Rapid Participatory Appraisal

Health in Butetown and Grangetown, Cardiff

Dr Kathrin Thomas, SpR Public Health
Susan Toner, Senior Health Promotion Specialist
Jasmin Chowdhury, Community Researcher

NPHS, October 2006
1. Executive Summary

- Butetown and Grangetown contain many communities, but particularly:
  - "old Grangetown" and "old Butetown"
  - large ethnic minority groups; Somali, Pakistani, Gujarati, Bengali, Yemeni etc
  - people in new housing who are a community only in the geographic sense
- The main health issues were felt to be about behaviour choices, long term health conditions and access to local health services.
- The area is changing rapidly, and this is seen as having both a positive and negative impact on health.
- The area is perceived as deprived with pockets of more wealthy people and this was felt to have a major impact on health and well being.
- There was felt to be strong social networks, sense of community, and community participation in all areas, except in the new developments. The latter were perceived to be a threat to social capital.
- The services that could benefit health that were perceived to be missing were:
  - dental care
  - podiatry/chiropody
  - a swimming pool
- Barriers to services were perceived to be:
  - Lack of services to overcome language differences, and literacy difficulties.
  - Lack of knowledge in how to use the system resulting in inequities.
  - Lack of awareness of services, in residents and referrers.
  - Long waiting times, especially for substance misuse services.
- Access to primary care services was felt to be to poor, because of lack of staff and increasing demand from a growing population.
- Butetown Health Centre was disliked by all who knew it (and some who would not go there at all). Premises in Grangetown were of better quality although some were felt to be too small.
• There is a lack of awareness of the other services available locally to support people with particular problems that might affect their health.

• There was felt to be a lack of active health promotion and preventative work.

• the main suggestions for improvements were:
  
  • Increase and enhance current Primary and Community Care services
    
    o More GPs and core Primary care services.
    
    o Dentists.
    
    o Podiatry/chiropody.
  
  • Better premises
    
    o Replace Butetown Health Centre
    
    o New Health centre for Grangetown and/or Butetown with room for extended services such as minor A and E service.

  • More support for the elderly, young people and families.

  • Better health promotion including leisure facilities, in particular a swimming pool
2. Introduction

This work is part of the information gathering for the Primary and Community Health Care Needs Assessment for Butetown and Grangetown in Cardiff.

It uses a method that can give a richer and more nuanced view of the issues, which can be added to other sources of information to build a better picture of needs, and solutions that address these needs.

3. Background

Butetown and Grangetown are two wards in the south of Cardiff. Both are rapidly changing areas, in terms of new housing development and in terms of flows of people in and out. They contain some areas that have some of the highest deprivation scores in the UK, and also some areas of expensive housing. There is an ethnically diverse mix of people, and evidence of many “communities” within this relatively small area.

There is also concern that the local health services have not been able to meet the often high health needs of the people living in these areas, especially as the population changes and increases. In particular, there have been concerns raised for a long time by residents and service providers about Primary and Community health services.

Cardiff Local Health Board asked for a Primary and Community Health Care Needs Assessment, which is due to report at the end of November 2006.

The full Report has the following agreed aims and objectives:

Aims

To inform the planning process for meeting the needs for primary health care services in Butetown and Grangetown.

Objectives

- To determine the health status and the wider determinants of health in the population of Grangetown and Butetown wards.
- To identify the primary health care needs of the current and future population.
- To determine the current health and social care services.
- To determine the effects of new developments in the area on future needs.
- To examine different models of meeting identified needs.
- To make recommendations on how to meet the need for primary and community care

The methods to achieve this include:

- Gathering routine data on death rates and ill health
- Identifying existing surveys, strategies and other documents.
- Identifying current services and interviewing service providers
- A postal survey of 3,800 households
- A literature search to identify possible comparable situations and solutions
- A Rapid Participatory Appraisal
4. The Rapid Participatory Appraisal (RPA)

This is based on World Health Organisation (WHO) guidelines, which are designed to be used anywhere in the world. They are simple to use by members of a community who may have little training in research techniques. However, the local team that was recruited for this RPA had considerable skills and experience, which enabled the work to proceed more efficiently and possibly more effectively.

