



**Liverpool
Public Health
Observatory**

Wellness Services – Evidence based review and examples of good practice

Final Report

Lyn Winters, Marie Armitage, Jude Stansfield,
Alex Scott-Samuel and Alison Farrar

**Observatory Report Series No. 76
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PROVIDING INTELLIGENCE FOR THE PUBLIC HEALTH

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Wellness Services – evidence based review and examples of good practice

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Background

This piece of work has emerged from some horizon scanning by the Directors of Public Health (DsPH) in Cheshire and Merseyside where a deficit in mental wellbeing relating to inequalities was identified as underpinning the challenges faced in unhealthy lifestyle behaviours. This has since been reinforced by the Marmot review¹ and the recent World Health Organisation report on inequalities in mental wellbeing.²

Mental wellbeing has been included in the work plan for the Cheshire and Merseyside Public Health Network (ChaMPs) and this piece of work was identified as a result. Within the North West the DsPH and others have also been doing some horizon scanning work with the International Futures Forum and also identified the need to re-focus existing lifestyle services towards a more integrated 'wellness' model which includes mental wellbeing.

This report is for:

Commissioners and providers of health improvement services

Local Authorities

Health and Wellbeing Boards

Directors of Public Health

Health Improvement Leads

GP Consortia

Introduction

There is likely to be an increasingly limited resource envelope for preventive services both within and outside of the NHS. An important component of prevention will be the broad area of 'wellness services'. It seems to make sense in terms of rationalising that resource but also in the overall client experience and quality of service provision to be able to describe these services in the round and inform the commissioning of such in this context.

This review will inform the North West transition work streams and influence the development of the new Public Health Service.

Traditionally, there tends to be a "silo" approach to the commissioning and provision of prevention services based on topic areas. The aim of this report is to bring together the available evidence base on models of provision that take a bio-psychosocial/holistic approach to health. Assessing mental wellbeing is also considered as part of the overall intervention. The report gathers the evidence regarding if and how this has been achieved in other areas. Where stated, it also produces an overview of the potential cost effectiveness and cost savings of preventive programmes and projects that are combined into a single point of referral/

contact and intervention as an alternative model to the traditional single topic area type of service provision.

This report reviews the regional and National evidence base regarding any programmes that commission on a “whole person” centred approach and potential benefits that might be achieved in terms of the economics and overall patient/ public experience and quality issues.

Objectives

- To undertake an initial scoping exercise to explore in Cheshire & Merseyside if service leads are already looking at “wellness service” type approaches.
- To produce a report reviewing the available evidence base on existing wellness services that offer more than one service at point of contact.
- To explore the potential cost savings and potential benefits to the service user of a “one stop shop” approach to service provision. Where evidence of cost-effectiveness is not available evidence on effectiveness has been included.

The report is aiming to extend the scope of the preventive programmes’ cost effectiveness review by taking the next step to explore what might be the benefits of offering “wellness” services instead.

Exclusions from Review

- Exclude services that provide a single topic service – e.g. just provides a smoking cessation service. This information will have been captured in previous reports.
- This is not a prescriptive service redesign request, though suggested benefits of service redesign would be included.

Methods

- A comprehensive literature review of the evidence base regarding the cost effectiveness and potential cost savings of wellness services.
- Sending a request for information on current strategic thinking and evaluations, particularly those involving cost-effectiveness of wellness services via the Cheshire and Merseyside Public Health Network (ChaMPs) Bulletin and direct email to Cheshire and Merseyside Directors of Public Health.

Discussion

There needs to be a change from the commissioning of individual lifestyle services to a more holistic approach taking into consideration the socio-economic determinants of health. This will be the most effective way to reduce health inequalities rather than tackling more proximal causes (such as smoking), through behaviour change programmes.³

The ‘medicalisation’ of public health provider services (once known as health promotion, or community health development provision) has been an unintended consequence of the increased investment in public health by PCTs. As the budget shifts to local authorities this might provide an opportunity to build a different style of

wellness provision. The national focus for improving lifestyle risk factors has been on topic based strategies rather than healthy individuals and healthy communities. This has led to targets around individual behaviours that have driven local programmes for stopping smoking, healthy weight and so forth. In the more deprived areas in the North West many of the topic based programmes and services all target the same people (e.g. the person who smokes, drinks heavily and is inactive etc). So, it makes sense to be person centred rather than programme focussed. Furthermore, referral patterns can be entrenched and behaviours can be hard to change. Health and social care professionals get bombarded with information and may overlook information on new service provision. Subsequently referrals and use of more holistic services can be slow to build. It is considered that the evidence-base is solid for a more holistic approach but has not always been put into value for money/cost benefit language.

It is important to establish clear underpinning principles to inform the development of wellness services. The guidelines and standards in Appendix 3 and 4 will be useful in this respect. These highlight community participation: moving beyond often routine, brief consultations to effective participation in which individuals and communities define the problems and develop community solutions. Also, working in partnership, providing services closer to home and the requirement to take action to address inequalities in health that arise because of inequalities in society – providing services that take a holistic approach tackling the wider determinants of health. Cost effectiveness would also be an important element to consider as part of the decision-making process as well as issues of equity, needs, and priorities. Wellness services that tackle the root causes of ill-health, particularly inequalities in health could make considerable savings. It is important to consider not just the existing public health interventions but also newer approaches informed by social marketing. Wirral's Quit Stop programme would be a good example of this. It is woven around the lives of smokers where they live (rather than a service which they are expected to go out of their way to attend).

Conclusions

A Wellness Service provides support to people in order to improve their health and well-being. The service aims to build people's capacity to live healthy lives by addressing the factors that influence health and wellbeing.

The examples of best practice in this report confirms that many service leads within Cheshire and Merseyside and in other counties are already exploring innovative ways of providing wellness services that offer more than one service at point of contact.

The benefits to the service user

This review has identified the following benefits to service users from Wellness services:

- Promote positive health that can empower individuals, enabling them to maintain and improve their own health.
- Providing, safe, natural means to boost physical and mental health without unpleasant side-effects. For example: tools, techniques, assistive technology and education.

- Wellness services can work in conjunction with traditional medical services or prevent or reduce the need for medical interventions
- Where necessary services and programmes facilitate lifestyle adjustments to enable individuals to gain wellness.
- The focus is on promoting quality of life not just length of life.
- Rather than considering just the diseased part the service considers the whole person: mind, body and spirit and the wider determinants of health such as lifestyle, social environment, living conditions and so forth where there can be imbalances in an individual's life – that are preventing them from reaching their optimum health.
- Wellness services take into consideration inequalities of health and where possible actively seeks out those individuals that do not usually benefit from mainstream health services. However, some services reviewed found it problematic to access the “hard to reach groups” – this has implications for equity.
- Specific wellness services can increase patient choice by linking patients up to non-medical facilities and services available in the wider community that can address psychosocial factors that influence wellbeing.
- There have been a range of reported positive mental health outcomes including: enhanced self-esteem, improved mood, opportunities for social participation, increased self-efficacy, various transferable skills and greater confidence that all enhance quality of life.
- Some of these wellness services can make available new opportunities for patients for meaningful activities.
- Preventive health programmes based on Occupational Therapy may mitigate against the health risks of older adulthood.
- Wellness services can provide contact with others facing similar challenges. This provides a sense of not being alone and opportunities to learn from others' coping strategies.
- Peer support or “buddying” can provide on-going mutual support for self help strategies beyond the professional intervention.
- Some services can enable some individuals to improve self-management of a long-term health condition and return to work.
- By tackling the causes of ill-health, wellness services have demonstrated a broad understanding of the links between life circumstances and health. For example “the Women's mental health demonstration project” in Glasgow, has found that significant impacts can be made in the lives and health of women with complex underlying problems in a relatively short period of time
- Improved outcomes for older people appear to be achieved through integrated, co-located health and social care teams.
- Appendix 2 also illustrates the benefits from some existing models of integrated lifestyle services.

Evidence of cost-effectiveness

In cost-effectiveness analysis there is often considerable uncertainty associated with the findings as a result of the assumptions and parameters used, therefore even when a sensitivity analysis is undertaken a degree of caution is required when reading the results.

Nevertheless, the majority of services reviewed, that considered costs, were found to be cost-effective and have shown the potential to bring a return on investment and to save on future costs of ill-health through early intervention. They can provide significant 'value for money' in return for the resources that they consume. For instance, the examples of good practice in the report using a case management approach show potential to reduce medicine and health service and business costs by tackling worklessness (used to describe individuals who are out of work but who would like a job).

By taking into consideration the wider determinants of health such services can potentially provide an effective response to frequent attenders in primary care, whilst tackling the underlying causes of their visits. Many services such as those involving social prescribing and psychological well-being have little or no cost compared to medical treatment. Indeed, they help individuals manage the triggers to their own distress. Relatively inexpensive mind-body interventions, such as stress management techniques, can improve health outcomes, while reducing the need for more expensive medical treatments and without any adverse effects. Furthermore, there are many indications that mind-body interventions can actually prevent the occurrence of disease as perceptions, thoughts and feelings can influence immune and hormonal systems in both adaptive and maladaptive ways.

Wellness services for the older generation and physically disabled adults, such as: OT and Partnerships for Older People Projects (POPP), can be cost-effective and make considerable savings in care costs while at the same time improving quality of life, enabling individuals to live independently. OT can often include "low tech" inexpensive applications such as assistive technology. A strong financial case exists for substituting and/or supplementing formal care with assistive technology, even for individuals with quite disabling conditions. Although needs and hence the cost of provision rise with an increasing level of disability, the savings in care costs accrue quickly and major savings are feasible. Economic factors reinforce the importance of the principle of parsimony in guiding treatment selection" utilising the most rapid and less complex (therefore least costly) methods first and using other methods only when less complicated methods have proved unsuccessful.

