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Lifestyles Advice in Primary Care

by

Rose Wiles

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LIFESTYLES ADVICE IN PRIMARY CARE

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Institute for Health Policy Studies**

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ISBN 085432 521 2
October 1994**

SUMMARY

This project sought to examine compliance with lifestyles advice given by Practice Nurses (PNs) in primary care in relation to the prevention of coronary heart disease (CHD). It was located within the policy context of 'The Health Of The Nation' and the Health Promotion Programmes (HPPs) for primary care which commenced in July 1993. The rationale for the project was to identify ways in which people could be encouraged to take responsibility for their health in order to limit demands on GPs' time.

A sample of patients was identified via practice nurses in seven band three practices. PNs in these practices were asked to distribute letters to all patients to whom they gave lifestyles advice during a specified period between October 1993 and February 1994. The letters invited patients to take part in an interview to discuss their experiences and views relating to the advice that they had been given. A total of 26 patients were interviewed.

The majority of patients interviewed had received advice about diet and exercise. This advice was given in a variety of contexts. The majority followed the advice that they had been given to some degree. Interviewees identified a number of factors that both motivated them to follow the advice and which constrained their ability to follow it. Motivating factors were perceived health risks and body image. Constraining factors were: stress; family responsibilities and lack of support; employment; time; recreation facilities; and, physical difficulties. PNs were identified as playing a very important role in supporting patients following lifestyles advice.

Data were collected from PNs in the seven participating practices and through a survey of PNs in one Health Commission area. The data collected suggest that the HPPs may not have had a significant impact on the work of some PNs and that targeting of patients and follow-up of interventions may not, at the present time, always be carried out. Furthermore, it indicated that PNs might benefit from further training in techniques of negotiating behavioural change with patients.

The project indicated that the health promotion currently provided in primary care may not be the most effective way to encourage patients to take responsibility for their health. Further research on the effectiveness of the HPPs, PN training, and the ways that advice is given by PNs and received and acted on by patients is clearly necessary.

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1. INTRODUCTION

1.1 The Institute for Health Policy Studies (IHPS) was approached by Wessex Regional Health Authority (RHA) early in 1992 and asked to submit a proposal for a research project examining the ways in which GPs could encourage patients to take responsibility for their health through lifestyle changes. Wessex RHA's interest in this topic arose from an awareness of the increase in GPs' workload resulting from the 1990 GP contract, in particular through GPs' increased responsibility for health checks and health promotion. An identification of some of the ways in which GPs could encourage patients to take responsibility for their own health was viewed as being one way that GPs could work most effectively and limit the demands made on their time.

1.2 The project was funded by the NHS Management Executive in the form of a Patient's Charter Fellowship in 1993. Funding was provided for ten months commencing in July 1993. A research fellow from the IHPS was appointed to work on the project during this period. A steering group was formed to guide the project consisting of a representative each from: the RHA's Primary Care Directorate; the Institute for Public Health Medicine; Southampton University's Department of Primary Medical Care and Department of Psychology; and, two senior members of staff from the IHPS.

1.3 It was agreed that the project would be in the form of a pilot study that would seek to identify a range of factors which influence patients' compliance with lifestyles advice (that is advice about diet, exercise, smoking and alcohol intake) given in primary care in relation to the primary prevention of coronary heart disease (CHD). This topic was chosen as the incidence of CHD, which is the single most common cause of death in England, has been linked with an unhealthy lifestyle (HMSO, 1992; Field and Henderson, 1993) and thus the adoption of a healthy lifestyle is one important way that people can take responsibility for their health.

1.4 Health professionals in primary care have, particularly since the 1990 GP contract, been encouraged to put a considerable focus on advising patients on healthy lifestyles with a view to reducing the incidence of CHD. 'The Health of the Nation' (HMSO, 1992) and

the Health Promotion Programmes (HPPs) for primary care which commenced in July 1993 have reinforced this trend. However, evidence to date suggests that lifestyle advice given in primary care is largely unsuccessful in bringing about a change in patients' behaviour, particularly in the long term (Family Heart Study, 1994; Imperial Cancer Research Fund OXCHECK Study Group, 1994). The identification of ways in which health professionals might encourage higher rates of compliance is clearly crucial both in terms of effective practice for health professionals and successful outcomes for patients.

1.5 It was decided that the project would focus on patients receiving lifestyles advice from practice nurses (PNs) rather than GPs as they have, since the 1990 GP contract, had the bulk of responsibility for routine health promotion in primary care through the running of screening programmes and health promotion clinics and many have received some form of training for these tasks (Atkin et al, 1993). While some GPs may offer lifestyles advice opportunistically this is not a routine feature of their work with every patient. Furthermore, some GPs are critical of this element of the 1990 GP contract and of subsequent developments (Kelly, 1993). Thus, it was felt that it would be more straightforward and productive to identify patients receiving lifestyles advice by working through PNs rather than GPs.

1.6 It was agreed that interviews would be carried out with a sample of around 50 patients who had received lifestyles advice from a small number of practices with different practice populations in order to have a range of age and social class groups represented in the sample. These interviews followed a semi-structured format on the grounds that open-ended qualitative data would produce greater insights into patients' reactions to advice received than would questionnaires with pre-determined response categories.

1.7 The primary aim of the study was to identify a range of factors that influence compliance with lifestyles advice. A secondary aim was to explore whether this information could be used to identify ways in which health professionals might encourage greater rates of compliance with advice.

2. POLICY AND RESEARCH CONTEXT OF THE PROJECT

2.1 The project is located within the policy context of 'The Health of the Nation' and the HPPs for primary care which commenced in July 1993 replacing the health promotion clinic scheme. Both 'The Health of the Nation' and the HPPs have the prevention of CHD through lifestyles interventions and advice as central features.

2.2 The HPPs offered GPs a framework in relation to health promotion informed by 'The Health of the Nation'. The aim of the programme is to 'improve the health of practice populations by taking action known to be effective on an individual level to reduce morbidity and mortality from CHD and stroke' (NHS Management Executive, FHSL (93)3). The programme uses a banding system and GPs were invited to apply to their FHSA for inclusion in one of the three bands. Over 90% of practices in Wessex (and in the rest of the country) applied, and were accepted, for inclusion in the highest band, band three, of the HPP. For inclusion in this band practices are expected to:

(i) collect information on: smoking; blood pressure; body mass index; alcohol consumption; family history (where appropriate); and monitor diet and physical activity in the target population.

(ii) Offer advice and other appropriate interventions and follow up, taking into account relevant local factors and following practice guidelines.

(iii) Focus activity on priority groups and ensure measures are taken to reach those in priority groups not presenting at the surgery.

(iv) Work jointly when appropriate with other individuals or agencies to further the aim of the programme.

(NHS, Management Executive, FHSA (93)3, paragraph 30 schedule 3)

2.3 There was no set format for the actual interventions that practices should use for inclusion in the programme; practices were free to state on their application the procedures

most appropriate for their practice populations and their own skills and experience providing they fulfilled the criteria set out above. Thus the methods used by practices and the personnel involved are likely to vary from practice to practice.

2.4 It is clear that the work involved for a band three practice is substantial and could not be carried out by one professional alone. Noakes (1993) notes that the data collection element of the programme requires the involvement of all the PHCT and the interventions element is likely to require the involvement of GPs, PNs and receptionists. It is likely that PNs have considerable responsibility for at least some of the interventions within the programme in most practices, given that their jobs have come increasingly to have a health promotion component and many PNs have had at least some training in this area (Atkin et al, 1993). GPs have less time, and arguably opportunity, to focus on extensive interventions with patients routinely and there is evidence that some GPs are unhappy about taking on this role (Kelly, 1993).

2.5 Given that the programme has been running for less than a year it is not possible at this stage to examine its impact. Both the extent to which practices granted band three status have fulfilled the requirements of the programme and, if they have, whether these have resulted in successful outcomes in terms of patients' behavioural change will need to be evaluated fully once practice reports on the first nine months of the programme become available. This project was not intended to address these questions but rather to identify, within the context of the HPP, some of the factors which influence patients' compliance with the lifestyle advice that they are given.

2.6 While the HPPs for general practice are a new initiative, lifestyle advice is not and there is a considerable amount of research that has examined its impact on behaviour. This research provides evidence of the types of outcomes of lifestyle advice and the factors that need consideration in encouraging compliance with advice.

2.7 Studies located within primary care have indicated that lifestyles advice is generally ineffective in bringing about long-term change in patients' behaviour. The two most recent large-scale evaluations of health checks and interventions for cardiovascular risk factors in

general practice found very slight changes despite intensive intervention (Stott, 1994). The Family Heart Study (1994) found only slightly lower weight, blood pressure and blood cholesterol concentration at one year in the intervention group which, if maintained long term, would only correspond to a 12% lower risk of coronary events. The OXCHECK study (1994) found no significant difference between the intervention and control group in the prevalence of smoking or body mass index. There was a significant difference between the groups in cholesterol concentration but the difference was small. Both studies concluded that, on the basis of their evidence, the likely effectiveness of the HPPs in bringing about reductions in risk are doubtful and that resources might be better spent on patients with high risk of CHD. A study in one Welsh general practice reached similar conclusions (Gibbins et al, 1993).