**Aims**

To inform the planning process for meeting the needs for primary health care services in Butetown and Grangetown.

**Objectives**

- To perform an overview study with a sample of people with strong local knowledge, examining health and social care needs in Butetown and Grangetown.
- To explore the perceptions of current primary care needs.
- To explore the perceptions of the causes of ill-health within the community.
- To inform the recommendations of the Health Needs Assessment Report on health and social care services in the area.

5. Method

The study asked for the views of people who have a strong local knowledge, through their role in the communities. The interviewees are chosen because they are in a position in the community to talk about the views of a group, or groups of people, and not just their personal views alone. It therefore is not a grassroots survey or a consultation. It tells what the problems are, but not how many people are affected by them. It is also specific to a particular area and cannot be generalised to other areas.

This Rapid Participatory Appraisal was carried out between June and October 2006. The team of 15 interviewers were drawn from:

- Cardiff Local Public Health Team including the core team, the ‘Barefoot’ Health Workers Project and Butetown/Grangetown Healthy Living Programme (National Public Health Service)
- Cardiff and Vale NHS Trust including the Multi-Cultural Health and Information Centre and Dental Health Service
- Cardiff Local Health Board (Heartlink)
- Surestart

All of the interviewers work in the area, and some also live in Butetown or Grangetown. They all therefore have extensive local knowledge and networks themselves.
The team used the following process:

A one day workshop with a two hour follow up was held to:
- Develop a questionnaire to be used in a semi-structured interview. This contained 33 questions.
- Identify the people in the area that the team felt would have a good knowledge of the community because of their role(s).
- Develop a guide to arranging and carrying out the interviews

Interviews were conducted by two of the team, one acting as note-taker, and were not audio-recorded. Most interviews were with one person but several had two or more people contributing. Three members of the team analysed the type written interview notes.

A draft report summarising the results was produced and sent to all the members of the team and to all the people interviewed, for comment and feedback.

A final half day workshop was held to:
- Check the analysis and the summary of results.
- Add the team’s own views and observations.
- Discuss the process of carrying out the RPA.

The original list of people the team wished to interview was:

| 7 Primary/Community Health care workers/teams | 1 police |
| 5 other health care                           | 5 local businesses |
| 2 councillors                                 | 6 community/religious/voluntary organisations |
| 3 school/youth                                | 1 leisure services |

It was not possible to complete interviews for the entire preferred list, for various reasons. This report uses the written notes from 25 interviews, with the following people:

| 6 Primary/ Community health care workers/teams | 1 police |
| 3 other health care                           | 2 local businesses |
| 2 councillors                                 | 7 community/religious/voluntary organisations |
| 3 school/youth                                | 1 leisure service |

The interviews were conducted by one person, with the other making hand-written notes on the standard questionnaire form. The interviews were then typed up.

The first 6 interviews were read by 3 members of the team, who coded each one. These were then compared and themes were identified and agreed. The remaining interviews were analysed by one member of the team and every part of every interview was placed in one (and occasionally two) themes. These were then reviewed by a second member of the team.

The 18 themes were discussed at the final workshop and the summary of each of the themes was checked with the original interview content by two members of the team.

Each main issue within each theme has only been included if it had been mentioned by at least three people. All participants are assured of anonymity and should not be personally identifiable from the quotes used here.
Results

The quotes used here are not direct verbatim. They are as written at the time by the note taker during the interview. They may therefore be a summary or paraphrasing of the interviewee’s conversation.

1 Top Health Issue

We included a very open question “What do you think is the top health issue in the area?” and this drew a variety of responses, but most did include the wider determinants of health such as deprivation as well as health care issues.

The main ones raised were, in order of frequency:

- Long health term conditions (e.g. diabetes, heart disease, especially in black and minority ethnic groups)
- Lifestyle and behaviour choices (e.g. food, smoking, physical activity, social isolation, obesity)
- Substance misuse (e.g. cocaine, cannabis, tranquillisers, alcohol, khat)
- Access to health care, mostly Primary and Community services, or services for the elderly. Also cultural issues, e.g. the stigma associated with mental health problems and substance misuse.
- Environment (e.g. housing, overcrowding)
- Socioeconomic factors
- Ability to understand the system and awareness of rights, leading to access to information and services.