Wellness services that facilitate true community engagement can build on what individuals themselves identify as supporting them to improve wellbeing. It recognises people as contributing to their own health and wellbeing and not purely as receivers of costly services/interventions and also recognises the skills and experience of non-clinical staff and volunteers in supporting health improvement. Therefore, the demand for complex health and social care services will be reduced. Guthrie House project provides a successful example of community led participation and shows the power of the community to identify and deliver cost-effective services to a previously underserved village.

Lifestyle services providing health trainers and food workers can also be cost-effective by saving costs on staff budgets releasing more costly professionals to perform strategic and clinical duties. As lifestyle factors are interconnected, providing an integrated holistic lifestyle person-centred service is potentially more cost-effective, by aligning services thus reducing duplication of service support structures, including buildings and staff. Wellness services to families or groups

could be more cost effective than one to one services as well as the integrated, co-location of health and social care teams.

Recommendation:

- Establish clear principles to inform the development of wellness services, based on the guidelines and standards in Appendix 3 and 4.

Background

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Definition of key concepts

These concepts, and definition of others used throughout the report, can also be found in the Glossary.

Bio-psychosocial model of health (BPS)

This model of health considers not only the body-focused biological components of health, but also the individual and societal contexts of the individual’s experience of health.⁴ The main determinants of health that can have an influence on an individual’s health are very broad as shown in figure 1.

The World Health Organisation (WHO) defines health as “a state of complete physical, mental and social wellbeing”.⁵ Furthermore, health is “a resource for everyday life, not the objective of living”.⁶ This reflects a move from a biomedical to a BPS view of health. In general, the health care practices associated with the biomedical or medical model are no longer accepted as the best means for achieving optimal health. The medical model tends to focus on the provision of treatments to individuals in reaction to manifest symptoms, while largely ignoring social, environmental and lifestyle determinants of health.⁷ In allied health literature the term BPS is used interchangeably with concepts such as holistic or the social model of health care that seeks to use non-medical treatments, promote self-help and the prevention of ill-health.⁷⁻⁸

Cost-effectiveness analysis

Cost-effectiveness analysis (CEA) is a full form of economic evaluation where both the relative costs and outcomes (effects) of two or more courses of action are compared.⁹ In a cost-effectiveness analysis, information is gathered on the ways in which a health intervention changes the average health status of a group of people alongside costs. Therefore a CEA estimates what an improvement in health status will produce in terms of quality and quantity of life and how much it will cost to achieve these improvements.¹⁰

The cost-effectiveness of a preventive intervention is the ratio of the cost of the intervention to a relevant measure of its effect. The measurement of outcomes from programmes depends on the intervention being considered such as increased life expectancy and/or quality of life.⁹ The quality-adjusted life year, known as a QALY, is a year of life lived in perfect health. The average number of QALYs we can expect to live is our quality-adjusted life expectancy (QALE). CEA helps determine how to maximize the quality and quantity of life in a particular society that is constrained by a particular budget. Cost-effectiveness examines the optimal course of action when there is considerable uncertainty. For instance, this can arise when one intervention is slightly more effective but costs considerably more than the competing alternative.¹⁰ When a choice has to be made between alternative interventions or programmes for the same condition an incremental cost-effectiveness ratio (ICER) is used:¹¹

$$\text{ICER} = \frac{\text{Difference in costs between programmes P1 and P2}}{\text{Difference in health effects between programmes P1 and P2}}$$

An ICER with a negative result means that the new programme/intervention brings about an improvement in health effects at a reduced cost. In CEA there is often considerable uncertainty associated with the findings based on assumptions used. ICERs also require some indication of the confidence that can be placed in them. Therefore they should be subject to a sensitivity analysis, which tests all the assumptions used in the model and enables the impact of changes on the baseline estimates to be investigated.¹¹ Virtually all health interventions cost something up front. But they also affect the amount of money spent on future medical care.¹⁰

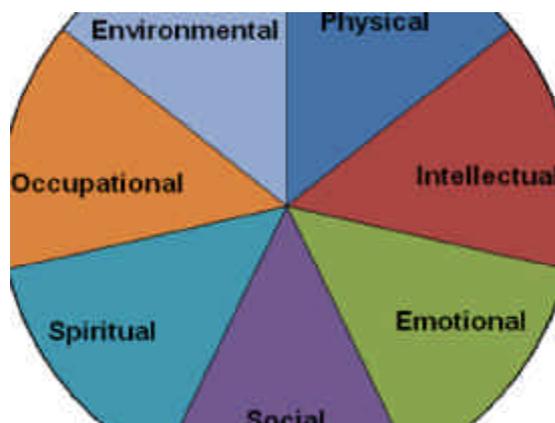
Wellness

There are a number of theories on the nature of wellness and a recent review for counsellors has found the following commonalities between authors in their interpretations:¹²

- Wellness is more than an absence of disease;
- it has several underlying factors or dimensions that interact in a complex, integrated and synergistic fashion - thus no one dimension operates independently;
- it is partially dependent on personal responsibility requiring a balance between the dimensions and a movement along a continuum towards optimal functioning.

Thus “wellness is conceptualized as a synergistic and multidimensional construct that is represented on a continuum, not as an end state”.¹² This proposed holistic model includes seven integrated dimensions: physical, intellectual, emotional, social, spiritual, occupational and environmental, as shown in Figure 1.^{12 13}

Figure 1: Seven dimensions of wellness



Physical wellness - maintenance of your body in good condition by eating right, exercising regularly, avoiding harmful habits, and making informed responsible decisions about your health, allowing for individual variation and circumstances.

Intellectual wellness - having a mind open to new ideas and concepts, to seek new experiences and challenges to stimulate personal growth and the betterment of society.

Emotional and psychological wellness - understanding emotions and knowing how to cope with problems that arise in everyday life, and how to endure stress.

This incorporates psychological wellness providing optimism about life, oneself and the future.

Social wellness - in interacting with others it is the ability to live in society effectively, comfortably, and supportively with others.

Spiritual wellness - state of balance and harmony or shared connection between yourself, others, nature, the universe and a higher power. In addition, spiritual wellness is a process of continually seeking meaning and purpose in life in the development of a personal belief system.

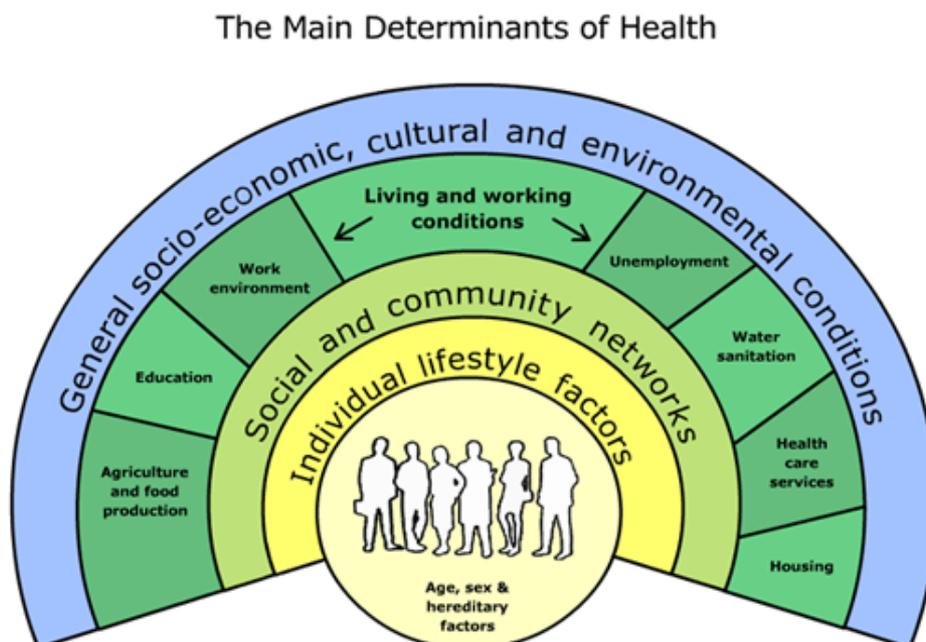
Occupational wellness - the extent to which you can express personal values whilst gaining enjoyment and enrichment from paid or unpaid employment. Furthermore, it is the ability to use skills and talents to contribute to the community and the balance between occupation and other commitments.

Environmental wellness - is the ability to recognize our own responsibility for the quality of the air, the water and the land surrounding us, the ability to make a positive impact on the quality of our environment.

Social and economic determinants of health

Much research has demonstrated that health and wellness can be affected by the determinants of health shown in the above diagram. These determinants range from constitutional and lifestyle factors, family, social and community networks, living and working conditions and general socio-economic, cultural and environmental conditions. This is a holistic model of health, where all these socio-economic

Figure 2: Social and economic determinants of health



Source: Dahlgren and Whitehead Model of Health¹⁴

determinants have a direct influence on health and can interact with each other in a synergistic way. Thus, people's lifestyles and conditions in which they live and work, act together to influence their health and wellbeing. "Poor socio-economic circumstances can affect health throughout life," producing health inequalities.¹⁵ People in poorer areas not only die approximately seven years earlier they also spend, on average seventeen more of their shorter lives with a disability.³

Also, problems that are more common amongst the least well off are worse in societies with bigger income differences. Indeed, thirty years' research from international sources, demonstrates that income inequalities within rich economically developed countries including the UK can harm the social fabric of society. The chronic stress this can produce has a detrimental effect on physical and mental health and social problems including: levels of trust, life expectancy, infant mortality, math and literacy levels, violence, drug and alcohol addiction, social mobility and teenage births. For all of these eleven health and social problems, outcomes are **substantially** worse in more unequal societies. There are two main ways proposed for reducing income inequality: smaller differences in pay before tax as in Japan or redistribution through taxes and benefits as in Sweden.¹⁶

For more information see: www.equalitytrust.org.uk



The socio-economic model shows how clinical health care services provide only a relatively small influence, as they are only one social determinant of health within living and working conditions. Whereas, wellness services can tackle some of these health determinants including lifestyle, social and community networks (including family relations). However, wellness services need to be complemented by healthy public policy, economic democracy and lobbying for changes in legislation to ensure a healthy standard of living for all.³

Wellness services

For this review wellness services are described as those that specifically promote health and wellbeing, (including the dimensions of wellness: physical, intellectual, emotional/psychological, social, spiritual, occupational and environmental) rather than diagnose and treat illness. This could be via healthy lifestyles, psychosocial interventions for individuals, families or groups. This might include a combination of smoking cessation, weight management, alcohol brief interventions, physical activity pathways, health trainers, social prescribing / referral, psychological well being interventions, e.g. mindfulness and stress management.