2.8 Smaller studies of brief interventions for behaviours such as smoking and alcohol consumption have similarly found low rates of success (Sacks et al, 1992). Rollnick et al (1993) note that while it is clear that brief interventions have some benefit, in that recipients fare better than their counterparts in control conditions, the size of the effects is quite small with success rates of 5-10% not uncommon. It is noted that one reason for this low success rate is the way that advice is given. A number of simple strategies and techniques that can be employed by advice-givers, such as repeating advice, writing it down and using simple language, have been outlined (Ley, 1989). However, more recently, drawing from research on addictions, the importance of negotiating change with patients in consultations rather than simply giving advice has been identified. Practitioners are advised to assess patients 'readiness to change' based on a 'stages of change model' and to offer counselling or advice that is appropriate to the patients' position in the model. (Field and Henderson, 1993; Rollnick, 1993). Thus, patients who are not 'ready' or motivated to change are encouraged, through counselling, to move to a position where they are ready to change before advice is offered. The primary care resource 'Better Living Better Life' which has been widely distributed to practices is based on this model of advice giving. This resource, which was developed by the Department of Health, the General Medical Services Committee and the Royal College of General Practitioners Working Group on Health Promotion, provides health professionals in primary care with practical advice on lifestyle interventions for CHD and stroke.

2.9 There is some evidence that motivational interviewing based on the stages of change model may be successful in bringing about behavioural change. Furthermore, health professionals have been informed of these methods through resources such as 'Better Living Better Life'. However, there is no evidence that there is a widespread adoption of such models in practice. Indeed there is some evidence that both GPs and PNs lack the knowledge and skills to give even basic lifestyles advice, particularly in relation to diet (Francis et al, 1989; Cade and O'Connell, 1991; Kyle, 1993; Murray et al, 1993). While a national census of PNs found that few PNs expressed a need for training in running health promotion clinics (Atkin et al, 1993), the haphazard nature of PN education and training (Ross et al, 1994) means inevitably that PNs have very variable levels of knowledge in relation to lifestyles advice. This may be one explanation for low levels of long-term behavioural change following lifestyles advice.

2.10 It is not only the way that advice is given that offers an explanation for low levels of behavioural change following lifestyles advice. The ways that advice is received, understood and acted on by patients also offers an explanation for low levels of compliance. It has been noted that the vast majority of people are aware of the health risks associated with behaviours such as smoking, a lack of exercise and a poor diet (Blaxter, 1990). However, many people do not behave in a purely rational way on the basis of this knowledge by changing their behaviour following lifestyles advice. While a direct and immediate health threat has been found to influence health behaviour (see, for example, Blaxter and Cyster, 1984), in cases where a threat to health is not immediate, beliefs and attitudes appear to be more clearly related to behaviour than knowledge (Shepherd and Towler, 1992).

2.11 Traditionally, aspects of people's health beliefs have been viewed as major explanatory tools for compliance with lifestyles advice. Two models have been constructed to account for why some people comply with lifestyles advice and others do not. The 'health belief model' asserts that compliance is predicted by three sets of beliefs: a person's perceived vulnerability to an illness; the perceived severity of the illness; and, the perceived benefits of, and barriers to, compliance with advice. Proponents of the health belief model argue that individuals make the decision to comply based on an assessment of these three factors (Janz and Becker, 1984; Donovan and Blake, 1992). The other model is the 'health

locus of control' which holds that people who believe that they have some control over their health are more likely to adopt health enhancing behaviour by following lifestyles advice than those who hold more fatalistic views of health and illness (Wallston et al, 1978). Explanations relating to people's health beliefs may offer some explanation for some people's failure to follow lifestyles advice (Kelly et al, 1991). However, more recently, research has indicated that structural, social and circumstantial factors may offer more adequate explanations for health behaviour (Calnan, 1991).

2.12 Explanations that take into account structural, social and circumstantial factors in explaining health behaviour fall into three main areas: environment; socio-economic factors; and, life cycle. Each area is not viewed as a mutually exclusive explanation but as multi-dimensional explanations for why some social groups may fail to respond to lifestyles advice.

2.13 Explanations that focus on the environment note that the areas in which people live may explain why certain groups find it more difficult than others to follow, and stick to, lifestyles advice. In a study in Glasgow comparing a middle-class and working-class area, Macintyre et al (1993) observed that the middle class area was more conducive to health. In the middle-class area more healthy foodstuffs were available locally and were cheaper, more sporting and recreation facilities were within easy reach and there were more extensive primary health care services compared with the working class area. The authors conclude that the areas in which people live may have an important role in promoting or inhibiting health. People living in an area with a greater number of facilities are likely to find following lifestyles advice far easier than people without such facilities.

2.14 A number of studies have identified socio-economic factors as explanations for particular types of health behaviour and why some groups may have difficulty in complying with lifestyles advice. These explanations identify the resources relating to people's socio-economic position, both financial and personal, as factors influencing health-related behaviour. Studies have found that the stresses relating to people's material and social situation may influence their lifestyle and their ability to change it. Research carried out by Graham (1993) showed not only that there was a significant association between smoking and low household income among women but also that smoking served as a way of coping with

on-going material and domestic difficulties. Food has been found to serve a similar purpose among some groups of women especially those not in paid employment (Charles and Kerr, 1988). Additionally, the use of food, cigarettes and alcohol have been identified as coping strategies employed by men to counteract stresses resulting from work (Mullen, 1992). Changing behaviour which provides an element of coping with particular difficulties has been identified as a complex task and one that mere advice giving may not be able to address.

2.15 People's position in the life cycle has also been identified as an explanation for particular types of health-related behaviour and a failure to comply with advice. Backett & Davison (1992(b)) have argued that people do not do what is 'rational' in terms of lifestyle but rather what is 'reasonable' or appropriate to their particular stage of life. Thus, what may be viewed as appropriate behaviour for teenagers is unlikely to be viewed as appropriate behaviour for the middle-aged and vice-versa. They argue that people giving lifestyles advice tend to give 'blanket' advice to everyone because particular behaviours are regarded as 'good' or 'bad' for everyone. While it may be the case that some behaviours are unhealthy for all, Backett & Davison argue that participation in potentially health-damaging behaviour 'can and does' seem appropriate behaviour for groups at particular stages of their lives (Backett & Davison, 1992(b):55). It is noted that unless those giving advice take into account how particular groups may regard their behaviour as appropriate to their age and social position, and give advice that engages with this, then advice is unlikely to be followed.

2.16 To summarise: research has shown that lifestyles advice given in primary care is largely unsuccessful in bringing about long-term change in patients' health behaviour. Explanations as to why patients fail to follow lifestyles advice received from health professionals fall into two broad categories. The first relates to the ways in which advice is given and the second relates to the ways that advice is received, understood and acted on by patients. As regards the ways that advice is given, the use of methods of assessing motivation are viewed as important in encouraging compliance but the extent to which such methods have been adopted by health professionals is questionable. As regards the ways that advice is received, people's health beliefs, and perhaps more importantly, a range of social and circumstantial factors have been identified as important constraints in relation to compliance with lifestyles advice.

2.17 Using existing research as a framework, this study sought to identify a range of factors which influence compliance among people given lifestyles advice within the HPPs in primary care.

3. METHODOLOGY

3.1 Following Ethical Committee approval, access was initially negotiated through GPs to three practices in one Health Commission area in Wessex in September 1993. GPs in two of the original practices contacted refused to participate and a further two were contacted to replace these. Reasons for refusal to participate were pressures of time and involvement in other research projects. All the practices invited to participate were in band three of the HPP. They were selected as the populations they served were viewed as representing a wide range of social and age groups and it was anticipated that this would allow for the identification of the widest number of factors affecting compliance with lifestyles advice.

3.2 It was anticipated that a sample size of 50 patients receiving lifestyles advice could be obtained from three practices given the high levels of lifestyles advice expected to be given to patients by band three practices. However, as the research progressed it became clear that to achieve the desired sample size it would be necessary to work with a larger number of practices and access was negotiated with a further four band three practices in the area. The total number of practices participating in the project was seven. Like the original three practices in the sample, these four practices were selected to participate on the basis of the populations that they served in order to obtain interviewees from a range of social and age groups.

3.3 The practices participating in the project can be characterised as follows:

PRACTICE 1 Single-handed practice in a predominantly working-class area with high levels of rented accommodation. The area has large Asian and student populations;

PRACTICE 2 Practice with three GPs with a mix of middle- and working-class populations. The area has some high rise council housing and rented student accommodation but privately owned housing predominates;

- PRACTICE 3** Practice with two rural surgeries in an affluent area with three partners. Predominantly middle-class, retired population. Very little public housing;
- PRACTICE 4** Practice with five partners and two urban surgeries. One practice has a mix of working- and middle-class populations and one has a predominantly working-class population with almost entirely public housing;
- PRACTICE 5** Practice with eight partners in a semi-rural area. The population is predominantly middle-class;
- PRACTICE 6** Practice with six partners in a health centre. Predominantly working class population which includes a small Asian population and a student population;
- PRACTICE 7** Practice with seven partners. The area contains a number of new housing estates and is predominantly middle class with a population dominated by young couples and children.