2 Social Capital

Definitions of social capital vary, but community coordination, cooperation, reciprocity, trust, social integration and supportive relationships are key features. Therefore it cannot be owned by any one person, it belongs to the group. Higher levels of social integration and social connectedness are associated with personal well-being, higher life expectancy and lower death rates from all causes. Better social support is associated with lower levels of anxiety and depression, and may help people to cope better with illness and have better prognoses when ill.

Many people used words like “community spirit”, “close community”, “tight community” about both Butetown and Grangetown. There were many comments about how people knew each other and took care of each other in informal and formal ways

“People in the community are very much giving of what they’ve got.”

A link was made between a sense of belonging to a community and a beneficial effect on health. Most people expressed pride in living and/or working in both areas. However, many people noted that the view of those who did not know the areas did not match the views of those who liked living in them:

“I think a lot of people have pre-conceived ideas, and have fears about the area. When I first got the job here people would say “you work down the docks!” This isn’t right”.

Version 1 Created on 25/01/2007 12:29 PM Status : Final
Author: Kathrin Thomas Page 7 of 19 Version 1
People pointed out there were actually many communities with strong networks in themselves, for example: the Somali community, “old Butetown”, the Gujarati community, “old Grangetown”.

Many said that people did not wish to leave the area and that being forced to do so through rising house prices or lack of social housing was a threat to the existing community.

While various aspects of “social capital” were seen as being strong in the area and beneficial, it was perceived that this was very different in the new housing, where there was thought to be little sense of community and some problems with people being isolated. The rapid increase of people moving in to new housing was perceived as a potential threat to social capital.

“Butetown is something special. Eventually because of these people (in new flats), others will be pushed out. This worries me.”

3 Services

Many people were aware of a large number of local statutory and non-statutory organisations although many were not aware of some long standing services.

Statutory services were more often mentioned by health workers than non-health workers were, not surprisingly.

The Community Mental Health team (Sealock Centre) seemed to be the most well-known among the health care workers and was viewed very positively, although mental health problems were mentioned as having a stigma and being under-recognised. It was recognised that some BME groups were not well served.

Interpreting services were frequently mentioned, with positive regard for several interpreters and link workers but less satisfaction with Languageline (the telephone interpreting service provided via the Local Health Board and Cardiff Council).

The perception of Social Services was generally of access being a major barrier (confusion over how to access and the difficulty of the process), although several people felt an explanation for this was that social services were overwhelmed by demand.

We specified that we were not asking about hospital services, and few people mentioned problems. Several did bring up long waiting times and the difficulty in accessing secondary care services for vulnerable or poor people (transport, literacy, understanding the system).

A large number of other services and projects were mentioned by many people, when we asked what they knew about what was available for particular groups (e.g. young people and families, the elderly etc). However, many were not mentioned at all by health workers.

Some organisations are very specialised and are unlikely to be known to people not directly involved with their client group. However, some were well known.
Some mentioned more than once as providing a useful service was:

The BUZZ centre in Grangetown
The Butetown/Grangetown Healthy Living Programme.
4Winds
Heartlink
Religious organisations – temples/mosques/churches
Surestart
CAB
Bee Healthy
SOYA
Butetown Youth Pavilion
Homestart
Butetown Community Centre
Somali Advice Centre
SOVA

There were many more that were mentioned by some people and this is therefore no measure of the quality or awareness of these organisations. However, many of them were not mentioned at all by health care workers which might indicate a lack of awareness among potential referrers to them.

3.1 Missing services and barriers to services

Lack of awareness by both local residents and potential referrers was frequently raised as a barrier to access.

The other major barrier was lack of services to overcome language and cultural differences, with many saying this impaired access. This extended to literacy problems, particularly with official letters, such as for hospital appointments. Many people mentioned using a family member to interpret which is not appropriate nor good practice. The health workers generally felt that someone with an advocacy role, as well as an interpreting role, was the most useful.

“Languageline – excellent and free, but not as good as having an interpreter.”

