



# Experiences of health and Care - Perspectives of men living in Foleshill and Spon End



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Cover photo - A member of the Bike workshop

## Introduction

Healthwatch Coventry is the independent champion for NHS and social care.

The Healthwatch Coventry mission is to hear the experience of NHS and social care services from those in Coventry who do not have strong voice or are ignored. Healthwatch are committed to reaching new people by trying different ways of hearing experiences.

Healthwatch Coventry have long established links with voluntary and community groups in Coventry and are hosted by a local charity. We advertised a small grants application programme for community research projects to gather experiences of health and care or of barriers to health and care from less heard groups of the local population. This was the second round of small grants. This time the focus was on hearing from:

- Young people
- Men from socially disadvantaged neighbourhoods
- People from diverse communities experiencing health inequality

This piece of work was carried out by Coventry Peace House, which is an inclusion project that has been running for 20 years with the aims of tackling inequality by highlighting social issues.

Coventry Peace House collaborated with Coventry Men's Shed, Foleshill Library, and their in-house bike workshop Coventry Cycle Centre. Men access these groups and community spaces for social support and wellbeing.

We wanted to gather their stories, good or bad, about the support they receive from health or social care services.

## How we did the work

Two facilitators from the Peace House conducted four focus groups each lasting around two hours and four one to one interviews, with a total of 21 men. This was completed during May 2024.

Volunteer helpers from the Men's Shed, and Coventry Peace House acted as peer researchers, participating in recruitment and data collection. This helped the conversations feel one of mutual respect and trust.

Participants were recruited via word of mouth, flier and poster through Coventry Men's Shed, Foleshill Library, and the bike workshop.

Focus groups took place in person at Coventry Men's Shed and Foleshill Library. Participants sat around a table with refreshments. Conversations started with getting to know each other and creating a 'health journey' - a

personal map of health and healthcare experiences doodled with pen and paper.

In addition to semi-structured questions, participants asked each other questions, creating a natural conversation. The conversations were recorded in addition to notetaking. Interviews took place in-person at the Men's Shed.

Participants gave their consent to take part in the data collection and their permission for findings and data to be shared with Healthwatch Coventry.

Audio and notes were coded, and themes were identified in a separate document with quotes and excerpts.

A member of the Healthwatch Coventry Team provided support to Peace House, with guidance on design, and reporting.

## Who took part

In focus group one there were seven participants, there were four participants in focus group two, two participants in focus group three, and eight in focus group four.

The piece of work focused on white British men (there were also two Asian British participants). Their ages ranged from 26-93; with the majority being in their 40s-50s.

Participants resided mostly in the Foleshill and Spon End areas of Coventry. All participants were from lower Social Economic status backgrounds.

According to the government website:

“A person's socio-economic status is based on the type of work they do, or what they used to do if they are retired”

Lower socio-economic groups include those who are in lower technical jobs or long term unemployed. It is also based on people's education, financial security, and housing. According to the King's Fund these factors play an important role in people's experience of health and life expectancy.

Participants had nearly all experienced health issues which affected their lives in some way - acute and chronic poor mental health, as well as long term pain, cancer, and disability or dysfunction following accidents.

## What we found

Theming of conversations mapped experiences under four topics:

- 1) Factors impacting care seeking behaviours,
- 2) Timely /delayed provision of care,
- 3) Factors impacting quality of care received,
- 4) Alternate forms of care.

### 1) Factors impacting initial care-seeking behaviours

Often the first step for the people we spoke to is through their GP. Participants spoke about barriers to seeking support for health problems such as difficulties in securing a GP appointment. One participant reported trying for months to get an appointment at their local GP, despite ringing at 8 am as instructed.

Some participants spoke about avoiding seeking GP appointments due to distrust in doctors, fear of diagnosis, or the belief that problems will resolve on their own.

“I generally just don't trust doctors. I never have. Before I came to Coventry I hadn't been to one for seven years.”

There was a sense that it was too difficult for some of the participants to make that first move to see their GP and that there needed to be no barriers.

Participants emphasised person-centred factors which had been successful in enabling them to see their GP. Things such as flexibility re-scheduling appointments, multi-disciplinary teams, and after-work appointments.

Bureaucratic systems had prevented help-seeking, for example being de-registered from a supportive practice when they moved home, or when one participant was homeless so could not get registered with a GP. Continuity of care was greatly valued.

“I'd prefer to go to someone who knows me. I've known her since birth.”

“I don't see many people, so if I can't get an appointment who is going to tell me there's something wrong with me, there's no one else around. I don't know.”

Participants liked having different options for how they could seek help. For example, for mental health needs an alternative to going through the GP is going through their Care Coordinator (who can be a Community Psychiatric Nurse, a Social Worker or an Occupational Therapist) who is attached to an Integrated Practice Unit, (IPU) and has access to psychiatrists and psychological support depending on the person's need. IPUs are being restructured through the Integrated Care System.

## Men's thoughts and experiences of prostate cancer

The following case study is about prostate cancer, Prostate cancer is the most common form of male cancer in the UK<sup>1</sup>.