3.4 Practice nurses in these practices were asked to distribute letters to all patients to whom they gave lifestyles advice over a specified period between October 1993 and February 1994. The original three practices were asked to distribute letters over a three month period and one of these practices extended the period of distribution to five months. Of the other four practices, one distributed letters over a four month period and three distributed letters over a six week period.

3.5 The letters distributed to patients invited them to participate in an interview with a researcher to talk about their feelings and experiences relating to the advice that they had been given by the practice nurse. Attached to each letter was a slip for them to return in a pre-paid envelope stating whether or not they would be willing to participate. A total of 28

interviewees returned the slip indicating that they would be willing to participate in an interview to discuss the advice that they had been given. Twenty-six of these were interviewed. Two returned their slip too late to be included in the sample. Details collected by PNs on the patients invited to participate did not indicate that any particular groups of patients were more likely to participate than others. Table one outlines the numbers of letters distributed by each practice, the period of distribution and the number of patients interviewed from each practice.

TABLE 1 **RESPONSE RATES FROM EACH PRACTICE**

	PERIOD OF DISTRIBUTION	NO. OF LETTERS DISTRIBUTED	NO. PARTICIPATING
PRACTICE 1	3 months	7	3
PRACTICE 2	3 months	11	10
PRACTICE 3	5 months	no record	2
PRACTICE 4	4 months	7	3
PRACTICE 5	6 weeks	2	1
PRACTICE 6	6 weeks	12	4
PRACTICE 7	6 weeks	6	3
TOTAL	-	45	26

3.6 It had been anticipated that it would be possible to obtain a sample of 50 patients from the original three practices contacted over a period of three months given the amount of lifestyles advice band three practices were expected to be giving. However, in the event it was only possible to obtain a sample half that size using seven practices over a longer period of time. Clearly, it may have been possible to have obtained the sample of 50 had seven practices been involved from the outset.

3.7 There are a number of possible reasons why the three practices originally involved were unable to produce the number of respondents anticipated. First, it may have been that practice nurses forgot to distribute the letters to all the patients to whom they gave lifestyles advice or that they chose which patients to give letters to on the basis of their views of which

patients might be most likely to respond positively. Attempts were made to limit the likelihood of this occurring in several ways. First, PNs were visited by the researcher who stressed that all patients to whom they gave lifestyles advice should be given a letter, providing the advice contained more than a passing comment that someone should change a particular aspect of their health behaviour. Second, the time-span of the project was short and PNs were telephoned by the researcher during the period in which they were distributing letters to encourage them to continue with the distribution. Third, practice nurses were asked to record on a supplied sheet some brief details of the patients to whom they distributed letters and the researcher informed them that she would call back and collect this sheet after the period of distribution. Each of these strategies would seem likely to encourage PNs to distribute the letters to as many patients as possible.

3.8 Another possible reason for the difficulties in obtaining a sample may have been that patients were reluctant to participate. PNs from six of the seven participating practices recorded basic information on patients to whom they gave a letter on a sheet supplied by the researcher. The sheet asked for information on the age and sex of the patient and whether advice was given in relation to diet, exercise, smoking or alcohol intake. The information collected by two of the three original practices showed that out of a total of 18 letters that were distributed in the three month period, 13 people participated in the project, making a response rate of 72%. Assuming that the information was recorded accurately it appears that reluctance to take part does not fully explain the low response rate of patients from these two initial practices.

3.9 A final explanation for the low numbers of patients participating from the three practices initially involved in the project is that PNs were not giving the amount of lifestyles advice that was anticipated would be given by band three practices. The interviews with the practice nurses in the initial three practices worked with, and the information recorded on the patients that were invited to participate, indicate that this may have been the case.

3.10 While the sample size was smaller than anticipated, the steering group agreed that the information collected would fulfil the primary aims of the project of identifying some of the factors which influence compliance with lifestyles advice.

3.11 Of the patients interviewed, 15 were female and 11 were male. Their ages ranged from 23 to 70. Table two sets out the numbers of men and women in each age category.

TABLE 2 **AGE AND SEX OF INTERVIEWEES**

	MALES	FEMALES	TOTAL
23-35 YEARS	4	5	9
36-45 YEARS	1	1	2
46-55 YEARS	1	3	4
56-65 YEARS	4	6	10
OVER 65 YEARS	1	-	1
TOTAL	11	15	26

3.12 The interviews took place between November 1993 and February 1994. The people agreeing to be interviewed were contacted and interviews were arranged in their own homes. The interviews were designed to obtain information on:

- patients' past experiences of advice and/or attempts to change their health behaviour;
- the types of advice that the interviewee had received from the practice nurse and the context in which this took place;
- patients' views of the advice;
- compliance with the advice;
- perceptions of factors which affected their compliance;
- patients' feelings of responsibility for their health.

3.13 The interviews were semi-structured with a list of questions that were asked of all interviewees, but the interviewer was free to pursue individual responses to any of the topics in more depth. Each interview lasted an average of 45 minutes and was tape-recorded. The tapes were subsequently transcribed in full and the transcripts were then analysed manually by grouping the types of responses interviewees made in relation to the key topics of the research.

3.14 Interviews were also carried out with PNs in each of the seven participating practices. These were carried out when the letters for distribution to patients were taken to the practices. The main aim of these interviews was to collect information on the general procedures and practices used by the PNs in giving lifestyles advice. Data was not collected on the specific advice given to the patients that were subsequently interviewed. The information collected was to be used to inform the interviews with patients by providing some pre-knowledge of the types of advice patients from individual practices would be expected to receive. However, these PN interviews also provided the opportunity to collect further information. PNs were asked about the training in health promotion/lifestyles advice that they had received, their perceptions of how successful lifestyle advice was in terms of compliance, and, the impact of the HPPs on their workload.

3.15 In four practices one PN was interviewed and in three practices two PNs participated in the interview. As with the patient interviews, these interviews followed a semi-structured format but without the use of a tape recorder. The interviews lasted between 15 minutes and one hour depending on how much time the PN(s) had available.

3.16 Both the difficulties in obtaining a sample and initial findings from the PN interviews indicated that PNs might not be giving as much detailed advice on lifestyle in relation to CHD as would be expected from band three practices. While an examination of the way that HPPs were working was not an original aim of this project, the interviews with PNs produced some interesting findings regarding this. It was decided, therefore, to supplement these findings with a questionnaire survey among PNs in the area in order to examine in more detail the impact that the HPPs had on the way PNs worked. The survey sought to examine:

- the effect that the HPPs had on the amount and type of work carried out by PNs;
- PNs' involvement in the application for banding;
- estimates of the number of patients given lifestyles advice and compliance;
- types of lifestyle advice most commonly given;
- arrangements for follow-up of patients;
- details of any work specifically relating to CHD prevention;
- details of education and/or training in giving lifestyles advice.

3.17 Questionnaires were sent by post in February 1994 to the senior PN in all the practices in the area which had not already been contacted to participate in the project. A total of 59 questionnaires were distributed. The questionnaire was structured but contained some open questions where respondents could provide more information on particular topics. Practices could not be identified from the questionnaires as it was felt this might discourage PNs from responding. A total of 41 PNs responded to the questionnaire, making a response rate of 69%. The questionnaires were analysed manually.

3.18 Of the 40 PNs who completed the part of the questionnaire asking for information about themselves and the practice, 11 had been in post for less than five years, 18 between five and 10 years, seven between 10 and 15 years, with the remaining four for more than 15 years. The PNs worked a range of hours. Most worked between 11 and 30 hours per week (70% n=28), three PNs reported working less than five hours per week and nine reported working more than 30 hours per week. Most of the PNs worked with other PN colleagues; only six respondents reported being the sole PN in the practice.

4. PRACTICE NURSE INTERVIEWS AND SURVEY DATA

4.1 Both the interviews and survey of PNs produced information on PNs' training and practice in relation to lifestyles advice and on the impact of the HPPs on PNs.

Perceptions of the Effect of Health Promotion Programmes on Workload

4.2 The 1990 GP contract introduced an obligation on GPs to carry out certain health promotion activities. GPs were obliged to invite certain patients not seen in the previous three years to attend for a health check and to offer health checks for people aged 75 and over at yearly intervals. In addition, GPs were able to set up health promotion clinics in their practices for which payments were made and a target system of payment was drawn up for cervical screening and immunisation. Much of this work involved PNs in some way as has been indicated by the growth in the employment of PNs since the introduction of the GP contract (Atkin et al, 1993). A census of PNs in England and Wales found that: most PNs are involved with immunisation and with running general health promotion clinics; over half are involved with chronic disease management; and, over half visited patients in their own home, mostly for over 75s assessments (Atkin et al, 1993). Clearly, the health promotion element in the GP contract has had a significant impact on PNs' roles and responsibilities resulting in their involvement in a wider range of tasks than the 'treatment room' duties for which many were originally employed.