“Need translation and interpretation (we use the man in the shop next door to help us in here in the Pharmacy – he speaks Somali).”

Services that were not sensitive to cultural and religious issues were also mentioned as creating a barrier, for instance alcohol being served in community organisations meant many Muslims would not be able to attend, or services that were only provided to mixed gender groups would exclude women who did not wish to mix with men.

Many people mentioned the lack of access to dental and podiatry services.

Many people talked of the lack of a swimming pool in the area, and linked this to a potential beneficial impact on health.
Those felt to be best served by local health services, were those who were able to understand the system and knew how to use it. Among those considered to be least well served were people without good English language skills and those who were recent arrivals.

“Cardiff Bay residents – they can work the system, they can use appointments systems. This depends on whether they can get registered – if they do, they could swamp the system.”

“(the best served are) Better communicators. People with more understanding of the system and know where to go”

3.2 Services for the Elderly

Elderly people were felt to be a particular group who were poorly served. The lack of any day centres in the area and a shortage of residential or sheltered accommodation were cited many times. Elderly people were felt to be more isolated and to have difficulty accessing services because of distance.

“Lack of local day centre. Have to go to Ely. Long time on bus with lot of pick ups and drop offs. Flats in area, people moving in are violent and threatening, lots of elderly people live in flats around this and can be distressing. Lack of residential and nursing care in area. Only Atlantic View which is very big. Rothsay House closed. Residential Care – people have to go to different area and their families have to travel to see them. Some people don’t want to go into a home outside the area.”

4 Perceptions of local health services

There was general agreement in the major issues between those who worked in local health services and those who lived and worked in the area.

4.1 Access and Equity

Most people felt there was a shortage of Primary Health Care, particularly in Butetown. It was felt to be difficult to register with a GP if new to the area and also sometimes to see a GP once registered. It was perceived that the population had been increasing but there had been no increase in Primary Care services to match this. This had led to most practices refusing to take on new patients at one time or another.

“Can’t get a GP from health point of view. Lists open on and off, don’t like other practices and general provision. Not enough.”

“Lists are full within GP surgeries in Grangetown”

“Good ones are difficult to see”
It was felt that some people were able to get better service than others, the better-off and articulate being said to be well-served. New immigrants and those without English were said to be least well served.

Language was felt to be a major issue. Practices using Languageline (a telephone interpreting service) felt this usually worked well but had inherent problems of prolonging consultations, being difficult or inappropriate in some situations and lacking an advocacy element. This latter was felt to be a major issue by many, as access to good quality local health care was felt to be more difficult for vulnerable groups such as:

- recent immigrants, especially if without English language skills
- homeless and substance misusers
- elderly people

“Languageline – excellent and free, but not as good as having an interpreter”

Most health workers did not have an awareness of many of the voluntary or non-statutory services in the area, even when they helped people with physical or mental health problems. Non-health workers seemed to have a greater awareness of these and suggested that this could affect the access that people had to local support as their practices may be less likely to refer them.

### 4.2 Acceptability

There was a perception that local health services did not always match up to expectations, with some comments about the reasons for this being lack of time, funding or a caring attitude. Many were able to distinguish between practices in their characteristics as they seemed to be well known in the communities.

“There are good, bad and indifferent”

“They think they (GPs) are rubbish. They are tarring all GPs with the same brush……. We get flak from misperceptions…….All expect the NHS to provide, that our medicine can fix everything and then they are disappointed.”

“People don’t want to go to GP services that are poor quality…….People want more and better quality GP services.”

“I would like to devote more time to patients but not practical. In this area, staff are always stressed – communication is difficult.”

“Bad communication with Doctors, don’t take them (patients) serious. Doctors just dish out paracetemol”

The relationship with a known GP or nurse or practice was valued. There were some consistently positive comments about some of the practices, mostly in terms of their attitude being caring. The negative comments were mostly about communication.

“Surgery as a whole (and other surgeries) are at core of community – big source of support. Taking over role of church in past. Generally satisfied and loving practices.”
“Some of our clients are not listened to and were given wrong medications due to language barriers and this can be dangerous. Communication is very important to describe your illness.”

