those who do the shopping and cooking (more affluent older people, carers, family and especially women) are the primary audience for achieving behavioural change. Older people seem to be aware of the need to eat healthily, but to do so, those who prepare the meals need to know how to shop and cook better, within their social and economic parameters.
- Going to the dentist is valued, but practical issues (cost, access to services and information) are creating barriers.
- HCPs do not look out for people at high risk of poor nutritional health, nor is information easily shared between service providers / carers.

Desired behavioural change:

- 'Meal providers' – to prepare healthier food for themselves and those they care for / share their lives with.
- For older people to visit the dentist at least once every 12 months.
- For HCPs, stakeholders, partners, the voluntary sector and community workers to look out for individuals at high risk and to pass information on from one service provider to another, as well as to provide the older person themselves with advice.

Proposed strategic approach:

The barriers to behavioural change can largely be ordered into 'service' barriers and 'customer' barriers, which interrelate.

For example, the new dentist's contract seems to have resulted in fewer dentists providing 'at home' services, with the result that older people are experiencing difficulty accessing services. This is exacerbated by the target audience's desire to stick with the same dentist, even though services outside the surgery may not be offered. In addition, information about the availability of NHS Dentists is not readily known and does not seem to be reaching older people.

Therefore, we would reiterate our recommendation from the first stage of this project to develop a 'push/pull' strategy.

In addition, we have also seen that the barriers to behavioural change vary across different audience segments. We therefore believe that the 'intervention mix' needs to be tailored at a micro level to ensure engagement within communities. However, there are common barriers, so we would recommend piloting an approach in two communities, to allow us to assess which interventions are the most effective.

This second stage of the project has also highlighted the key role of the 'meal provider' in effecting behavioural change, which leads us to a subtle but important shift in emphasis in target audience.

Target audiences:

1. 'Meal providers'
2. Older people at risk
3. Service providers (incl HCPs, voluntary sector, community groups, etc)

We would also like to reiterate the importance of (3) above. Whilst we recognise that these individuals can be difficult to engage with due to their workloads, priorities, etc, we believe that it is important to find a way to actively engage them in a way that is sustainable.

Example intervention mix:

Service pull

- Improved marketing of NHS Dental Helpline to older people and their carers
- New scheme aimed at raising awareness of nutritional and oral health issues with bespoke materials to aid provider-to-provider communication
- Brief interventions training and materials for HCPs and non-HCPs

Customer push

- Programme of cooking classes at lunch clubs and community centres, or at special community events, e.g. for Pakistani women promoted through the mosque
- Targeted door-to-door leaflets
- Information leaflets distributed through community locations
- Advertising in very local media – community newsletters, notice boards, etc
- Word of mouth – recruitment of community 'advocates' – people respected in local communities who are well placed to help deliver key messages, case studies of people who've improved their quality of life through taking part in the programme.
- PR in key local media – TV, radio and local press

Example proposition:

Service pull – materials developed to help providers 'flag' concerns about the nutritional health of individuals. Brief interventions developed for a range of providers – HCPs and non-HCPs. Quick simple device that can be used to raise awareness and around which more substantial service pull initiatives can be wrapped. Not NHS branded so is equally applicable across all partners.

Customer push – used as a branding device for a programme of community-based social marketing interventions. Provides a device for messaging without labelling or stigmatising individuals.