4.3 The HPPs were set up in 1993 to replace the health promotion clinic scheme which was seen as expensive and largely unsuccessful in reaching patients most in need (Noakes, 1993). It was anticipated that the tasks relating to the programmes would be largely delegated to nurses (Atkin et al, 1993). The requirements of the HPPs are not only to collect data on lifestyle but also to 'reach out to people in priority groups within the target population including those who do not present at the surgery and offer programmes of intervention which concentrate on lifestyle alteration' (NHS Management Executive, 1993 FHSL (93)3 par.8). The requirements of the HPPs are specific and differ from those of the health promotion clinic scheme, most notably in that the HPPs aim to target interventions on those most at risk. Band three practices in particular are expected to have a high degree of

activity in this regard. It would be expected, therefore, that PNs in band three practices would experience a marked difference in their ways of working following the advent of the HPPs.

4.4 PNs in six of the seven practices which participated in the project were asked what effect the HPP had had on their ways of working or their workload. PNs in five practices reported that they perceived no difference following the introduction of the HPPs. These PNs noted that there was a significant change in the types of work that they did following the 1990 GP contract but that the change since July 1993, if noted at all, was minimal. One PN, for example, said:

'There's little change really. No, I don't think there's been a change. I've been a PN here for five years. To start with I just used to do specific things but now it's got much more general. We give much more advice than we used to when I first came but it hasn't changed much since July'

4.5 A total of 39 survey respondents answered the question relating to the impact of the HPPs on the amount and type of work they carried out. Just over half (54%) reported that the HPPs had had an impact on their work and just under half (46%) reported that they had not. Those who reported a change in the amount or type of work they were doing were asked to give details of the ways in which this was so. Of the details provided, only six PNs referred specifically to targeting of patients or particular interventions that they were using. The rest of the PNs referred to a general increase in the amount of lifestyles advice given in their comments but did not refer to the contexts in which they gave advice or the types of advice that they gave.

4.6 Of those PNs who responded to the question on banding, half stated that they were involved with the application for banding made by the practice. One might assume that those involved with the application might be more likely to perceive that the HPPs had had an impact. However, this association was not particularly strong. As Table three shows, of those who were involved with the application for banding (n=20), only 50% perceived that the HPPs had had an impact on the amount or type of work they carried out.

**TABLE 3 RELATIONSHIP BETWEEN INVOLVEMENT IN
BANDING APPLICATION AND PERCEIVED IMPACT OF HPPS**

	HPP PERCEIVED AS HAVING AN IMPACT	HPP NOT PERCEIVED AS HAVING AN IMPACT	TOTAL
INVOLVED IN BANDING	10	8	18*
NOT INVOLVED IN BANDING	10	10	20
TOTAL	20	18	38*

* two respondents did not respond to the question relating to the impact of the HPPs and one did not respond to either question.

4.7 It is surprising that only just over half of PNs in the survey, and only one of the PNs interviewed, reported the HPPs having an impact on their roles and responsibilities. It is also surprising that, of those in the survey who did report a change in workload, so few mentioned targeting and particular interventions which are the central features of the HPPs. However, this does not necessarily mean that PNs are not carrying out the requirements of the HPPs. It may be that, in comparison with the changes resulting from the GP contract, the HPPs are not perceived as affecting a significant change in PNs' role. Data collected from both the interviews and the survey on the ways PNs were actually working with the HPPs give a clearer indication of the impact of the HPPs on their work.

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4.8 The PNs interviewed were asked about the contexts in which they gave lifestyles advice. It was assumed that if particular groups were being targeted for interventions, as the HPPs require, there would be some mechanism for reaching such groups which PNs would identify. Lifestyles advice appeared to be given in three contexts: first, as part of on-going monitoring of, for example, blood pressure or diabetes; second, when patients self-referred for health checks or dietary advice; and, third, opportunistically when patients were seen for something unrelated to lifestyles, for example a new patient check. PNs saw these patients

through patient self-referral, GP referral or when patients were instructed by receptionists or health professionals to see the PN. Only one PN mentioned a particular group that was being targeted for advice. Typical comments were:

'I use new patient checks to give lifestyles advice. Also I often find that patients come to see me about something else and then they ask me about their weight and I give them advice'

'We get to see patients in all sorts of ways: patients can make their own appointments for a health check; the doctors here are keen to give everyone a health check if they haven't been to the surgery for three years so we see them; we see the elderly for their checks and the doctors refer people to us if they haven't got time to deal with it themselves'

4.9 The PNs were also asked which groups of people they gave advice to most commonly to see if this produced any information on the targeting of groups. The PNs identified young and middle-aged women and elderly people as groups most commonly given advice. They reported that advice to these groups was given most frequently because they tended to self-refer and seek advice or to attend for particular health clinics or screening where advice was given opportunistically. As one PN noted:

'It's more women than men for lots of reasons I suppose - because they're at home more and able to come in. We get mostly the upper age groups - the middle aged and the elderly. The elderly are more easy to motivate because they are more likely to have the physical problems that have accumulated through a lifetime of having a poor lifestyle'.

4.10 The PNs interviewed were also asked about the types of lifestyle interventions they used most commonly to try to identify the extent to which the advice was related to CHD prevention. PNs in six of the seven practices interviewed reported that interventions relating to diet and exercise were most commonly used. These PNs noted that they tended to give only a minimal amount of advice relating to alcohol or smoking. Two reasons were given

for this, first, because they tended not to see patients with these problems and second, because, when they did, they tended to give advice only when patients seemed highly motivated because rates of compliance with such advice was perceived as low. Interventions for diet and exercise were used most frequently because they were most commonly sought by patients and furthermore it was an area where PNs felt they could work effectively. The following comments were typical:

'We spend longer on diet I suppose. We do discuss alcohol and smoking at all the health checks but only at quite a minimal level . We sort of flash information at patients. I don't get that many Smokestop patients'.

'We don't do much on smoking and alcohol. We do point out the risks and if patients are motivated we advise them to cut down ... but most of them know about the risks and don't really want to change'

4.11 However, in the questionnaire survey, the majority of respondents (75%) reported that they gave a range of lifestyles advice rather than concentrating on diet and exercise. It is not possible to ascertain whether these respondents gave detailed advice in all areas or whether, as was the case with the interview respondents, the most detailed advice was given for diet and exercise and advice on other aspects was 'flashed' at patients.

4.12 The PNs who were interviewed were asked about the arrangements that were made for follow-up after initial lifestyles advice. Follow-up is very important in relation to the HPPs in order to monitor the effectiveness of interventions. Arrangements for follow-up were dependent on the context and reasons for advice being given. As has been noted above, lifestyles advice appeared to be given in three contexts: as part of on-going monitoring; when patients self-referred; and, opportunistically. The only group of patients that was 'followed up' were those that were seen for on-going monitoring of another condition. 'Follow up' in this context generally meant asking a patient to make a further appointment. It is not clear if patients were actually 'followed up' if they did not make further appointments with the PN, although it is likely that their notes were 'tagged' in some way. Other patients were not followed up but were invited to come back and see the practice nurse following initial advice.

Only motivated patients tended to do this and PNs noted that others were lost in the system:

'We don't always get feedback. Although we always ask people to come back and let us know how they get on, a lot of people don't. Some people we do get to find out about, people who have yearly checks for example and people that we see regularly for certain conditions. But in a lot of cases we just don't know. It's not logged'

4.13 PNs participating in the survey were asked to state if they routinely followed up patients given lifestyles advice. The majority (88%) stated that they followed up some, but not all, patients. This probably indicates that most PNs have a similar system to those interviewed as regards follow up of patients, that is, that patients identified as at risk are followed up but others offered lifestyles advice are not.

4.14 The findings from both the interviews and the survey suggest that the HPPs may not have had a significant impact on the way PNs are working in relation to the giving of lifestyles advice for the prevention of CHD. The PN interviews, in particular, have indicated that PNs are involved in giving a considerable amount of lifestyles advice but that much of their time is taken up by giving lifestyles advice opportunistically or to patients who self-refer. Furthermore, much of the advice given may be related to diet and exercise rather than other risk factors. Clearly PNs are giving advice to patients in relation to CHD prevention and such patients are monitored; all the PNs interviewed noted that lifestyle advice was given to patients seen for conditions such as high blood pressure and hypercholesterolaemia and 85% of the survey respondents reported giving advice specifically in relation to CHD prevention. However, whether the HPPs have brought an increase in the level of this work and whether patients at risk are actively targeted is not clear.

4.15 There are a number of other explanations for the apparent lack of change in ways of working reported by some PNs. It may be that in some practices GPs are more involved with the HPPs than had been assumed or it may be simply that the HPPs have not yet had a noticeable impact on PNs given that they have been in operation only since July 1993. Clearly further research is necessary to examine the extent to which the requirements of the

HPPs are being met in practice. If the HPPs are found, in practice, to differ little to the old health promotion clinics then they will be ineffective in reaching and helping patients most at risk.