Table 1: Characteristics of the medical and wellness models

Medical model	Wellness Model
<p>Problem orientation A patient’s signs and symptoms identify the problem so a diagnosis is made. The medical system relies heavily on mortality data in identifying health problems and monitoring health programmes.</p>	<p>No Problem Enabling person to maintain and improve health</p>
<p>Focus on what is wrong – negative and pessimistic After diagnosis all efforts are directed toward treating the disease or condition. Having to deal with this, especially with a poor prognosis, is negative and pessimistic.</p>	<p>Focus on what is right – positive and optimistic The individual wants to identify the cause of symptoms and then make necessary lifestyle adjustments to gain wellness.</p>
<p>Parts of the patient Traditional medical treatment is aimed at improving the functioning of the diseased part or parts.</p>	<p>The whole person The integration of mind, body and spirit is the orientation of wellness.</p>
<p>Prevention of disease All knowledge and activities are directed toward the avoidance of disease.</p>	<p>Promotion of health An emphasis on improving one’s state of health.</p>
<p>Treatment of symptoms Attention is rarely given to the cause of a patient’s problems, except in the physical area.</p>	<p>Working with the cause Deals with the person’s lifestyle and focus on determining the causes of outcomes.</p>
<p>Treatments are artificial Treatments prescribed for patients include drugs and surgery.</p>	<p>Natural means Artificial products are avoided and people strive to live as naturally as possible.</p>
<p>Diet as a treatment Diets are prescribed for the purpose of avoiding one or more substances known to cause further problems in patients with a particular diagnosis.</p>	<p>Diet plays a major role People strive to eat healthy food as what you eat greatly influences, and can even determine your state of health.</p>
<p>External causes of disease People are often considered victims so a person can feel powerless to avoid a disease or do anything about it.</p>	<p>Internal causes of disease Illness is believed to be the effect of an imbalance in one’s life. It is often viewed as a challenge to make lifestyle changes.</p>

<p>External control, power and responsibility Patients regard themselves as ill or incapacitated and try to get well by complying with expert advice or treatment.</p>	<p>Internal control, power, and responsibility People take responsibility for themselves and know they must live with the consequences of their decisions.</p>
<p>Fear as a motivator Fear is a tool used to maintain patient compliance.</p>	<p>Feeling good as a motivator Feeling good or improving the health one has is the major motivator.</p>
<p>Aspiritual The scientific process is used for solving problems. There is no spiritual component.</p>	<p>Spiritual Human beings are made up of mind, body and spirit. These components are interactive and what happens in one component affects all the other components. The body has a tremendous wisdom and knows how to heal itself.</p>
<p>Focus on quantity of life This model is committed to life to the extent it can use extreme measures to keep people alive, often without regard for the quality of the patient's life.</p>	<p>Focus on quality of life The quality of a person's life is seen as more important than just being alive.</p>
<p>Individual focussed One-to-one diagnostic and treatment services</p>	<p>Collective approach Following an individual assessment courses, group work sessions can provide support from others facing similar challenges.</p>

Source: A comparison of the medical model and the wellness model¹⁷

Wellness is a personal thing – one person's idea of wellness may be different to another's. Similarly the means to gaining wellness may be different for different people. The elements to the achievement and maintenance of wellness in its holistic sense may include political change, arts and culture, spirituality for some and the overcoming of anti-social behaviour, or having enough money to live on for others. It is more complex than: quitting smoking, drinking at a sensible level, taking six sessions of exercise, eating 5 a day and measuring BMI. It will need different ways of measuring which are positive (not just about minimising risk or extending life expectancy). Some quality of life indicators may be useful for this purpose.¹⁸

Please follow the following link: <http://tinyurl.com/376n35a>

(See also Appendix 2, 3 and 4)

Human wellness is also related to environmental wellness and sustainability. A previous Observatory report: "Top Tips for a healthy planned environment" has explored these issues and provided examples of good practice.¹⁹

Wellness services should be guided by the guidelines and standards outlined in Appendix 3 and 4.

These highlight community participation: moving beyond often routine, brief consultations to effective participation in which individuals and communities define the problems and develop community solutions.³ Also, working in partnership, providing services closer to home and the requirement to take action to address inequalities in health that arise because of inequalities in society – providing services that take a holistic approach tackling the wider determinants of health.

Cost effectiveness is also an important element to consider. Wellness services that tackle the root causes of ill-health, particularly inequalities in health could make considerable savings. It is estimated that inequality in illness accounts for productivity losses of £31-33 billion each year, lost taxes and higher welfare payments in the range of £20-32 billion per year, and additional NHS healthcare costs associated with inequality are well in excess of £5.5 billion a year.³

Problems of conducting an economic analysis of public health interventions

Mounting pressure on healthcare budgets has led to an increased emphasis on economic evidence to guide healthcare policy and practice decisions. In health economics the aim of **cost-effectiveness analysis (CEA)** and other techniques is to identify efficient use of scarce healthcare resources, through identifying the interventions that provide the maximum additional effects per additional unit of resource consumed.²⁰ CEA has become synonymous with health economic evaluation and representing value for money. However, it is only one method of economic evaluation that measures outcomes in 'natural units' such as life-years gained, deaths avoided, and heart attacks avoided or cases detected. In **cost-utility analysis** the benefits are expressed as quality-adjusted life-years (QALYs) and in **cost-benefit analysis** in monetary terms.¹¹

However, there are methodological problems in using cost-effectiveness analysis for public health interventions²¹:

- *Attribution of effects* – public health programmes, notably prevention may impact on health over the longer term. Thus there is a difficulty in assigning cause and effect.
- *Measuring and valuing outcomes* – Other outcomes (than QALYs) may be relevant to public health programmes, including the effects that interventions may have on individuals not directly targeted by the programme; e.g. reassurance, creation of an informed public, and other non-health-related outcomes such as an education outcome.
- *Identification of intersectoral costs and consequences.* Costs and benefits can fall on many parts of the public sector. In addition individuals may incur associated out-of-pocket costs and there may be ripple effects within the economy at large.
- *Incorporating equity considerations:* The value of a QALY is the same no matter who receives it, but impact on health inequalities is important and may be the main objective of the intervention.

Therefore, cost-effectiveness is only one of a number of criteria that should be employed in determining whether interventions are made available. For instance, Issues of equity, needs, and priorities should also form part of the decision-making process.¹¹

Evaluation of services taking a holistic approach to care

Development of wellness services

Well women services

In a national study of experiences and attributes of health care that women want in primary health care, women valued excellent medical care, generally defined as health care that is in tune with women's bodies and lives and is **holistic in scope**. Also, women stated that primary health care for women should be focussed on issues that they consider important such as nutrition, fitness, complementary medicine, sexuality, and domestic violence. Women also noted the importance of thinking in terms of the woman's life circumstance, not just her medical condition.²² Well Woman services, aim to promote the health of 'the whole woman' and have developed throughout Britain since the first Well Woman clinic was established in London in 1973.²³

The early development of Well Woman Centres has its roots in the Women's health movement of the 1980s. These early services need to be seen in a historic context. At the time primary care services were in the main provided in single handed practices by a male GP. In Wirral the Well Woman Centre was based on a non-medical holistic model although there were medical and other professional staff 'on tap' such as a psychologist, a social worker and a drugs counsellor. There was on offer a one to one individual 'consultation' with a volunteer lay health worker (predecessor of today's health trainer) where a health questionnaire covering all aspects of health including mental wellbeing and wider determinants and **an action plan could be co-produced with the woman**. This could include medical interventions like cervical screening however it also included a selection from a menu of self help groups, education sessions or self referral to other helping agencies e.g. CAB. There was also a resource library of books and information about all aspects of health including the wider determinants. This was presented in a friendly informal environment with lay health worker staff on hand to provide support if needed. Empowerment was an important principle of the centre and the process reflected Ron Labonte's 'empowerment holosphere'.²⁴

An important aspect was the progression route taken by many women using the service from an initial one to one session and consultation with the various professionals through the into various groups and activities with some women becoming lay health workers themselves or active in their own community. A spin off was the development of two community led neighbourhood women's centres in the most deprived parts of the borough. A review of the outcomes for volunteer lay health workers some time later identified that 90% had gone on to further education or employment (some now have senior roles in the public sector). This developed

into a network of local groups (efforts were made to improve provision and engagement in more deprived communities) and activities which then lobbied for additional resources and involvement in policy within the borough. Unfortunately although the service name continued (until 2009) it gradually lost its original ethos, and became more medically focussed. Although it retained volunteers their role was gradually diminished. The community led women's centres have continued to this day providing two generations of women with improved education opportunities and raised aspirations for themselves and their children.²⁵⁻²⁷ This learning has partially informed the development of other provision in Wirral, including the health action area approach.

Although there have been many innovative clinics in Northern towns and cities, in the UK well woman clinics have tended to develop out of cytology clinics and have therefore reflected a medical model retaining their emphasis on cervical screening and contraception.