The main risk factors, being 50 or older and having a family history of the disease. Early diagnosis is crucial. Encouragingly, several of the older men spoken to were positive about their experience of prostate examinations.

These are some of the things that they said:

- “I've been for a prostate exam. Before I knew it, he (the doctor) was doing it. It really wasn't that bad. They just check to see if it feels alright. And if it doesn't, they get the camera.”

There was a strong feeling that prevention was better than cure. There was also recognition of their hesitancy to seek help if they weren't encouraged.

- “I'm reluctant to take the initiative to get checked for anything. The thing that would change that is someone telling me to. So, if you're this age then you need to get checked.”
- “I'd be more likely to be tested if I were called for a test rather than ask to be tested”

Overall, the men appeared to want to be looked after by routine NHS health checks such as the prostate examinations, even feeling concerned if they had not been.

- “My dad did die of it. You'd think they would have called me. I've had regular bowel cancer tests, and the aortic aneurysm test. So, they're picking up on some things, but not that.”

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<sup>1</sup> [Prostate cancer statistics | Cancer Research UK](#) viewed 27/6/24

## 2) Timely /delayed provision of care

The men spoke about their experiences seeking help through hospital services, for both for mental and physical health.

Their sense was that the onus is on the individual to continuously push for treatment and navigate through various obstacles, including dealing with receptionists and filling out forms, and making follow-up calls.

Participants reflecting on good experiences of seeking help, felt that the service is there, but you had to be confident in pursuing it. Family members, especially partners, had played an important role – not only encouraging the seeking of medical help but ensuring they received it.

“Before I met my wife, I just got on with it, never saw the doctor, but she encourages me to.”

Several discussions focused on experiences when participants had sought help, for example in Accident and Emergency Department (A&E) but been discouraged from seeing it through due to experiences in A&E related to limited capacity in the service, and inadequate space. This discouraged attendance and waiting for treatment even if people know they are in significant need.

“I went on a Friday afternoon so there weren't many staff available. I was waiting and waiting and waiting and I just left. I just wanted support. Then I went home, and the door went, and I was being sectioned. And they took me back to the hospital”.

Participants experiencing poor mental health had been particularly affected by not having an appropriate place in which to receive emergency care. Several participants spoke about being forced to wait to be seen in the Accident and Emergency Department during a mental health crisis. They knew their symptoms were making other attendees feel uncomfortable and scared, which exacerbated their distress, and worry about alarming others. They desired specialised facilities for mental health emergencies.

More than a few participants spoke of experiences where inconsistent communication between different hospital settings and teams had delayed their care. A joined-up system would also benefit patients frustrated with repeatedly providing the same information on forms. While filling out forms was an obstacle for many of the participants, it was particularly unhelpful for patients seeking treatment for mental health.

## Case study

“I had been forced to seek help during mental health emergencies in A&E settings where staff didn't know about appropriate processes. I feel that mental health hospitals like the Caludon should have its own A&E for people to go to”

“Even a small one with 10-20 places, it would then free up places in the hospital A&E. I was there at half three in the morning. We went down to somewhere. And then they said no we're closing, you have to go to A&E. A&E was crammed. They went no, you're not supposed to be here. You're meant to be somewhere else. I ended up in UAR or whatever. You've wasted three different places then. They should be talking to each other, know what's right for which place and people”

### 3) Factors impacting quality of care received

Participants were understanding of the challenges the NHS face in providing timely and quality healthcare.

“I think it's a lack of funding that's what it is.”

Largely the groups were advocates of prevention for both improving their own quality of life and to save the NHS money. Nearly all participants were happy with recommended health screenings (e.g. prostate, eye, chronic diseases) and would feel satisfied with more annual health checks. This feeling linked with the previously discussed hesitancy about seeking help without encouragement or instruction.

Positive stories from participants about their healthcare experiences underscored the importance of patient-centred care. Participants emphasised the efficacy of personalised messages encouraging them to attend health screenings, for example, emails or a letter linking their age or their family history to a particular appointment.

In-patients had been affected by the quality of the environment - feeling more comfortable and happier to stay the course.

Even the location of hospitals impacted patient's state of mind. That is, hospitals which are closer to town prevent the person feeling that they're trapped there.

For some participants, their individual barriers meant flexibility and thoughtfulness on behalf of their health providers was vital.



## An example of good practice and customer service

“If I hadn't been for a while my GP would make me an appointment. They were also open till 7 pm, so if I was working, I could go in after and not worry about losing my wages with no sick pay.”

When participants had been patients they had been impacted by poor communication or education on their illness or treatment plan. Participants spoke of being given medicine without understanding what it was for or having had blood tests yet receiving no outcome.

Patients seeking treatment for their mental health had been affected by poor understanding of how difficult it is for them to fit into society's impression of typical help-seeking behaviours. For example, it is challenging if you are experiencing mental health problems to fill in forms and wait around to be seen. The quality of care was further undermined by a high patient load for mental health services.