Training

4.16 The HPPs have placed specific skill requirements on PNs in relation to the giving of lifestyles advice with the aim of preventing CHD. The interviews and survey provided an opportunity to explore the level of training relating to lifestyles advice that the PNs had received. To a lesser degree, they provided an opportunity to examine whether PNs were aware of and practised methods of negotiating change with patients, which have been identified as effective in promoting behavioural change. PNs, and other health professionals involved in giving lifestyles advice, need to be able to give advice in an effective way in order to encourage compliance. This is important, not only for successful patient outcomes but also for work satisfaction for PNs.

4.17 The PN census (Atkin et al, 1993) notes that PNs hold a range of professional qualifications. However, it found that only 14% of respondents held a community nursing qualification and less than half had attended a course on practice nursing validated by one of the national boards. The authors conclude that there 'appear(s) to be a shortfall in the number of nurses qualified to run health promotion clinics' (Atkin et al, 1993:75). Furthermore, the scope for education and training 'on the job' which might rectify this has been found to be haphazard (Ross et al, 1994), both because of a lack of funds earmarked for PN training (Evans, 1992) and the reluctance of GPs to support courses if no cover is provided (Slaughter, 1991). However, the PN census indicated that while only one third of PNs have a specified number of study days a year, only one in ten had not taken a study day in the last 12 months although many may have to attend in their own time or to pay for the study days themselves. Recently the NHS Management Executive has argued that FHSAs need to take a proactive role and ensure the provision of training and support for PNs (NHS Management Executive, 1993).

4.18 In the area in which this research was carried out, three workshops were held prior to the introduction of the HPPs to which all practices were invited to send representatives, including PNs. The aims of these workshops were to explain the HPPs and to answer any questions about the programmes that individuals might have. At these workshops two copies of the primary care resource, 'Better Living Better Life' (Field and Henderson, 1993) were distributed to each practice. In addition, the availability of 'Better Living Better Life' was advertised in the 'Health Promotion Bulletin' from the FHSA. 'Better Living Better Life' was developed in order to help those giving advice on lifestyle for CHD and stroke prevention to make their advice as effective as possible. It is based on methods of negotiating change with patients. This resource, in conjunction with training in giving lifestyles advice, are the primary means of educating PNs in giving lifestyles advice.

4.19 PNs were asked, both in the interviews and survey, for details of any training that they had received relating to lifestyles advice. Of the 39 respondents who replied to this question in the survey, only 15% (n=6) reported that they had received no training relating to lifestyles advice. One of these was a new appointment and had not had the opportunity to attend any training. Of the rest, three had been working as PNs for over eight years and worked at least 20 hours per week, one had been working as a PN for two years and worked 12 hours per week and no details were given for the remaining PN. It is not clear why five of these six PNs had not received any training in lifestyles advice. Three of these PNs reported giving lifestyles advice to over 50% of patients seen per week and without training it is not clear how effective such advice might be.

4.20 Thirty-two respondents gave details of the education/ training in lifestyles advice that they had received. All but three of these identified specific study days relating to one or more of the following: CHD prevention; lifestyles; smoking; healthy eating; health education; and, health promotion. The other three PNs reported attending study days but did not state what these study days were about. In addition, 19 PNs reported having taken part in longer training courses on smoking cessation and weight control and four PNs reported participating in more detailed education and training which included a MSc in health promotion and the 'Screening and Motivating Change' course.

4.21 PNs interviewed in four of the seven practices reported having attended study days and seemed satisfied with the training in lifestyles advice that they had received. Two of the other three nurses interviewed had also attended study days but there was a sense that these were not viewed as adequate to meet their needs in giving lifestyles advice:

'I haven't really had any training. I've had a day with the chief dietitian and I've been on the PN course and PN updates which have lectures on lifestyle advice and cholesterol screening'

'I haven't really had any training. We don't know much about alcohol and smoking advice. We've been on the 'eat it beat it' course but apart from that we've just picked up things from other courses like the diabetes one'

Only one PN reported having no training in lifestyles advice at all due to a lack of time to attend:

'I've just had my nurse's training and I try to keep up with the literature but I haven't had any specific training. I know there are these courses but I haven't got the time. I've got another job, I'm only here part time'.

4.22 Interview and survey respondents were asked if they had seen 'Better Living Better Life' (BLBL) and if they used it as a basis for the lifestyles advice that they gave. The great majority (85%) of survey respondents reported that they had seen BLBL but 38% of these stated that they did not use it in giving lifestyles advice. One of these respondents said that she did not use it because she was already giving advice in the ways set out in BLBL before she received it. Of the seven practices in which PNs were interviewed, PNs in three practices noted that they had not seen BLBL and in only two practices did PNs say that they did, or intended to, use it in practice.

4.23 Two issues emerged as constraining factors against the use of BLBL; first, lack of time to consult a document which in some respects seemed inappropriate for its audience because of its size and appearance, and second, an inaccurate view of what BLBL was about

coupled with a notion that such a resource was unnecessary because PNs had received training on the topic and therefore already knew how to do it. Comments from three PNs illustrate these points:

'We don't use it - I don't think 'Better Living Better Life' would mean much to a lot of our patients'

'To be honest I haven't given it the attention I should. It's time really, you can't do everything. You just end up being a jack of all trades and a master of none'

'I haven't read it cover to cover I must say and I don't think you can follow a formula for giving advice, it would be very stilted'

4.24 Interviewees were asked about the practices used in giving lifestyles advice and about the procedures for patients who appeared unmotivated. The aim of this was to attempt to identify if PNs were aware of procedures relating to the assessment of motivation and negotiating change with patients, as set out in BLBL, and if PNs used such methods. Only one of the PNs interviewed specifically mentioned assessing motivation before giving advice. However, they did all note the importance of motivation in determining whether a patient followed advice and the importance of tailoring advice to individuals. Two of the seven PNs reported that they made attempts to motivate some patients with low motivation. In general, it seemed that PNs used their experience in judging what was appropriate advice for each person but, where patients lacked motivation, advice was still given, even if they felt this advice would probably not be followed. Such patients were not followed up. The following quotation illustrates the approach used by all the PNs:

'We do what's appropriate, we pick up the vibes from the patient. I always give advice but if there's no way that people are going to follow it then I just leave it and tell them to come back and see me if they feel they would like to have a go at changing their lifestyle in the future'

4.25 The extent to which PNs feel that the advice they give is effective in bringing about a change in patients' behaviour may be important in affecting the types of advice they give and their propensity to give it. Both interview and survey respondents were asked to estimate the percentage of patients seen each week to whom they gave lifestyles advice and the percentage of patients they perceived as following their advice. The majority of survey respondents (57%) reported giving lifestyles advice to more than 50% of the patients that they saw. Only 10% of respondents reported that they gave lifestyles advice to less than 25% of the patients that they saw. However many perceived the advice that they gave as ineffective in bringing about behavioural change among the majority of patients. Forty -six per cent of PNs reported that they perceived compliance rates to be less than 25% and 84% of PNs reported perceived compliance rates of less than 50%. Two of the interview respondents reported low levels of perceived compliance rates but the others commented that compliance varied according to patients' motivation and the area on which advice focused. The surveyed PNs' perceptions of advice given and compliance rates is set out in Table four.

TABLE 4 PNs' PERCEPTIONS OF PERCENTAGE OF PATIENTS GIVEN ADVICE BY PERCENTAGE OF PATIENTS COMPLYING

ESTIMATED % COMPLYING					
	UP TO 25	25-50	51-75	OVER 75	TOTAL
ADVICE GIVEN TO LESS THAN 25% OF PATIENTS	3	1	-	-	4
ADVICE GIVEN TO 25- 50% OF PATIENTS	9	3	1	-	13
ADVICE GIVEN TO 51- 75% OF PATIENTS	3	7	1	-	11
ADVICE GIVEN TO MORE THAN 75% OF PATIENTS	2	2	4	-	8
TOTAL	17	13	6	-	36*

* five respondents did not respond to both questions.

4.26 The data collected on training indicate that the vast majority of PNs in the area have received at least some training in lifestyles advice in relation to CHD prevention. For most

PNs this training has been provided through study days although almost half of the PNs surveyed reported having taken part in additional training courses. However, it is not clear if the training that PNs have had has met the needs of the PNs in relation to lifestyle advice giving; two of the PNs interviewed indicated that while they had attended courses relating to lifestyles advice they did not consider this as 'training' in giving lifestyles advice. More importantly, it is not clear whether methods of negotiating change with patients are part of the training that PNs have received. If they are not, it seems likely that resources such as BLBL are not an adequate substitute.

4.27 It is difficult to assess the extent to which methods of negotiating change with patients are used in practice. From the small number of interviews carried out it seems that they probably have neither the time nor the inclination to 'negotiate change' with patients given the low numbers that PNs perceive as complying with advice. If further research confirms this, there is a case for more intensive training and education of PNs in the methods of behavioural change.

Conclusion

4.28 The data collected for this part of the project do not allow clear conclusions to be drawn in relation to the extent to which the requirements of the HPPs are being met in practice. Indeed, the project was not intended to address this issue. Methodological problems relating to the unrepresentativeness of the interview sample and the different points at which the interviews and survey were carried out make interpretation of the data difficult. However, the data collected have provided some indications of the initial impact of the HPPs on PNs and the ways that PNs may be working in relation to lifestyles advice within the HPPs. The findings suggest that the HPPs have not had a significant impact on the work of some PNs and that targeting of patients and follow up of interventions may not always be carried out. Furthermore, the data suggest that PNs might benefit from further training in giving effective lifestyles advice.