At the very least well woman services should offer women not only medical screening and basic health checks, but also a counselling service, self-support groups and health education programmes. Ideally they should be provided in an informal setting to attract woman who underuse preventive healthcare.⁷

Only one evaluation that included costs was found that looked at a health promotion programme in a Well woman's clinic (WWC) in the USA. The participants were involved in breast self-examination (BSE) and various screening tests: diabetic, hypertension and cervical/breast cancer and given limited counselling on lifestyle. The service was well received by participants with 99% rating it excellent or good and 99% saying they would recommend to a friend. There was also a 37% increase in the number of women claiming to be doing BSE 6-8 weeks after attendance at the WWC. It was acknowledged that longitudinal studies are needed to determine whether there was any actual behaviour change in BSE by women. The clinic was provided free at the weekend and was significantly staffed with volunteers. An estimated calculation on time and experience donated by physicians, student nurses, nurse midwives and hospital auxiliaries to each clinic was valued at \$2,506.64 during September 1984 on the WWC cost revenue report. Using an exchange rate of \$1 = £0.65 on 30/7/10 this amounts to £1,627.27. The total actual costs were \$1,887.77 (£1,225.51). The WWC generated hospital revenues (minus total actual costs) amounting to \$13,916.23 (£9,034.17). However, potential savings of health promotion programmes in terms of less severe personal illnesses, decreasing numbers of lost work days, and minimising health care insurance costs were not provided.

Well man health service (WMS) pilots evaluation

Men's health has been a particular policy concern in Scotland as men have lower life expectancy and are less frequent users of health services compared to women. Also, there are marked health inequalities between men from different social circumstances. The 18 well man pilots in Scotland funded between June 2004-March 2006, aimed to:

- promote healthier lifestyles and attitudes among men;

- provide men with an opportunity to undertake a health assessment and to obtain advice and support on health and lifestyle issues;
- effectively engage all men in particular, those who were hardest to reach as a consequence of social exclusion or discrimination. They were also intended to identify what worked in promoting and sustaining health awareness and improvement in men.

The term 'hard-to-reach' was defined as people who were socially excluded "by either their age, faith/religious beliefs, sexuality, disability, race/ethnicity or because of a general lack of interest or concern..." However, this was interpreted differently by each individual pilot project, which reflected the specific concerns of different Health Board areas.

The economic analysis focussed on the costs and outcomes relating to the comprehensive health assessment and considered various approaches taken in the pilot projects.²⁸ Staff variation was the main factor in different session costs and attendance rate was the main factor in cost per health assessment, particularly at drop-in services in community venues, where attendance was unpredictable. Similar costs could be achieved in different settings, but workplace delivery had the lowest range of costs. However, the costs did not include those incurred by patients.

Table 2: Cost comparison of delivery modes – well men service pilots

Location	Cost per session		Cost per assessment	
	Number	Range	Number	Range
Health Clinics	9	£189-£836	9	£43-£284
Workplaces	2	£208-£220	3	£27-£103
Community venues (incl. Pharmacies)	6	£101-£428	4	£63-£1117

Outcomes were considered in terms of contacts, onward referrals and potential health gain. The range of outcomes or consequences from pilots was potentially wide and diverse. **The relatively short timescale of the interventions made it impossible to measure changes in final health outcomes, and information from the literature was used to model health effects.** Data on lifestyle factors amongst Well Man Service (WMS) users, their willingness to change behaviour and the rate of referrals for interventions, were combined with information about the effectiveness of interventions to estimate health outcomes. This framework was also used to estimate the added value of the WMS based on assumptions about alternative provision, such as routine GP visits.

The value which men placed on different attributes of WMS was elicited directly by the use of a discrete choice experiment (DCE) approach. A postal survey of a large population-based sample was carried out in an area where no WMS had been established. With some exceptions, generally, men favoured mainstream health services and liked physical tests and measurements and valued follow-up.

Sessions held in community venues or workplaces were more likely to contact men who had not seen their GP in the past two years, but these men did not appear to have greater health needs. Projects with higher staffing levels at sessions tended to have higher rates of onward referral. There was considerable potential for health gain with men reporting problems with smoking, alcohol and exercise. However,

referral rates for alcohol and exercise were very low, suggesting that an opportunity for health gain was being missed.

Although potential health gains could be achieved through WMS at a cost per QALY below the threshold for many clinical interventions, **the limited data collected for this evaluation cannot provide clear evidence of cost-effectiveness**. This was because the evaluation was not high on the agenda of most service providers, and there was a lack of planning for their contribution to the evaluation process. Furthermore, the project changed and evolved in response to population uptake during the implementation phase making it harder to measure cause and effect.

It was estimated that combining the results for changes in 5 modifiable risk factors (smoking, alcohol, physical activity, BMI and blood pressure) the cost per QALY was between £3-6K (at £100-£200 per health assessment). This figure could be more than halved if referrals for alcohol and exercise interventions were increased to the levels achieved for smoking cessation.

The cost per QALY (without a prior health assessment) was £73-£487 for smoking and £20-£670 for physical activity interventions. This is much lower than the combined assessment, but assumes that no intervention would take place in the absence of the WMS (therefore the real cost per QALY could be higher). If GPs offered lifestyle advice during routine consultations then, for example, the additional cost per QALY for smoking cessation provided through the WMS would be £9,828 (£100 per assessment) to £19,383 (£200 per assessment). For alcohol interventions and exercise, the referral rates from WMS were so low that any reasonable assumptions about GP intervention rates produce outcomes that dominate the WMS (i.e. they produce more benefit at less cost).

The authors concluded that: Opportunistic intervention in primary care is likely to be more cost-effective for the majority of men **but may have limitations for hard-to-reach men**. A combination of approaches may be more likely to achieve the desired combination of efficiency and wide coverage.

Job Centre Plus: Condition management programmes

The Pathways to Work pilots were introduced in October 2003 (becoming a national programme in 2008) with the aim of increasing the number of Incapacity Benefit recipients who move towards work. An innovative element of the pilot is the voluntary Condition Management Programme (CMP), developed jointly between Jobcentre Plus and local NHS providers.²⁹

The CMP is a six to thirteen week voluntary intervention designed to enable clients to cope with the main 'moderate medical conditions' experienced by Incapacity Benefit (IB) claimants (mental health, cardio-respiratory, and musculo-skeletal conditions).³⁰ It is based on a bio-psychosocial model of health and illness, the aim is to tackle deep-seated barriers to work such as anxiety, lack of confidence and social isolation.²⁹ The CMP is not designed to replace standard health care interventions; rather it uses 'cognitive behaviour therapy' and related techniques to challenge negative attitudes and help clients to learn to cope with conditions in such a way that they may return to some form of employment.

However, CBT and related therapies is considered inappropriate for some and particularly those with severe or chronic problems.³⁰ Experiences of participants in the CMPs are generally positive. Participants have reported improved pain management techniques and improved health behaviours (specifically better diets and increased exercise). Also reported are positive psychosocial outcomes (including increased self-esteem, confidence and social support) and in some cases, return to work. The holistic biopsychosocial approach to the programmes was considered to be particularly helpful. However, there is a role for employers to create a supportive environment for example by offering ergonomic work stations, courses on stress management or flexible working conditions to facilitate a return to work. Concerns have been expressed about the shortness of interventions and their accessibility. The findings also illustrate that there is no 'one size fits all' template for CMPs. Rather, interventions should be adapted to take account of the dynamics of specific conditions, the context in which the intervention is based and the characteristics of the individuals involved.³¹

CMPs appeared to have real benefits for the partner agencies, in facilitating effective interprofessional and interagency working and the dissemination of new working practices. There are also indications that involvement in CMP might act as an impetus for more widespread changes to policy and practice with regards to the management of long term health conditions with a shift in the focus from incapacity to potential.³²

Cost-effectiveness

To date no cost-effectiveness reviews or cost savings have been reported.

Partnership for Older People Projects (POPP)

The POPP programme was funded by the Department of Health to develop services for older people, aimed at promoting their health, well-being, reducing social exclusion and isolation and promoting independence by providing earlier and better targeted interventions within community settings that prevented or delayed their need for higher intensity or institutional care. The programme began in May 2006 and was completed in April 2009, with a total of £60 million available to 29 pilot sites, which set up 146 core local projects. Local authorities (LAs) were involved as pilot sites (this included a pilot in Knowsley Metropolitan Borough Council) working in partnership with health and the voluntary sector. An evaluation found that, compared to those having no POPP intervention, a wide range of projects resulted in improved quality of life and well-being for participants whilst achieving considerable savings, as well as better local working relationships.³³

The POPP programmes were led by local priorities. The direct involvement of older people in projects increased over time; such involvement was generally heaviest in the design and governance of projects, compared to service delivery; the older people involved tended to be newly retired (the 'young old'), healthy and well-educated.

Over a quarter of a million (264,637) people used one or more of the POPP services, however, projects found it difficult to access 'hard to reach' people and services may

have been insufficiently responsive to the needs of black and minority ethnic (BME) groups.

The projects ranged from low-level services, such as provision of practical help, lunch-clubs, to more formal preventive initiatives, such as hospital discharge and rapid response services. The overwhelming majority of projects have been retained with only 3% (n=5) being closed, either because they did not deliver intended outcomes or because local strategic priorities had changed. Two-thirds of the projects were primarily directed to reducing social isolation or promoting healthy living (Community Facing) and one-third focused primarily on avoiding hospital admission or facilitating early discharge from acute or institutional care (Hospital Facing).

The 29 pilot sites spent a total of £50.7m on POPP projects over the lifetime of the initiative. £32.3m (64%) of this total was spent on projects that were Community Facing, with £14.6m (36%) being spent on Hospital Facing projects.

Efficiency savings

Interventions across the POPP programme have produced an average of approximately £1.20 saving (range: £0.80 - £1.60) in emergency bed days for every extra £1 spent on prevention.