One participant reported that their GP had told them they do not believe in mental health which had impacted the quality of consultation and treatment plan.

### Case study

I was having a mental health crisis. My meds were not working. I asked the GP to get a new prescription, but because I am under the Caludon Centre my GP cannot prescribe medication. My GP then has to ring the psychiatrist at the Caludon, then the paperwork once it's signed off from the psychiatrist has to go back to my GP, and this can all take time.

As part of that process, I can have a prescription, but that process can take from 6 hours to two weeks. You only hear back from them when they have capacity to get back to you. I know there is a lot of people out there suffering from it, but the system needs reviewing. It's long winded.

I feel that the stigma attached to mental health problems is behind the lack of funding.

I'm not being horrible but mental health is a broken system. It's like the MIND support workers will only support people now for six months. When you need the service it's not there. Because you can't see mental illness, it's hidden.”

## 4) Different forms of receiving care

### Phone or video call

While participants with mental health difficulties reported no issue with talking with services over the phone such as the Samaritans. They felt that getting through to NHS mental health teams and receiving support over the phone was poor.

Participants also criticised that health services assume that people have video phones and Wi-Fi.

“It's a bit poor really., I think it's better on a face-to-face basis. You diagnose things better. If you want to diagnose someone or give medications over the phone, you can't do it very well.”

### Support groups and activities

The value of friends and social connections came up frequently. Attendees at the men's groups spoke warmly of what they got from these. Several men spoke about the value of men being allowed to talk about their feelings, particularly with people who understand what they are going through. This group laughed about how sometimes people do not know what to say, but it was clear that they felt comfortable amongst each other to try.

- “I'm making some great connections and I hope they carry on being friends.” It's like building resilience, people who have been there and understand how hard it is. It's a force inside you, helps you learn and move forward”
- “If things build up then have a good cry. A man who cries is a stronger man than a man who doesn't cry. You feel like a new person once you've got that feeling out. If you bottle it up you're just going to explode.”

They had heard of social prescribing, but no one had been offered it.

### Alternative support

We were interested in finding out whether the men used alternative ways to meet their health and care needs, such as meditation.

The majority had not used other ways to manage their wellbeing. One participant said that he had tried Calms and Quiet Life herbal tablets to help with his anxiety in the past however he is currently on prescribed medication. He was also interested in using 'tapping' and was looking into the role of gut biome in his health.

## Conclusions

There were many positive stories about help seeking, and quality of care, however the men recognised that they need encouragement to book appointments and the confidence to persist in seeking help. Supportive friends and family increase the likelihood of seeking help. Older men generally responded well to NHS advice and desired more recommended health checks and screenings to catch problems they felt unlikely to notice or face up to.

The findings spoke of this group of men's need for social support. There can be gaps in family support and social interaction for middle aged men as there can be focus on other age groups such as activities for older people and for young people, thus missing out middle age. Friendship groups and activities were holding many of the men spoken to together, especially when they felt that services were letting them down. Directing funding to social groups and social prescribing may have wide reaching benefits for these men.

The findings suggested potential issues in mental health care characterised by a perceived lack of coordinated care, insufficient communication among staff, a shortage of beds, inadequate staffing levels, and insufficient training. Participants with mental health difficulties had felt ignored and uncared for because of these issues. However, there were positive experiences of the Integrated Practice Units that worked well for the men using them.

## Key asks

- For health and social care organisations including community and voluntary organisations to provide more men only groups for men to access support, information and opportunities for networks and potential friendships.
- For health and social care services to raise awareness about services for middle aged men about support, services and tests available to them.
- For health organisations to send email and texts to remind/ call men to attend appointments and check-ups around preventable cancers and other health conditions.
- For health services and professionals to understand that men, especially men with poor mental health understand their impact on the people around them and want to help improve services.

## Acknowledgements

Our thanks to Coventry Peace House, the Bike Project, Men's Shed and all the men and volunteers who participated in the research and made it possible.



# Appendix

## Questions

The men were asked a series of questions starting with a warmup exploring their own history of health.

Followed by more focussed group work around three main questions:

1. What is your experience of health and social care
2. what influences you about when and how you seek health and social care
3. how timely and useful were/ are the health and care interventions to you.
4. what could be improved in terms of your health and care
5. whether the men used any other alternative sources of health and care

The men were encouraged to talk through their pathways and experiences of care.

Semi Structured Questions, these were developed following the initial focus groups.

Some areas to discussions to consider for further interviews include:

1. Experiences along the pathways to receiving care: scheduling, visits, referrals, testing, medications, follow-up
2. Satisfaction with care received and other concepts of their experiences with care providers including respect, trust, empathy, engagement, communication about their illness and clear instructions about their treatment.
3. Impact of race, ethnicity, cultural and religious practices, education, deprivation, language competencies on the services they seek and/or receive. Consider health literacy and digital poverty and whether staff understand their particular needs e.g. culturally or class competent
4. Recommendations for improvement on the problems and issues they raise.



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