4.3 Female GPs
There was felt to be a lack of access to female GPs, both in Grangetown and Butetown.

“People do not have choice. Not enough women – mostly GP’s are men, especially those with an ethnic minority language.”

4.4 Dentist
There was a strong perception that there was a lack of access to dentists, for all age groups and in both wards. Some people believed there were no NHS dentists.

4.5 Pharmacists/ Chemists
Comments were all positive, with access and quality being rated highly.

4.6 Premises
There were some strong feelings that Butetown Health Centre was unsuitable for many reasons, with the building felt to be unsafe and unpleasant to work in, or go to as a patient.

“Butetown Health Centre is a disgrace”

“Health Centre in Butetown is run down. Toilets not working. People around health centre actively chosen to go elsewhere because centre so poor.”

In Grangetown, the issue was more diffuse with a general comment that practices were in too small accommodation, rather than in poor quality buildings:

“Premises – old fashioned buildings that can’t respond to needs, so poorer service. Access to health centres not ideal for disabled.”

5 Socioeconomic Status

Poverty, unemployment, lack of educational achievement, long-term benefit claiming and insecurity of job and housing were felt to be common in all areas. This was more so in Butetown and in some ethnic minority groups (recently arrived refugees, asylum seekers, migrant workers).

‘Still a lot with financial problems’

‘There is poverty from what I can see. They struggle: they do their utmost to manage but find it a struggle to make ends meet’

A link with well being and health was often made:

“Minority ethnic community have particular health issues but lots of health issues are concerned with fact that the community is poor.”

“Many people don’t have cars, so have to pay for taxis” (causing difficulty in accessing services)

There were also comments linking poverty and poor health, particularly mental health.

However, there were felt to be quite wealthy areas, and not just in the new housing developments. Parts of “old Grangetown” were felt to be attracting people in higher social classes to move in, raising house prices. Some people felt that Grangetown as a whole could not be described as deprived.

Several people made connections between the sense of deprivation and the closeness of relative affluence.

“Very split area: people in area who have great amount of money (in apartments), but there are people here who are poor. Nobody in-between. Very difficult area for those who are struggling who see the rich people. A lot of money is being pumped in, but not local people, they are not being given jobs. A few – Techniquest/ Mermaid Quay /UCI Cinema. There is poverty from what I can see. They struggle; they do their utmost to manage but find it a struggle to make ends meet.”

“Butetown is like a ‘box’- inside is deprived, outside ‘box’ (there are) more opportunities and development”

“Split communities – Butetown – railway is like the Berlin Wall – on one side people are doing well – but the other side is very deprived.”

“Considering the money being put in is not creating jobs, highly deprived area. Has got worse in Butetown”

6 Fear of crime and antisocial behaviour

Fear of crime (both against the person and property such as cars) was mentioned by many people as a main worry. Another commonly mentioned issue was antisocial behaviour, such as alcohol-related abuse and prostitution in Grangetown streets. Groups of young people in the streets especially in Butetown were mentioned although several people said this was a perception of threat rather than a reality and suggested more facilities for young people, especially boys and those from black and minority ethnic groups. Domestic violence was also particularly mentioned.

Several people said crime and anti-social behaviour did have a major impact on people’s wellbeing or health.

One question we asked was about the views of these areas by people who did not live in them. Most people said perceptions of Butetown were very negative.

“People are quite intimidated by it”

“character changes after dark, spooky at night”
“They have a bad perception and they assume it’s a dangerous place to live and work”

“There are still areas that I wouldn’t walk in e.g. Loudoun Square – probably because of perception and not knowledge”.

Grangetown had a more mixed picture. Crime and anti social behaviour was also cited as having a major impact on well being but was less so than Butetown.

“Crime is a main worry – but it’s not as bad as other places”.

Poverty and drug misuse was specifically linked as being causes for crime by many respondents.

7 Substance Misuse

Substance misuse was brought up by many people, especially alcohol, smoking, cocaine and qat.

Some were linked with health problems and some people made explicit links with poverty and crime. Services for people with substance misuse problems were thought to be difficult to access because of very long waiting times but were felt to be good for those who reached them. There was felt to be little service in primary care, other than referring to specialist services.