Compared with the use of health services before the POPP intervention:

- hospital overnight stays reduced by 47%
- accident and emergency attendances reduced by 29%
- clinic or outpatient appointments reduced by 11%; and
- physiotherapy/occupational therapy appointments reduced by 8%

Efficiency gains in health service use appear to have been achieved without any adverse impact on the use of social care resources.

Improved outcomes for older people appear to be achieved through integrated, co-located health and social care teams.

Cost-effectiveness

Projects were analysed using the cost-effectiveness acceptability curve (CEAC), compared to outcomes in areas with no POPP projects, using the “willingness to pay” cut-off figure of £30K (equivalent to \$47800.5) for a point increase in QALY employed by the National Institute for Health and Clinical Excellence (NICE).³⁴ Considering the POPP projects as a whole, there was a very high probability (86%) that the overarching POPP programme was cost-effective, compared with usual care. This means that there is a risk that 1.4 in 10 projects may not be cost-effective.

Within three categories of project (practical help, social/emotional support and pro-active case finding) there was greater than a 98% probability that at £10,000 or less

per point increase in QALY, such projects were cost-effective compared with 'usual care'. Therefore there was a small risk that 0.2 projects in ten would not be cost effective.

There was a high probability (80%) that projects focused on primary prevention were cost effective, compared with usual care. This figure was lower (71%) for projects addressing secondary prevention, but these varied considerably. Projects addressing tertiary prevention were much more costly, being focused on people with very high levels of need, but there was nonetheless a very high probability (96%) that they were cost effective compared with usual care.

Commissioners will need to decide on the level of 'risk' around funding such projects. One operational example can be given by focusing on those projects that improve well-being through the provision of practical help, small housing repairs, gardening, limited assistive technology or shopping. For an extra spend of £5,000 per person (at £96.15 per week) there is a 98% probability that such projects are cost-effective compared with 'usual care'. Commissioners putting in place such projects could be reasonably confident that only around 0.2 projects in 10 would not be cost-effective.

Social Prescribing

Social prescribing aims to provide a holistic package of support tailored to individual need.³⁵ In so doing, it seeks to link patients up with the non-medical facilities and services available in the wider community that they can access to address the psychosocial factors that influence their wellbeing.³⁶ Thus social prescribing expands the options available in a primary care consultation – through referral or signposting - which increases patient choice. Indeed, an estimated third of all GP consultations are the result of psychosocial problems, although this may not always be recognised as such.³⁷ These options can make available new life opportunities for such patients, that can add meaning³⁸ including: opportunities for arts and creativity, physical activity, learning and volunteering, mutual aid, help to form new relationships and self-help, as well as support with, for example, benefits, housing, debt, employment, legal advice or parenting. These interventions can be provided through the voluntary, community and social enterprise sector (third sector) and Local Authorities. Social prescribing also acts as a mechanism to strengthen community-professional relationships.³⁵

Case study 1: Social Prescribing - Community Volunteering

Following a stroke a man in his 70's had to give up driving and playing golf. In addition to his physical health condition he became depressed and for the first time in his life was prescribed antidepressants. The social network issue in this case related to the individual not being able to engage in the things he enjoyed and the loss of socialisation. He was matched up with a local volunteer buddy who encouraged him to become involved in other social activities. This new relationship had a very positive effective on the individual's mental health to the point where he no longer required the anti-depressants.

This case study asserts the benefits of social prescribing where people in communities can make a major impact on health.¹²¹

Effectiveness depends on the quality of the partnerships and joint working between the third sector and LAs with primary care staff.³⁹ The North West development project found that central co-ordination would improve the efficiency and effectiveness of the service.⁴⁰ There have been a range of reported positive outcomes including enhanced self-esteem, improved mood, opportunities for social contact, increased self-efficacy, various transferable skills and greater confidence.⁴¹

It has the potential to save future costs of ill-health through early intervention. For example: social prescribing provides a means to keep people in work and maintain social contacts. Once a person has reached crisis point, it is much more difficult and costly to restore their employment and social status, with a subsequent exacerbation of economic and health inequalities. It can potentially be an effective response to frequent attenders in primary and secondary care, whilst tackling underlying issues associated with frequent attendance,⁴⁰ such as social problems.⁴² However, it may not have an immediate impact on attendance rates of these patients and associated costs due to their being embedded within a 'medical model' of health and illness.⁴³

The use of computers and internet-based programmes for computerised therapy have the potential to make psychological assessment and treatment more cost-effective.⁴⁰ A review from NICE found good evidence for the effectiveness of some **computerised Cognitive Behavioural Therapy** (CBT) for depression and anxiety – for example, Beating the Blues™.⁴⁴ The British Association for Behavioural and Cognitive Psychotherapies has published a useful review of free sites, making the following recommendations to PCTs:

- CCBT may provide users with substantial benefits.
- Although the free-to-access programmes may provide some benefit if used on their own, the benefits may increase if the user is encouraged to use the site by a professional.
- Information about the following websites should be made freely available:
MoodGym (<http://moodgym.anu.edu.au>)
Living Life to the Full (<http://www.livinglifetothefull.com>)
Feel Better (<http://www.kpchr.org/feelbetter/>)

Bibliotherapy has high patient acceptability, a tendency to continued improvement over time and low relapse rates.⁴⁵ Bibliotherapy is also cost-effective⁴⁶ although the level of effectiveness depends on the quality of the book and the motivation and application (as well as the literacy) of the user.

A report commissioned from the University of Essex by Mind (Mind 2007) suggests that **ecotherapy** is an accessible, cost-effective complement to existing treatment options for mild to moderate mental health problems. It is described as a natural, free and accessible treatment, with no unpleasant side-effects that boosts mental wellbeing.⁴⁷ MIND supports their cost-effectiveness assertion by support from previous research, to show the costs that could be avoided through the use of ecotherapy. For example:

Research from the Mental Health Foundation has found that: 78% of GPs have prescribed an antidepressant despite believing that an alternative approach might have been more appropriate. Sixty-six per cent of these have done so because a suitable alternative was not available. In 2003, 27.7 million antidepressant prescriptions were written in England, at a cost of £395.2 million to the NHS.⁴⁸ The Department of Media Culture and Sport (2002)⁴⁹ estimated that a 10 per cent increase in adult physical activity would benefit the UK by £500 million per year, saving 6,000 lives; this calculation does not include the potential economic impact of improved mental wellbeing. The annual costs of physical inactivity in England are estimated at £8.2 billion – including the rising costs of treating chronic diseases such as coronary heart disease and diabetes and the indirect costs caused through sickness absence. This does not include the contribution of inactivity to obesity – an estimated further £2.5 billion cost to the economy each year.⁵⁰

For **Arts on prescription** evidence of effectiveness addresses three key areas:

- the impact of participation in the arts on self-esteem, self-worth and identity;
- the role of creativity in reducing symptoms (e.g. anxiety, depression and feelings of hopelessness); and
- arts and creativity as resources for promoting social inclusion and strengthening communities.
- Offering social interventions alongside psychological therapies has the potential to maximise the effectiveness of the “Improving Access to Psychological Therapies” IAPT scheme. The IAPT programme is a Department of Health initiative aimed at ensuring that people presenting in primary care with mild or moderate depression have greater access to a range of psychological therapies.⁵¹

The above review shows how social prescribing can benefit patients with mild to moderate mental health problems. The patients who might also benefit from social prescribing are those where medical interventions are inappropriate or have been exhausted. In particular social prescribing is ideal for patients who are: isolated, lonely, older carers and bereaved also patients who have no diagnosis, repeated ailments or unresolved problems.⁴³ However, in areas without a strong community or voluntary sector social prescribing may be inappropriate. Nor should it detract from the need to address health inequalities through macro-economic policies and public health programmes.³⁵

Health trainers

Health trainers were part of a national health promotion initiative proposed in the 2004 white paper: *“Choosing Health: making healthy choices easier”* to reduce health inequalities.⁵² They form part of the wider public health workforce who are employed, trained and resourced to give practical advice and support to the most disadvantaged individuals who want to adopt healthy lifestyles. They operate from a range of sites from GP surgeries to religious buildings to libraries and even at school gates. A key feature is their ability to relate to common concerns. For this reason, they are, ideally, drawn from and based in deprived communities who do not normally interact with health agencies and professionals. They use the techniques of ‘motivational interviewing’ and ‘active listening’ to support individuals to overcome their hesitations and start to make healthy choices.⁵³ They can also signpost people to a range of support services.

There have been fears that health trainers represented a backward step to individualised health education. However, findings from one of the early adopter sites has found that these front line public health workers can offer much needed one-to-one support in disadvantage communities. Furthermore, it has been suggested that their ability to offer empathy and support to people in their own communities may prove to be of most value in addressing health inequalities at a micro level.⁵⁴ Even so, within Cheshire and Merseyside, in practice not all Health Trainer recruits come from local communities and some are over-qualified for the role. As the labour market contracts during the recession, more professional people are likely to apply for these posts. However in areas where recruits are employed in the voluntary sector, in particular Liverpool, it appeared easier to recruit locally.⁵⁵ It has been argued the these trainers are unlikely to have a sustained impact upon improving health behaviours, in particular on levels of physical activity, without simultaneous policy focusing on changing features of neighbourhoods to make them more health promoting.⁵⁶ Long term investment is required to ensure these schemes are sustained to maximise effectiveness.⁵⁷ Initial funding from the Department of Health was £36m in 2006/7 and £77m in 2007/8.⁵⁸

The Department of Health⁵⁹ issued a favourable review in June 2009 stating that:

- Nearly 90% of Primary Care Trusts have a Health Trainer Service
- More than 3100 Health Trainers (level 3) and Health Trainer Champions (level 2) were either trained or in training
- 60,000 clients have been seen by Health Trainers
- Nearly half of Health Trainer clients are drawn from the 20% most deprived communities in the country
- Two thirds of clients fall within one or more deprivation indicators
- More than two thirds of clients have achieved a goal within their Personal Health Plans (PHPs)
- There has been considerable enthusiasm for the concept among third party organisations.
- Offender Health has made great strides with their health trainer programme, numbers are currently in the region of 80 Health Trainers
- The British Army has trained 2,450 Physical Training Instructor Health Trainers, with a further 2000 in training, as of April 2008
- Royal Mail has trained two cohorts of first aid staff to RSPH Level 2
- The programme is also working with organisations such as National Pharmacy Association and the Football Foundation.