5. PATIENT INTERVIEWS

The Sample

5.1 The 26 patients interviewed were not an homogenous group in terms of the types of lifestyle advice that they received and the context in which the advice was given. The majority of interviewees (77%, n=20) received advice relating to diet or diet and exercise. Of the rest: two people received advice about smoking; one person received advice about exercise; and, three people received advice relating to diet, exercise and smoking. Most of the interviewees had made previous attempts to change their lifestyle. Almost three quarters (n=19) had tried to change their lifestyle in some way before.

5.2 The advice received by patients was given in a variety of contexts. Nine interviewees (35%) were referred to the PN for advice by their GP because of conditions such as high blood pressure, diabetes or obesity. A further two patients in the sample received lifestyles advice direct from their GP. Six patients (23%) made appointments to see the PN for health checks or for weight clinics without any prompting by health professionals. Most of these interviewees saw notices advertising health checks or weight clinics in the surgery or had been told by friends or family of the existence of such services. The rest received lifestyles advice opportunistically; five patients (19%) received advice at a new patients check and four (15%) received advice at a particular PN clinic they attended for an unrelated condition, such as asthma.

5.3 The majority of the interviewees received regular follow-up to monitor their progress with the advice that they were given. Four-fifths of interviewees (n=21) received regular follow-up and 90% of these saw the PN at least monthly. Two interviewees saw the PN every six months. Only five interviewees were given advice without any arrangements for follow-up.

5.4 This sample may not be representative of the range of patients that are given lifestyles advice by PNs in primary care. Research has indicated that the take-up of lifestyles advice is low (Family Heart Study, 1994; Imperial Cancer Research Fund OXCHECK Study Group,

1994). Yet nearly all the patients in this sample reported making attempts to change their lifestyle in some of the ways advised by their PN. There was no indication that patients were reporting this falsely. The fact that most were attending follow-up sessions with the PNs indicates they were attempting lifestyle changes. Only four patients (15%) reported being unable, or unwilling, to attempt to change their lifestyle. It is worth noting here that the two people given advice about smoking in the sample came into this category and that one of these, and another patient in this category, were not followed up by the PN following advice.

5.5 Although this sample may not be representative of patients given lifestyles advice, there is no reason to suppose that they are not representative of patients who *follow* lifestyles advice. The patients in this sample who attempted to follow the advice that they were given came into one or more of the following three categories: patients with an immediate health threat which was controllable by lifestyle changes; patients highly motivated for reasons other than health-related ones, such as people who wanted to lose weight to improve their appearance; or, patients in regular contact with the PN for another condition, such as asthma. Such factors have been found to have a positive effect on patients' compliance with advice (Blaxter and Cyster, 1984; Rollnick et al, 1993; Field and Henderson, 1993; Powell and Greenhalgh, 1994).

5.6 Patients not in regular contact with PNs for health checks and without strong reasons for following the advice that they have been given may be far less likely to comply with lifestyles advice. Such groups may make up the majority of people that are given lifestyles advice especially if targeting within the HPPs focuses on younger age groups and follow-up of patients does not occur routinely. Research focusing on the factors influencing compliance and non-compliance among these groups is clearly very important but such groups are likely to be harder to contact and less keen to agree to participate in research than those who comply with advice.

5.7 The data presented here are based, in the main, on a sample of patients who complied with advice, at least to some degree. However, while the majority of respondents did make attempts to comply with the advice that they were given, all interviewees were able to identify factors which made this difficult. Most were also able to identify the factors that

motivated or enabled them to comply with advice.

Patients Views of the Advice They Were Given

5.8 Patients were asked for details of the advice that they were given and their views about the advice. All but one interviewee were given specific advice about the changes that should be made to their lifestyle. In the case of diet, alcohol consumption and exercise, patients were advised what foods they should eat and avoid, the number of units of alcohol they should have a week and the amount and types of exercise they should undertake. The majority of interviewees given advice on these areas (71%) reported that their PN did not discuss the problems they might have in following the advice and ways in which these might be overcome. However, 35% (n=6) of these interviewees felt that they did not need such discussions as they followed the advice immediately because of the perceived health risks of not complying. Advice for smokers is a different case in that it involves giving up rather than changing a habit. Advice to give up smoking on its own is unlikely to be successful unless it is backed up with practical help and support of the ways this might be achieved (Steele, 1993). Of the two smokers in the sample, one was not given any advice on how to give up smoking. Both felt unable to stop smoking.

5.9 Patients were asked how they felt about the advice they had received. The majority of responses were positive. Only four interviewees responded in a negative way. Three interviewees felt that the advice had not been helpful either because they did not want or did not feel able to follow the advice. Two of these interviewees were the patients in the sample given advice about smoking. One other interviewee felt that the advice had had no effect because he had already made up his mind that he wanted to change his lifestyle.

5.10 Interviewees responded in three ways in commenting on the positive aspects of the advice that they had been given. Comments focused on the practical nature of the advice, the appropriateness of advice and the personal attributes of the PNs. All these issues emerged as important in encouraging compliance with the advice.

5.11 For eight interviewees the practical nature of the advice given was viewed as

important. Interviewees who had received advice in the past particularly valued advice that could be easily fitted into a daily routine. One interviewee commented:

'The sorts of exercise she suggested was helpful. It didn't mean I'd have to put on shorts every night and run round the block. Knowing that walking would be helpful, where I probably wouldn't have thought of that before'.
(male, aged 23, Practice 4)

Another positive aspect of the advice identified by the interviewees was that it was accepted as appropriate advice. Nine interviewees noted that the advice 'made sense' to them. This is clearly an important factor in motivating people to follow advice. Typical comments regarding this were:

'His opinion was based on fact. He was very persuasive. ...He knows what he is talking about, I don't. He's not wrong, or at least my brain tells me he is not wrong. ... Logically it makes sense. He explained it very well'. (male, aged 43, Practice 1)

'Oh it [the advice] was absolutely on the ball ... I knew she was absolutely right'. (female, aged 64, Practice 3)

'everything she has said made absolute perfect common sense' (male, aged 59, Practice 2)

5.12 The other area identified in interviewees' positive comments were the personal attributes of the PNs giving advice; these were mentioned by nine interviewees. These nine interviewees were patients at different practices. The manner and attitudes of PNs emerged as a very important factor, not only in encouraging patients to take up lifestyle changes, but also in encouraging them to continue with such changes. It is likely that patients who dislike the manner and attitude of their PN will be disinclined to attend for follow-up visits. The interviewees' comments indicate the difficult balance that needs to be made between encouraging patients to adopt healthy lifestyles without being too dictatorial on the one hand

or too casual on the other:

'We usually end up having a laugh and a joke. She doesn't bully me , which would make me feel resentful - I might get angry and defiant and that wouldn't help me. ... I would probably go out and eat a packet of chips just to spite her. ... she is ever so sweet, I look forward to seeing her actually' (female, aged 58, Practice 1)

'She's got such a lovely way of saying things to you that she is telling you off but you don't realise it. She is ever so nice. She is very good and has a beautiful way of talking to you. ... She's telling you what to do and asking you at the same time. And at the same time you'll have your knuckles rapped if you don't do it' (male, aged 59, Practice 2).

Obligations To Follow Advice

5.13 It was not only the manner and attitude of the PNs that interviewees identified as important in encouraging them to take up and continue with life style changes. Of the 21 interviewees who had regular contact with the PN for follow-up and monitoring, 90% reported that the support obtained by seeing the PN regularly was an important factor which encouraged them to follow the advice. Eleven of these interviewees went further and noted that being in regular contact with the PN led to feelings of obligation to her to follow the advice that they had been given. Both male (n=6) and female (n=5) interviewees of various ages (ranging from 23-65 years) from all but one practice in the study reported this feeling of obligation to their PN. The interviewees reporting this noted that they felt they would be letting the PN down and that the PN might think she was wasting her time if they did not follow the advice. Some interviewees said that if they did not follow the advice they felt that they would be letting themselves down in front of somebody else. There was also an element of anxiety about the disapproval that the PN might express if patients failed to comply with the advice. This was particularly so with patients attempting to lose weight because the practice of weighing patients at every visit meant PNs could tell if their advice had been followed or not. Worries about the PN's disapproval appeared to be a strong element in

encouraging people to follow the advice that they had been given. Most people acknowledged that they should be doing it for themselves rather than to please the PN but nevertheless acknowledged that feelings of obligation to the PN provided a stronger motivation than feelings of obligation to themselves. The following quotations indicate the feelings of obligation patients identified towards the PNs:

.. 'Seeing her each week gives you that little incentive that you've got to take it easy otherwise at the end of the week there is a danger that you've put it [weight] on. If you've only got yourself to look at the scales it doesn't matter if you cheat because you are only cheating yourself and you don't mind that. If somebody else is looking at the scales and keeping a record then you know that you can't start putting on too much otherwise something is going to be said' (male, aged 48, Practice 1).