Qat was mentioned by several people as a particular issue within the Somali community. It was felt to have an impact on health by several people and solutions to this issue were not felt to be easily available.

Knowledge to be able to access drug and alcohol services was felt to be lacking, as well as overall lack of services.

8 Integration

There was a perception of the existence of many separate communities, but the sense that both Butetown and Grangetown had been very successful in integrating succeeding waves of newcomers, especially from diverse ethnic origins.

“(Grangetown) is friendly, accommodating, welcomes different cultures”

“Ethnic minorities – they like (the) high prevalence of ethnic minorities, always been diverse, now more so, more tolerant. But less overlap between communities – Somali, Asian (2 largest), Black, Chinese and others. People are not worried re: ethnic influx. No racist sentiments expressed.”

However, there was also a perception that this tolerance was being stretched and may become harder to maintain,

“Bad – high risk of influx of outsiders. “Old Grangetown” residents welcoming, but may be overwhelmed which will affect well being of original and new residents.”

Some people talked of racism, although several said it was less of an issue than elsewhere.
“Harmony between communities. Not like any other community. Racial harmony seems to exist here. (Facilities for BMEG) – others of their own community around them.”

There was a sense that previous integration was unravelling, for instance that people in the new housing were not integrating into the existing communities, unlike any previous incomers. There was mention of the “physical boundary” between the older part of Butetown and the newer developments of Atlantic Wharf.

“Split communities – in Butetown the railway is like the Berlin wall - on one side people are doing well but the other side is very deprived”

“Years ago Butetown and Grangetown used to mix a lot more….. The apartments being built and people coming in, but contributing nothing to the community. They sleep here. They go away to work. I would hate this community to be destroyed.”

9 Population changes

The population is perceived to be increasing significantly, both into the existing housing and into new housing. There was mention of students, Eastern European migrants, Yemeni and Arab family members, and more middle class people moving in. There was also felt to be changes in the population characteristics (such as more single-parent households, more elderly people and vulnerably housed in local hostels and overcrowding)

This was often linked with concern over the impact on local services.

“New influx of ‘professional’ people-impact on the services provided e.g. will they make Channel View become an elite fitness Centre?”

10 Environment

There was both good and bad in people’s views. People mentioned the good aspects of being close to the city centre, Cardiff Bay and local shops with most being satisfied with public transport and access to green spaces. It was felt that parts of both Butetown and Grangetown had improved in terms of facilities and housing, however there were lots of comments about the quality of housing still being poor.

House prices are increasing, especially in the older housing stock in Grangetown, and people linked increasing proportion of rental accommodation with poor quality and increasing deprivation. Linked to this, access to social housing or affordable housing was said to be difficult.

“There is a lot of money being spent to upgrade/regenerate. Vast improvements made, but only to certain parts. Aesthetically improved.”

“Old Grangetown – run down, deprived, grim and dark. Housing old, dated. Problem with old houses not being kept up.”

“1970s style housing estates in Butetown – wrong.”

The local shops were said to be run down, especially in Butetown. There were more mixed views in Grangetown. Traffic was also felt to be an issue.
“Too much traffic – parking issues in parts mainly north Grangetown with commuters”

There was a perception of Butetown in particular being an unpleasant environment to live or work in.

“Dirty/scruffy, rubbish, vandalism”

“The Council misses rubbish collections frequently and this result in the rubbish being left on the street which is not swept up by the Council. It looks like a dog's breakfast.”

11 New Developments

The new developments, in terms of housing and other new buildings in Cardiff Bay, were talked of repeatedly. This was about their effect on the existing communities and their well being. There was a positive welcoming of an improved environment, economic regeneration and an influx of new people. However, there was a greater wariness of negative impacts in terms of lack of economic benefit to local people, being excluded from expensive facilities although having them on the doorstep and also that services were being overstretched. Several people called them gated communities and there is an impression of them being built in a way to keep local people out (e.g. high walls, security measures).

“Lot of people are worried about the new development.”

“More housing, more people coming in. Old community moving out also. Increase in population will be more apparent over time. Butetown is an expanding community and how this impacts on services need to be considered.”