From this evidence, the scheme does appear to be reaching its target group. Analysis of common themes emerging from interviews with managers from health improvement/promotion, within Cheshire and Merseyside, has found the strengths of Health Trainers to be:⁵⁵

- Work one-to-one
- Have time to spend with the client
- Non-judgmental
- Non-clinical/non-medical

- Personalised service
- Can accompany people to activities
- Practical focus
- Understand the challenges faced by local communities
- Empower people
- Promote health 'literacy' and understanding of messages about healthy living
- Bridge between communities and PCT

There are still concerns that there is a lack of evidence to support the scheme and there has been no economic analysis. The mode of operation varies according to local priorities and interpretations making it difficult to evaluate Health Trainer performance according to a common framework⁵⁵ or to ascertain the most effective model for practice. However, the programme is building an evidence base through the Health Trainer Data Collection and Reporting System (DCRS), although it is not compulsory for Health Trainers to contribute to this system. The service could potentially be cost-effective by reducing the number of visits to GPs.⁵⁸ The health trainers are doing things now that might take many years to measure in terms of reductions in mortality and morbidity.⁵⁷ A national evaluation of the health trainer scheme: *"Scoping review of Health Trainers Initiative. Exploring implementation"* is being conducted by Birmingham University but was not published in time to be included in this report.

Nevertheless, promising qualitative research exploring the experiences of lay food and health workers (LFHWs) in Bolton has recently been reported.⁶⁰ LFHWs (paid and unpaid) have a similar role and background to health trainers indigenous to the socially disadvantaged neighbourhoods they serve. Their primary role was to "encourage dietary change by translating complex messages into credible and culturally appropriate advice". This research, backed by supportive literature, found that LFHWs were able to fulfil this role. Also, they provided additional benefits to both the community nutrition and dietetics service and local communities whilst enabling their own personal development. LFHWs can be cost-effective by saving costs on staff budgets through a complementary skill mix of professional and lay involvement: therefore releasing professionals to perform strategic and clinical duties. Furthermore, they extended service coverage to include the 'hard-to-reach' which conventional services found it difficult to engage with. For communities they provided opportunities for local people to build socially supportive networks. Indeed, the LFHW were keen to extend their role, beyond lifestyle change, to provide wider benefits such as: social support, facilitate access to services and individual empowerment. This is in keeping with a broad definition of health and health promotion as a resource for living.

Occupational therapy

Occupational therapy is a profession that is concerned with promoting health and well being through occupation, that is: participation in purposeful activity and the activities of everyday life that add structure and meaning. Occupational therapists (OTs) promote quality of life by enabling people to do things that will enhance their ability to participate or by modifying the environment to better support participation.⁶¹ OTs use careful analysis of physical, environmental, psychosocial, mental, spiritual,

political and cultural factors to identify barriers to occupation. Quite simply, OTs enable individuals or groups of all ages who have physical, mental or social problems as a result of accident, illness or ageing to do the things they want to do.⁶² This includes employing their unique skills to modify homes, schools, the work place, and any other environment through the use of assistive technologies (AT).

AT can often include “low tech” applications such as lever door handles, amplifiers on door bells and telephones, grab rails, handrails, ramps, stair lifts, external lighting with passive infra-red, lowered light switches, raised electrical outlets, level thresholds, wider doors and corridors, and electric window and door openers. A UK research project explored issues relating to the introduction of AT into the existing homes of older people in order to provide them with the opportunity to remain at home. The analyses provided a strong financial case for substituting and/or supplementing formal care with assistive technology, even for individuals with quite disabling conditions. Although needs and hence the cost of provision rise with an increasing level of disability, the savings in care costs accrue quickly. The authors concluded that with careful specification of assistive technology major savings are feasible.⁶³

A randomised controlled trial (RCT) compared preventive occupational therapy to obtain successful ageing, with a control group receiving generalised social activity programmes and a no therapy group (passive control).⁶⁴ The 9-month preventive OT therapy consisted of weekly sessions involving 8-10 participants, who were helped to a better appreciation of the importance of meaningful activity in their lives through didactic teaching and direct experience with a broad range of activities. The central theme of the OT programme was health through occupation, defined as regularly performed activities such as grooming, exercising, and shopping. The subjects were healthy older adults of 60 years or older living independently. The study was conducted in two federally subsidised apartment complexes for older adults in Los Angeles. Significant benefits for the OT preventive treatment group were found for functional ability, social participation and quality of life. As the control groups tended to decline over the study interval, the results suggest that preventive health programmes based on OT may mitigate against the health risks of older adulthood. Indeed, the OT profession’s emphasis on occupation appears to be the main determinant for the efficacy reported.

An incremental cost-utility analysis of this study (OT versus each of the control groups) was used to combine costs (using 1995 prices) and benefits of the interventions. As total costs were not statistically significantly different across study groups, only programme costs were considered. The incremental cost per QALY gained with OT was \$10,666 (95% CI: \$6,747 - \$25,430) over the combined controls, \$13,784 (95% CI: \$7,724 - \$57,879) over the passive control, and \$7,820 (95% CI: \$4,993 - \$18,025) over the active control. The authors conclude that OT led to gains in quality of life scores and showed a trend toward decreased medical expenditures. However, the issue of generalisability of the study results to other settings was not addressed and sensitivity analyses were not performed, thus limiting the external validity of the analysis. The authors reported some limitations of their analysis, mainly related to the limited follow-up period of six months and the variability in the estimated costs. Future research with a longer follow-up would more adequately document the ultimate cost savings of therapy.⁶⁵

From these studies OT can be cost-effective in promoting wellness in older individuals or those showing physical disabilities enabling them to live independently.

Psychological wellbeing interventions

Thoughts, feelings and moods can have a significant effect on the onset of some diseases, the course of many, and the management of nearly all. Neglecting the psychosocial health needs of people can lead to frustration, ineffectiveness and wasted health resources.⁶⁶ Mind-body medicine encompasses a wide range of practices and therapies designed to facilitate the mind's capacity to affect health.⁶⁷ There are an increasing number of studies, including randomised controlled trials, showing that relatively inexpensive mind-body interventions can improve health outcomes while reducing the need for more expensive medical treatments and without any adverse effects.^{66 68} Furthermore, there are many indications that it can actually prevent the occurrence of disease, as perceptions, thoughts and feelings can influence immune and hormonal systems in both adaptive and maladaptive ways.⁶⁹ Examples of psychological wellbeing interventions are below.

Mindfulness

Mindfulness is a core construct of Buddhist teachings and is a key requirement of meditation.⁷⁰ It involves the self-regulation of attention so that it is maintained on immediate experience, thereby allowing for increased recognition of mental events in the present moment.⁷¹ A quality of "bare attention" is attained whereby all elaborate and judgmental processes are suspended: a complete acceptance of all experience.^{72 73} It can also involve adopting a particular orientation toward one's experiences in the present moment, an orientation that is characterized by curiosity, openness and acceptance.⁷¹

Like other forms of meditation mindfulness can increase resilience to stress therefore making it a useful preventive measure and support for individual lifestyle changes. By increasing awareness in the present moment it can assist in interrupting existing patterns of behaviour and enable wiser choices. Many studies have shown that meditation reduces anxiety and increases positive affect.⁷⁴⁻⁷⁶ Research shows a direct link between positive affective states resulting in stronger immune function and decreased incidence of illness.⁷⁷ There is also accumulating data indicating that it is both clinically efficacious and cost-effective, particularly in the treatment of chronic disease, reducing the need for more expensive health interventions, as well as an important adjunct to conventional healthcare.⁶⁹

Routine training in mindfulness meditation for health care staff can both improve the professional lives of clinicians and the health of patients. Also, this will reduce the costs associated with burnout,⁷⁸ high staff turnover, clinical errors,⁷⁹ generalised stress for the practitioner⁸⁰ and lower quality care for patients.⁶⁹ Furthermore, if the prevailing paradigm within healthcare can be shifted from treating to preventing disease, it is claimed that the costs associated with delivering mindfulness-based services and training healthcare professionals to deliver such services will pay for themselves.⁶⁹

In clinical and some non-clinical settings two mindfulness based interventions have been used. Mindfulness Based Stress Reduction (MBSR) was developed by John Kabat-Zinn to address the cognitive and somatic dimensions of unmanaged stress associated with chronic pain and illness. The intervention programme consists of 8 weekly two-hour sessions and a final 8-hour whole day retreat.⁷⁰ Group mindfulness-based cognitive therapy (MBCT) integrated aspects of Cognitive Behavioural Therapy (CBT) and MBSR. MBCT should normally be delivered in groups of 8-15 participants and consist of weekly 2-hour meetings over 8 weeks and 4 follow-up sessions in the 12 months after the end of treatment. It is intended to impart skills that empower patients in remission from recurrent major depression. MBCT has been recommended by NICE since 2004, for people who are currently well but have experienced three or more previous episodes of depression.⁸¹