'I like the idea of having to report to somebody. I know it's like going back to childhood or the forces or something like that but it's like somebody is watching over you. You can get away with it with the wife but you can't get away with it with the nurse' (male, aged 59, Practice 2).

'If you go and see the nurse rather than weigh yourself you are doing it in front of somebody else. I think that is good. Whether the nurse actually gives a damn or not I don't know, but I don't want to let myself down in front of somebody else' (male, aged 23, Practice 4).

Motivating and Enabling Factors

5.14 Interviewees were asked what motivated them to want to change their lifestyle and the factors which encouraged or enabled them to do this. These questions led to the identification of both motivating and enabling factors concerning compliance. Motivating factors are defined as the reasons why interviewees wanted to, or did, follow the advice that they were given and enabling factors as the conditions which encouraged them to follow the advice. All but two interviewees were able to identify factors that enabled and/or motivated

them to follow the advice that they had been given. Two of the four interviewees who did not follow the advice that they were given were still able to identify motivating factors for why they would like to, or should, follow the advice.

5.15 Two main areas were identified as motivating factors, or reasons, for wanting to follow the advice given. The first area was health-related reasons and the second, self-image.

5.16 Fifteen interviewees (58%) identified health-related reasons as motivating factors for lifestyle change. Within this broad area of health, two specific reasons were identified by interviewees. The first was wanting to change their lifestyle to become more healthy. Within this category, some patients wanted to become more healthy to alleviate the chronic health problems that they had. One woman, for example, commented:

'Well, I've got arthritis in my knees, I think they say it's the weight. Obviously I want to lose weight for my health' (female, aged 58, Practice 1).

Other interviewees, particularly young men, wanted to become more healthy in terms of fitness so that they could take-up or continue participation in sporting activities. Others identified wanting to become more healthy for its own sake. This was generally identified as a secondary motivation to other factors, such as appearance in cases where people were trying to lose weight. It may be that this explanation was offered because it was viewed as the appropriate explanation for lifestyle change when in fact other factors were more important. Other research has indicated that, where no illness is present, health is not a strong motivation for changing lifestyle (Wiles, 1992). The second health-related reason concerned people who had a recent health 'scare'. The interviewees identifying this factor included newly diagnosed diabetics and patients identified as at serious, and in some cases immediate, risk of ill health. All the interviewees in this category were informed that their condition could be controlled or their risks minimised with lifestyle changes. This was a very strong motivating factor as illustrated in the following statements:

'I had diabetes during my pregnancy. They told me after I had him that I needed to lose some weight otherwise I would get it in later life. My father

was quite a bad diabetic and lost both his legs and that was shock treatment I think, more than anything. ... I didn't want to end up like my dad' (female, aged 35, Practice 3).

'I went to the doctor and he said something to the effect of "don't plan on Christmas". My blood pressure was dangerously high, cholesterol was high, I had a kidney that wasn't functioning as well as it should and .. my heart was enlarged ... If you get that sort of advice it pays to listen to it' (male, aged 43, Practice 1).

5.17 Self-image was the second area identified as a motivating factor by the interviewees. This was identified by seven of the interviewees, all of whom were attempting to lose weight. The interviewees identified the difficulties of buying clothes in larger sizes and not being able to fit into their own clothes as problems. In addition, some interviewees reported feeling very negatively about themselves and feeling that they were viewed negatively by others because of their weight. This has been identified in previous research as a common problem for women who view themselves as overweight (Charles and Kerr, 1988; Wiles, 1994). However, in this study both men (n=3) and women (n=4) mentioned this factor. Again this was a strong motivation for losing weight:

'[I want to lose weight] because I want to find a boyfriend, a partner' (female, aged 39, Practice 4).

' It had got to the stage where, because of my stomach, people used to think I was pregnant and it really upset me' (female, aged 27, Practice 7).

'If you go out, or on holiday, everybody tends to look at you ... They sort of pick you out. All my clothes don't fit me' (male, aged 57, Practice 7).

5.18 A further five motivating factors were identified by individual interviewees. These were: to be well enough to continue caring for a disabled partner; because of the enjoyment obtained from exercise; because exercise helped with feelings of anger; because of

encouragement from the GP; and, because lifestyle change was perceived as obtainable because other people had achieved it. Of these, the desire, or need, to be well to care for a ill partner appeared a very strong motivation:

'I'm registered disabled now. I can't afford to let myself get any worse because I have to look after her [his partner] which worries me. They [PNs] say up there "don't do it for yourself, do it for her" so that's what I'm doing really. It's what keeps me going' (male, aged 57, Practice 7).

5.19 As regards *enabling* factors, clearly the manner and attitude of the PN giving advice and the support patients obtained from regular contact following advice were important as has been discussed above. In addition, interviewees identified the support of partners, children and colleagues as important in enabling them to follow advice. This was identified by 13 interviewees. Support from partners was identified as both practical and emotional. On the practical side, some interviewees' partners attended GP and PN appointments with them and discussed the lifestyle changes their partner should make with the health professional involved. One man agreed to lose weight with his partner and they attended the PN clinic together. Others provided practical support by changing their lifestyle to fit in with the advice given to their partners. This was particularly the case with dieting where partners agreed to change what they cooked or ate at mealtimes or the food that was kept in the house in order to support their partners in attempting to change their lifestyle. Some provided emotional support by encouraging the efforts that their partners had made. Children tended to provide support in the form of encouragement. One interviewee identified the support of work colleagues as important in that it enabled her to take time off of work to attend appointments and a programme of exercise without feeling she was letting her colleagues down. The following quotations illustrate some of these issues:

'She's come in with me to see my doctor. ... I told him he can tell her anything he wants, there's no problem with that. He told her in black and white where I was at and what's going on. She is totally up to speed with that and it makes life so much easier' (male, aged 43, Practice 1).

'The wife has been very good and has put up with all the "got to have this, got to have that". She is probably sick of it, in fact I'm certain she is. But she does salads and sometimes she is cooking three different meals. ... She is very supportive, yes' (male, aged 48, Practice 1).

'They [her children] tell me off if I don't do well. If I'm good and I've lost weight than it's "oh good mum, you can borrow my clothes"' (female, aged 39, Practice 7).

5.20 A further five enabling factors were identified by individual interviewees: will-power; money; being sponsored to lose weight; time; and, being able to use exercise facilities at work.

Constraining Factors

5.21 Interviewees were asked to identify the things that made it difficult for them to follow the advice that they had been given. All but one interviewee were able to identify at least one factor that they felt constrained them in their attempts to follow the advice. A number of issues were identified. These have been separated into *constraints* against following advice and *disincentives* to following advice. Constraints are defined as factors which make following advice difficult and for which no easy solutions are apparent. Disincentives are defined as factors which discourage people from following advice but to which possible solutions could be identified by health professionals or patients.

5.22 Six issues were identified as constraints against following advice. These were: stress; family responsibilities and lack of support; employment; time; recreation facilities; and, physical difficulties.

5.23 Eleven interviewees identified issues relating to stress as constraining their ability to follow the advice that they had been given. Some people reported that a stressful life event, such as bereavement, resulted in an inability to continue with lifestyle changes such as giving up smoking. Others identified very stressful jobs or situations at home, in particular looking

after young children, as reasons that prevented them changing their lifestyle. In all these cases the behaviour interviewees were trying to change offered them some comfort or means of coping with the stress that they experienced and thus, as other research has shown, change was identified as very difficult within the interviewees' current situation (Graham, 1993; Mullen, 1992). Typical comments were:

'I think I did very, very well and then my sister died ... That set me off again, it got quite bad for a while, well she was younger than me, it was very unexpected' (female, aged 56, Practice 2).

'If I'm worried I start smoking more. If the children are playing up I normally smoke more and also I'll go and eat some cake or something ... At work I'm quite under stress. I'm in charge two and a half days a week and some times it does get rather demanding' (male, aged 28, Practice 3).

'.. Pressure of all these children. When they start to really wind me up and they are fighting and arguing. I start screaming and shouting and have to shut myself away and have a cigarette' (female, aged 30, Practice 4).

5.24 Family responsibilities and a lack of support at home were identified as constraining interviewees from following advice in seven cases. Interviewees whose partners offered no help or encouragement with a lifestyle change were viewed as experiencing a considerable constraint in terms of following advice. One woman, a smoker, illustrates this:

'He just says "if you shouldn't smoke then don't smoke" and "it's up to you". I think he's not a lot of support as regards giving up. He just says "if you don't want to smoke, don't smoke, I won't smoke indoors". Then I say "yes, but when I've done it before, I can smell it on your clothing and it doesn't make it very easy". It's terribly difficult. ... Then he was going out in mid-winter time and he was standing outside under an umbrella with waterproof clothing on in the pouring rain having a cigarette and I felt so guilty so I started again' (female, aged 56, Practice 2).

Family responsibilities in relation to the buying and cooking of food for the family were identified as making dieting very difficult for some interviewees. This was especially so where partners were not prepared to adjust their eating habits or where foods that interviewees wanted to avoid were bought for children.