Many of the local GP practices said they were intermittently closing their lists to new patients, as demand was greater than they felt they could cope with. The demand was mostly from people in the new housing.

12 Education and Training opportunities

Education was felt to be closely linked to well-being and health, through increased socio-economic status and ability to access health care services.

“Health and education go hand in hand. Relates to access to services. Facilities available but problem is how you get people to access opportunities. Ability of people to access employment is dependent on education”

The primary schools in the area were perceived to be very good and appropriate to the needs of the ethnic diversity of their children.

“As long as their children are happy, the parents are happy.”

However, it was felt that it was wrong not to have a secondary school within the area as children had to travel longer distances to get to school and were also then liable to be excluded from out of school activities.
A range of adult education and training facilities and services were mentioned including the Enterprise Centre, basic skills and computer classes.

However, motivation was cited by several people as a barrier to accessing opportunities and health services:

"I see it as people have choices, if they don’t want to go to work then that is their choice. In this area, people are working. We have the job centre, enterprise centre and they really do try to help them to find job. There are classes everywhere to help to train them up in languages etc to help them in looking for work."

13 Promoting Health

Many people commented on the relative lack of preventive action and positive health promotion, and in fact many suggestions for improvement focussed in this area. Most people were very aware of the wider determinants of health and gave ones such as socioeconomic status, educational achievement and lifestyle patterns as having a big impact on health.

Health promotion initiatives were mentioned as part of other themes. It is possible that people expect health promotion to equal leaflets, posters, etc so may be a misconception about health promotion.

"(The biggest impact on well-being is) jobs, crime, housing, environmental issues."

"Good scheme is exercise for health scheme, popular with a lot but some don’t want to. Need resources for outreach / health promotion / education. e.g. very unusual for someone to belong to a gym."

"Young people avoid local health seminars re: STI’s, pregnancy in case people recognise them. Constructive work with young people (means) future better health. (Need) permanent strategy – not 2 year/3 year projects. Preventative work.

"Health promotion has good impact on people. It raises their awareness and it being done since the projects’ (Butetown/ Grangetown Healthy Living Project) been around….. It is also if people want to help and do things for themselves. People’s own perception for own health need and not so sure people wanted to take up responsibilities of their own health"

Many people mentioned having a swimming pool locally as being a good method of health promotion.

"What this area needs is good leisure and sporting facilities; swimming. These are very good sporting children. With the 2012 Olympics coming it would be nice to have some successes."
14 Interviewers Observations

The team of interviewers felt that there was no mechanism for health promotion services and projects to link in with GPs and Primary Care Teams. They also felt that there was sometimes a negative view held by GPs of other services in particular health promotion services and projects.

15 Suggestions for Improvement

There were very many diverse and interesting ideas, most of which fell into the following areas:

- Increase and enhance current Primary and Community Care services
  - More GPs and core Primary care services.
  - Dentists.
  - Podiatry/ chiropody.
- Better premises
  - Replace Butetown Health Centre
  - New Health centre for Grangetown and/or Butetown with room for extended services such as minor A and E service.
- More support for the elderly, young people and families.
- Better health promotion including leisure facilities, in particular a swimming pool
16 Conclusion

The process of carrying out this research was intensive and time-consuming. However, it has given some insights into the perceptions and concerns and beliefs of people living in Grangetown and Butetown. It did not attempt to be representative of all views in the communities but has been able to highlight key issues for service planners, who may not know the small areas concerned in detail.

It has given qualitative information to be included in a full Primary and Community Health Care Needs Assessment for Butetown and Grangetown, which will be completed in late November 2006 and will be used to inform service planning in these areas.

Acknowledgments

Many thanks to the members of the RPA team:

Shahzad Ahmad
Abdirahman Ahmed
Bronwen Bermingham
Sian Biddy
Dinah Channing
Jasmin Chowdhury
Helena Jones
Lisa Mabbs
Karen Proctor
Carly Stevens
Mui Chen Tan
Susan Toner
Musa Yousuf

Many thanks are due to the people who freely gave of their time to be interviewed by us.