A review of research has concluded that the technique of MBSR was able to reduce stress levels in healthy people. The authors advised that further more rigorous research was needed to determine any long-term specific effects.⁸² Patients with chronic pain have shown a statistically significant reduction in various measures of pain symptoms when trained in MBSR.⁸³ Indeed, it is useful for a wide-range of difficult to treat chronic disorders including depression, anxiety, fibromyalgia, mixed cancer diagnoses, coronary artery disease, obesity, and eating disorders.⁸⁴ MBSR may be cost-effective by reducing the need for healthcare. A significant decrease in healthcare utilisation (chronic care visits and medical visits) has been found after a MBSR programme with US inner city health centre patients with significant co-morbidity of medical and mental health diagnosis.⁸⁵ A low-cost "low-dose" 6-week worksite MBSR intervention significantly reduced perceived stress in members of the active intervention group, compared with those who served as wait-list controls. This could reduce stress-related healthcare costs.⁸⁶

A well conducted economic analysis using a randomised controlled trial found that for people at risk of depressive relapse, MBCT was more effective than maintenance antidepressants in reducing residual depressive symptoms and psychiatric co-morbidity and in improving quality of life in the physical and psychological domains. There was a non-significant difference in average annual cost between the 2 groups. MBCT was consistently more expensive than antidepressants over the first 12 months but it become cheaper over the final 3-month period (12-15 months) of the study. If this trend were to continue, the relative cost effectiveness of MBCT may increase over time. Including all health and social services costs and productivity losses, the incremental cost-effectiveness ratio was \$962 per relapse/recurrence prevented and \$50 per depression-free day. For health care cost only, these ratios were \$439 and \$23, respectively.⁸⁷ All unit costs were for the financial year 2005-2006 and were converted to international dollars using a purchasing power parity exchange rate of 0.6 as recommended by the World Bank.

Stress management

Stress management encompasses a wide range of techniques designed to treat the physical and emotional effects of stress and also to identify stress factors and teach coping mechanisms to alter the experience of stress. Ideally stress management should also attempt to reduce the actual source of stress that may lie outside the individual's control such as social, environmental or political factors. A balance

needs to be met between good and positive stress known as eustress which eliminates boredom and bad or negative stress (distress).⁸⁸ The approaches used can include mindfulness and other forms of meditation, counselling, relaxation techniques, biofeedback and education.

The term stress was coined by Hans Selye in 1936 who described it as "the non-specific response of the body to any demand for change".⁸⁹ This triggers the sympathetic nervous system to cause a "flight or fight" response. After prolonged undue pressure, stress can be experienced as an uncomfortable feeling which can cause symptoms such as: difficulty sleeping or concentrating, sweating and loss of appetite. If not treated, the body begins to adapt to stress leading to health problems such as high blood pressure (hypertension), anxiety, depression, muscle/joint pains, insomnia and fatigue.⁹⁰ Also chronic stress at work is an important risk factor for the metabolic syndrome – a cluster of risk factors that increase the risk of heart disease, and type 2 diabetes.⁹¹ Chronic stress (accurately measured by the level of cortisol in the hair in the months prior to an acute event) has recently been found to play an important role in heart attacks.⁹² Furthermore, if untreated, hypertension alone can cause many different types of cardiovascular disease.⁹⁰ A recent study has found that many commonly prescribed hypertensive drugs such as beta blockers or ACE inhibitors are not suitable for all hypertensive patients and when given to those with low renin levels they can actually elevate blood pressure. The authors suggest that doctors could select drugs most suitable for their patients - by measuring blood levels of the enzyme renin through a blood test that is becoming more widely available.⁹³

In the meantime, stress management is a low-tech (inexpensive) alternative that may help without side-effects that patients can be trained to perform and therefore control their own stress levels. A recent community-based randomized study comparing a 5-week mindfulness meditation course ($n = 19$) with one on progressive muscle relaxation ($n = 24$) found comparable post-treatment levels of stress-reduction.⁹⁴

The typical components of Stress Management interventions that have been frequently used are⁹⁵:

- **Imagery, relaxation and meditation** – diaphragmatic breathing, directive and receptive imagery, yoga, progressive muscle relaxation, autogenic training (German form of meditation/self-hypnosis) and massage therapy.
- **Cognitive-behavioural approaches** – emotion-focused or problem-focused cognitive coping skills, self-monitoring of stress intensity, thought record keeping and rewriting, cognitive reappraisal, time management, assertiveness training, systematic desensitization and various didactic and educational topics.
- **Systemic approaches** (altering the social environmental or political factors, those external to the individual, which contribute to stress) – a lower level intervention might include attempting to modify family dynamics and personal relationships that may cause or exacerbate existing stressors and a high-level approach may involve inducing societal change through creating and implementing new government policies.

Cost-effectiveness

Meditation has been found to help health indirectly in the avoidance of maladaptive behaviours in response to stress that significantly contribute to the rising costs of chronic disease.⁶⁹

A cohort study of clergy suffering from chronic stress found that the group that participated in a stress management programme called HeartMath (HM) designed to help participants manage stress and increase physiological resilience had reduced health care costs. When compared to non-participants (control group), adjusted medical costs were reduced by 3.8% for the HM participants in comparison to a 9% increase for the control group. For the pharmacy costs an increase of 7.9% was found compared with an increase of 13.3% for the control group. Total 2008 savings as a result of the HM program are estimated at \$585 per participant, **yielding a return on investment of 1.95:1.**⁹⁶

In a recent review⁹⁷ of controlled research on the use of self-hypnosis training (including autogenic training) it has been found to be effective for:

- Reducing generalised stress: improved heart rate variability and improved autonomic function, reduced sympathetic activity and enhanced parasympathetic activity. When used with attentional control: significant reductions were seen in systolic and diastolic blood pressure and pulse rate.
- Treating anxiety-related disorders, such as tension headaches, migraines and irritable bowel syndrome. Proving to be a rapid, cost-effective (although no actual figures are provided), non-addictive, side-effect free and safe alternative to medication that is acceptable to the majority of the general public
- Patients with more severe problems when combined with other forms of treatment (e.g. cognitive behaviour therapy or acupuncture) can improve the outcomes obtained by the other therapeutic modalities alone.

The authors stress that “economic factors reinforce the importance of the principle of parsimony in guiding treatment selection” utilising the most rapid and less complex (therefore least costly) methods first and using other methods only when less complicated methods have proved unsuccessful.⁹⁷ Indeed, the UK economy “loses” around £30bn a year because of work absence and unemployment linked to poor mental health. The NHS and social care spend around £21bn every year treating psychological illness. The human costs of reduced quality of life are estimated to be £53.6 bn per annum. Thus the aggregate cost of mental health problems has increased 36% between 2002/03 and 2009/10 from £77.4 bn to £105.2 bn.⁹⁸

Wellness services within Merseyside and Cheshire

The Homeless Games – Alt Valley

The Homeless Games builds upon the success of the Homeless World Cup, which has operated for eight years providing football opportunities for homeless males on a global scale.

The Homeless Games is a more inclusive project, which offers a range of sports and inclusive activities to both males and females. The Homeless Games was initiated with sports coaching programmes at numerous hostels across Merseyside leading up to a two day event similar to the Olympic Games. The two day event engaged 172 homeless individuals from across the six boroughs of Merseyside and took place on 9th and 10th September 2010 in Sefton with up to 15 different sports/ activities taking place at four venues.

Prior to the Games initiating, a comprehensive consultation took place at hostels across Merseyside to identify the most popular sports/ activities, which has been coupled with analysing previous activities that have been delivered by partners to homeless groups. This has resulted in a programme of activities being delivered that meet the needs and desires of the homeless population.

During and after the two day event participants were signposted and supported by multi-agencies (education, training, employment, physical activity, healthy eating, sexual health, alcohol awareness, drug awareness) all designed to improve lifestyle and career prospects to help raise aspirations and ultimately provide meaningful options and route ways for individuals.

Follow on sport sessions will be delivered to sustain participation and recruit new participants. The Homeless Games will become an annual event with sport sessions taking place throughout the year at venues across Merseyside.

Funding for the Homeless Games came from various sources including the Lottery and housing associations. The Trustee and Funding Coordinator's post has been funded by Liverpool PCT. Planning is already underway for The Homeless Games 2011, which will expand from Merseyside to the North West.

For further information please contact: Michael Salla: 0151 233 1467
michael.salla@liverpool.gov.uk

Advice on Prescription scheme in Halton & St Helens

This is a joint project run by NHS Halton and St Helens Health Improvement Team and the local Citizens Advice Bureau (CAB). The aim of the project is to fast-track people visiting their GP with mental health problems due to social welfare issues, to appropriate support services rather than referring to psychological therapy services.

The difficult economic climate has seen many support organisations like the CAB struggle to cope with the significant rise in numbers of people seeking debt advice. Waiting times to see debt advisers have lengthened, sometimes to be in excess of 8 weeks. Problems involving debt, employment, benefits or housing issues are common topics increasingly being presented to GP's and primary care staff. These difficulties bring about anxiety or low mood type symptoms which potentially may worsen whilst someone is waiting for a traditional clinical intervention service.

NHS Halton and St Helens are currently funding six debt advisors for the CAB. The *Advice on Prescription* service forms part of the collaborative approach between

these two organisations, and the Health Improvement Team, to provide social welfare support locally.

In the initial 12 week evaluation period 5 GP practices, the single point of access to mental services and the psychological therapy service used in the pilot, referred 35 people. Thirty-eight per cent of people referred had their level of mental health intervention stepped down, within the recognised stepped care model, as a result of the CAB helping them to manage the trigger to their distress. Furthermore, two mental health practitioners reported that two patients in crisis services had their suicidal risk level significantly reduced or eliminated as their issues were resolved by the *Advice on Prescription* service.

Over the next year NHS Halton and St Helens are looking to expand the service to other key partners who provide support and advice.



The service has also been shortlisted as a finalist in the HSJ 2010 finals under mental health innovation.

For more information about the service please contact Jen.Brown@hsthpcct.nhs.uk or 01744 621835.