5.25 The particular jobs that some interviewees had constrained the ability to follow advice in five cases. One interviewee was employed as a chef and working with food led to considerable difficulties for him in trying to diet. Other interviewees found that the availability of food during their working day, either at work or 'on the road', made it difficult to diet or follow a healthy eating plan. One interviewee experienced difficulties in reducing his alcohol consumption, as he had been advised to do by the PN, because of the type of work that he did:

'The job I do is working for Whitbread and it's out in the field, going to pubs selling beer to people. ... In some places it can be expected, you know ... it can be awkward not having a drink' (male, aged 31, Practice 7).

5.26 Lack of time was also identified as a constraint in attempting to follow advice. Five people identified this, mostly in relation to taking up exercise. Lack of time is often viewed as an 'excuse' for not following advice, the argument being that if it is important people should make time. However, the reality of many people's lives is that this is often very hard to do. Two female interviewees were involved in a range of paid and voluntary work in caring roles within their communities. Both these women had many demands made on their time and consequently had a lack of 'spare' time. Making spare time which would involve withdrawing care from others was identified as extremely difficult:

'I've got a really busy life and it is having the time to do it. ... I do counselling work and somebody comes along and you think they've got a really big need and you agree to see them. You are pulled in different directions and that is the thing that would tend to go by the board, if somebody's need is far greater than the exercising' (female, aged 55, Practice 6).

One other interviewee was self-employed and she encountered similar problems:

'It's just so difficult to get away. We're in a very competitive field and we're only small so we just have to put our all into it or we'll go under. It's been a real problem with the recession, we have to work very hard. It's our whole life, 24 hours a day really' (female, aged 53, Practice 3).

5.27 A lack of local recreation facilities or problems using recreation facilities were identified as a constraining factor for five interviewees. Those who identified problems using recreation facilities noted the difficulties of being able to use the facilities at times that suited them. Difficulties of cost and of feelings of not fitting in with other client groups using facilities were identified. One interviewee noted in a similar vein that a lack of local shops was a similar constraint. This client could not buy fresh foods locally, other than in an expensive supermarket, and he noted that this was a constraint against eating healthily.

5.28 The last constraining factor identified was perceived physical difficulties with following lifestyles advice relating to diet and exercise. One man, a diabetic, felt unable to stick to the diet that had been suggested to him because he felt it was not adequate to control his diabetes effectively. Others felt unable to carry out the exercise suggested to them because of physical problems.

5.29 The interviewees identified two major disincentives which discouraged them from following the advice that they had been given. The first related to leisure activities and the second to feelings of boredom.

5.30 Eleven interviewees reported that leisure activities made following advice difficult. Some interviewees ate out regularly and noted that food in restaurants often did not fit in with a diet. Other reported similar difficulties on holiday, especially when food and alcohol was provided as part of the cost of the holiday. Having visitors at home or meals with extended family members presented similar difficulties. Some interviewees participated in particular leisure activities at which food was provided and this presented problems, particularly where interviewees did not want to tell others that they were trying to lose

weight. Interviewees with social lives that were largely pub based experienced difficulties in relation to alcohol consumption, smoking and eating.

5.31 Eight people noted that boredom was a factor which presented difficulties for them in complying with advice. This was reported in relation to eating, smoking and drinking. Interviewees reported this occurred most commonly during the evenings especially if they were at home on their own with little to occupy them.

5.32 A further four disincentives were identified by individual interviewees. These were: being a vegetarian; a dislike of sport; the impact of retirement on eating and exercise; and, difficulties associated with exercising and dieting in the winter.

Personal Responsibility for health

5.33 The issue of patients taking responsibility for their health is complex. In this study, this issue was examined in relation to compliance with lifestyles advice based on the assumption that following lifestyles advice will lead to better health. Thus, complying with lifestyles advice is one way patients can 'take responsibility for their health'. However, it should be noted that while there is evidence that adopting a healthy lifestyle is health enhancing, there is no evidence that compliance with lifestyles advice will lead to patients making less demands on doctors' time.

5.34 The majority of patients in this sample followed the lifestyle advice that they were given, at least to some degree. The sample was highly motivated to follow the advice that they were given for various reasons, many of which were unrelated to health. However, those most at risk from ill health followed the advice most strictly and 'improving health' was identified as an outcome, if not a motivation, for most people in following advice. To that extent this sample of patients can be viewed, on the whole, as taking some element of responsibility for their health. However for the majority, regular support from health professionals was viewed as important, and for just over half of interviewees as essential, in enabling them to follow the advice. Thus, patients appeared to be not so much taking responsibility for their health themselves but rather taking responsibility for their health either

for or with the support of the PN. On one level this is not problematic in that it still has the desired effect of encouraging compliance. However, following advice with the support of PNs cannot be equated with patients taking responsibility for their health. Only if patients continue with health enhancing behaviour without the regular support of health professionals can they be viewed as taking responsibility for their health themselves. Given the low rates of long-term follow up of lifestyles advice found in other studies it may be that long-term change can only be achieved with long-term follow-up. If PNs have to spend considerable amounts of time with patients to ensure compliance with lifestyles advice, GPs' time may be saved (assuming following advice leads to less ill health) but only at the expense of another group of health professionals.

5.35 It is not clear what health professionals can do to encourage patients to take responsibility for their health themselves. Such a task is beyond the scope of this pilot project. However, it is possible to make some recommendations regarding compliance with lifestyles advice. These will be outlined in the conclusion. It may be that one of the most effective ways of limiting the demands made on GPs' time is not through health promotion at all but rather through educating patients to act responsibly in relation to their use of primary care services (see, General Practitioner, 1994).

6. CONCLUSION

6.1 This project has examined the factors which influence people's compliance with lifestyles advice given by PNs within the context of the HPPs. It has identified a number of issues that affect people's ability and willingness to follow lifestyles advice. It has also produced some data on the ways lifestyles advice is being given by PNs and the contexts in which this is taking place.

6.2 A substantial amount of research has been carried out on lifestyles advice. Research has examined: people's attitudes and beliefs relating to lifestyles (Davison, 1992; Backett, 1992(a)); the reasons why people adopt particular healthy and unhealthy lifestyles (Graham, 1993; Backett and Davison, 1992(b)); and, the ways lifestyles advice can be given most effectively (Blackburn and Graham, 1993; Field and Henderson, 1993). It is not clear that this mass of research evidence has been taken into account in training health professionals to give lifestyles advice, or indeed that it is used in practice by health professionals in giving advice. Even though researchers and practitioners have sought to ensure that their findings and expertise are disseminated to health professionals working in the field (eg, Blackburn and Graham, 1993; Field and Henderson, 1993) these may often not be incorporated into practice due to lack of time, inaccessibility of materials, or a negative image of resources held by health professionals. Clearly much more work needs to be done on training PNs in a systematic and coherent way in methods of negotiating behavioural change with patients. Further work on promoting 'Better Living Better Life' would be helpful as a foundation for such training.

6.3 An important finding of this project has been to identify the important role PNs play in supporting patients given lifestyles advice. PNs can clearly be very influential in encouraging patients to change their lifestyle. The identification of factors which motivate and constrain patients' ability to follow advice need to be taken into account by those giving advice.

6.4 The project has identified a number of factors which motivate and enable patients to change their lifestyle. These factors may offer positive areas for the development of advice-

giving. The main areas identified were:

- health-related reasons (for example, to improve a chronic condition or to become fitter)
- self-image
- support from health professionals
- support from partners, family, friends and colleagues

6.5 The project has also shown that, even among patients highly motivated to follow advice, a number of constraints make complying with advice difficult. Early discussion of potential constraints affecting patients' ability to follow lifestyles advice is clearly of great importance. It may be advisable for PNs to discuss the constraints identified by the interviewees in this project as a matter of course with all motivated patients given lifestyles advice. The constraints identified in this project were:

- stress
- family responsibilities and support
- employment
- time
- availability of recreation facilities
- physical difficulties

6.6 Discussion of these issues at an initial session where lifestyles advice is given, if appropriate, may encourage greater rates of compliance. However, clearly this will only be possible if the HPPs are organised in such a way as to allow PNs sufficient time to give appropriate lifestyles advice and sufficient training to enable them to do this effectively. The HPPs are likely to be unsuccessful without these basic requirements.

6.7 The recommendations of this study are:

1. that systematic training of PNs in negotiating behavioural change with patients be carried out on the model outlined in 'Better Living Better

Life’;

2. that health professionals giving lifestyles advice allow sufficient time with patients so that they can discuss the social and economic constraints (such as those identified in this study) that may influence people’s ability to comply with advice.

6.8 Further research is clearly necessary to develop some of the issues which it has been possible only to identify in the short time scale of this project. Issues that warrant research in greater depth are:

1. The effectiveness of the HPPs in reaching patients most at risk and in affecting behavioural change.
2. The training of PNs in giving lifestyles advice.
3. The ways that advice is given by PNs and received and acted on by patients.
4. The ways in which patients can be encouraged to act responsibly in relation to their use of primary care services.

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