NHS Wirral Wellness Services

Public Health lifestyle services

In recent years as public health provider services have been developed and funded from within the NHS they have mirrored other community health services based on a medical model in being:

- individual focussed
- problem focussed
- use a deficit model
- use of drugs (for smoking and referral for drugs or surgery for obesity)
- expert/specialist led (particularly at level 3)
- reductionist – focus on smoking or obesity or alcohol as ‘lifestyle problems’ rather than on the whole person and the underlying reasons why a person is miss-using substances to deal with everyday life

Although, unlike medical services they do include some aspects of wider determinants work e.g. smoking advisors often present the case for saving money by stopping smoking.⁹⁹

However, some elements of existing public health ‘lifestyle’ services could provide a sound basis for the development of a wellness focus. Although these services are usually separate (for smoking, healthy weight, alcohol, etc), when looked at as a ‘healthy person clinical pathway’, there are elements which are already potentially more ‘joined up’ and holistic, particularly at the beginning or prevention end of the

pathway. For example in Wirral public health provider services operate at different levels:

Level 1 opportunistic brief intervention and signposting to services

Level 2 intermediate service

Level 3 specialist service

Training at level 1 is provided for primary care staff, pharmacy staff, local authority one stop shop counter staff, housing association support staff, fire service staff, etc. These staff may be trained in alcohol, smoking and healthy weight along with mental health resilience and generic behaviour change. They apply this training to provide brief intervention alongside their professional role (which may relate to wider determinants e.g. housing, benefits advice). Some will have the more advanced level 2 training in one or more topic area. Used in this context alongside their substantive role they could be seen as providing a holistic wellness service delivered either within another service or within the home.

The next planned development is a single point of contact for a more integrated Wirral wide specialist public health provider service. This would involve a single phone number and an integrated patient database. Sefton are also taking this approach. It will allow for simplification of referral from primary care staff or self referral but will also provide an opportunity for a re-focus on wellness within the specialist element of the service.

Cost-effectiveness review has been carried out on the **Wirral Lifestyle and weight management programme** (LWMP). The LWMP is a free NHS weight management programme that can be accessed following a health check with a GP or practice nurse. It is funded by NHS Wirral for individuals who are obese (having a BMI > 30) or for persons with a BMI greater than 28 with at least two coexisting co-morbidities (diabetes, hypertension or hyperlipidemia - an excess of fatty substances called lipids, largely cholesterol and triglycerides, in the blood). The LWMP is an intensive 12 week programme consisting of a variety of group meetings and one-to-one sessions tailored to the needs of each individual client.

A preliminary cost-effectiveness analysis of the LWMP estimated that the service averts 38 CHD deaths, and provides an additional 13.2 Quality Adjusted Life Years [QALYs] to the population of Wirral per year, (12.0 QALYs from averted CHD and 1.2 QALYs from averted Non-Insulin-Dependent Diabetes Mellitus (NIDDMs)).

The estimated annual cost of the programme (£486,000) is significantly offset by savings generated through anticipated annual reductions in the costs of treating NIDDM (£18,720) and particularly in CHD (£288,240). As a consequence, the net cost of the programme from the perspective of Wirral PCT as a whole is reduced to £179,040 during the year 2007-08. This makes the programme effective and good value for money at a net cost of £13,564 per QALY gained. However, the evaluation concludes that to maintain a sustained change in weight loss, a long-term integrated approach for tackling obesity should include dietary and behaviour modification as well as increased physical activity and be supported by drug therapy or cognitive behavioural therapy as required.¹⁰⁰

It is important to highlight that this preliminary analysis did have acknowledged limitations:

- The estimates are based upon a range of assumptions with regard to the relationship between weight loss in obese patients and their health experience.
- A more exhaustive economic analysis would be required to take into account the health benefits from the programme for other co-morbidities associated with obesity.
- A major uncertainty in the model relates to the actual cost of the Wirral Anti-Obesity Project, as many of the additional costs could not be effectively captured e.g. privately borne costs of visiting the GP; the opportunity cost arising from health professionals concentrating on obesity management.
- Inability to directly calculate sustainability of health benefits of participants. The analysis of outcomes concentrated entirely on the health benefits that were gained during the 12 week period when clients were supported on the programme. Unfortunately, insufficient, reliable data was provided by participants on the 12 month follow-up to provide any meaningful analysis.

For further information on public health 'lifestyle' services please contact: Neil Perris, Head of Public Health Provider Services, NHS Wirral: neil.perris@wirral.nhs.uk

Health Action Area - community programme

Within the Wirral Health Action Area (20% most deprived LSOAs or 35% of the population) specialist lifestyle advisor staff are co-located with Health Trainers and Community health development staff. These teams work with individuals and groups and provide (or commission) a community programme of lifestyle activities including mental wellbeing. They also work closely with employability programmes such as the Condition Management Programme and Wirral Working 4 Health. The teams are based in a variety of community venues including a Children's Centre and they also work closely with a wide network of other partner agencies particularly where there is a common interest e.g. in accessing particular groups such as men over 50 or homeless people.

This example illustrates a model of wellness which takes a network approach within a particular neighbourhood potentially involving all aspects of the wellbeing of an individual or family through joint working rather than a discrete wellness service. However this element is not necessarily reflected in the current performance indicators (based on national targets e.g. 4 week smoking quitters) set by Public Health commissioners i.e. they are not being asked to co-produce individual, family community wellbeing but it's probably happening as a by-product. An example of this is the training provided to local community champions to enable them to support individuals or deliver activities, such as healthy eating, within their own community.

This raises an important issue about the evaluation and performance management of wellness approaches in terms of how and by whom successful outcome measures are defined.

A recent evaluation of the community programme showed that the average cost per client is £32.75. The potential cost effectiveness of the community programme shown here is very good. This is based on using the QALYs from a Norwegian study on community based interventions to lower cholesterol. The actual activities in the community programme may not have a high level of fidelity to this. However even if

the QALY gain was 1/10th of that gained in the Norwegian study this programme would still most likely be cost effective with a cost per QALY of around £16,000. The activity from the community programmes is only collected by team and by quarter so there could be a lot of duplicate clients in the data. Improved data quality would allow a more reliable estimate.¹⁰¹

For further information please contact: Becky Mellor, Health Improvement Specialist
rebecca.mellor@wirral.nhs.uk

Quit Stop Wirral Social Marketing Campaign



It is important to consider not just the existing public health provision but also newer approaches informed by social marketing. Wirral's Quit Stop programme is a good example of this. It is woven around the lives of smokers where they live (rather than a service which they are expected to go out of their way to attend). It's web-based, designed by smokers for smokers, 24 hour accessible, in partnership with ASDA and aimed at the same customer base following mosaic analysis, is supported by a street level Quit Stop camper van, NRT is posted to an individual's home so they don't have to leave the house to quit, it uses incentives (ASDA vouchers), has high visibility in the media and street level posters using local people who have quit, aims to engender 'quit smoking fever'. Recent additions include payment by results of smoking champions who work in pubs and local communities.

In its first 4 months (February-June 2010), the Quit Stop Wirral campaign registered 2389 smokers, 93% of whom set quit dates. The proportions setting a quit date from the 20% most deprived communities and from smokers under 25 years were significantly higher than the existing NHS Stop Smoking Services (86%). Although resulting 4 week quit rates were lower than for the more established service, there is early evidence to suggest that the campaign has been effective in preferentially engaging smokers from the 20% most deprived communities. If maintained, this performance, in combination with the established services, will increase the rate by which the inequality in smoking prevalence reduces within Wirral. This in turn will positively impact other health inequality, including life expectancy.¹⁰¹

For further information on smoking services please contact: Kim Ozano, Senior Health Improvement Advisor, kim.ozano@wirral.nhs.uk

Wirral Working for Health (WW4H)

WW4H project provides support to get back to work for people on working age benefits and employees on sickness absence, through combining existing health services, additional specialist health support and appropriate employability programmes, combining bio-psychosocial rehabilitation services with employment services. WW4H became operational in June 2009 forming a central element of NHS Wirral's Health & Wellbeing Strategy to tackle health inequalities. It recognises that employability is central to health and wellbeing.

An open referral system has been established whereby clients can self refer, as well as accepting referrals from Talking Changes (Primary Health Care Psychological therapy service), GPs, Health Action Area teams and community based partners. Employability partners include Job Centre Plus (JCP), JCP Pathways Advisory Service, Connexions Next Steps, Condition Management Programme and Wirral Jobs.

For clients on working age benefits, case managers undertake assessment and health action planning. Action plans may include measures to improve self-management of long-term health conditions, support to increase physical activity levels and referral to (and joint case conferencing with) services provided for specific health conditions. Case managers also provide on-going advice and motivational support for individuals whilst they move towards the job market, including referral to appropriate 'employability' partners. For people in employment, case managers provide early intervention support for employees on sickness absence and an employer liaison lead raises awareness amongst local employers regarding health and wellbeing issues. Case managers can also provide a prevention service enabling people to stay in work.

Table 3: WW4H Activity (June-March 2010)

Completed health action plans	(184)
Referral into volunteering/ training/ lifelong learning/ social prescribing	63% (115/184)
Employees returning to work	13% (23/184)
People on benefits gaining work	3% (5/184)

Source: Year 1 Report¹⁰¹

From data recorded on the WW4H database (ELPHIN), during July 2009 - May 2010 a total of 365 people have accessed the service, approximately 40 new clients per month. During this time, 26% (74/281) of clients were still in their employment and 48% (134/281) were unemployed at time of referral. Data were available for 159 clients on their health condition, and the most commonly reported condition was stress, anxiety or 'feeling depressed' (67% 106/159). Even when not recorded as a primary presenting condition, depression and low self esteem (related to a debilitating health condition) was commonly alluded to by users. Evaluation of the service suggested that unemployed individuals showed a measure of similar job seeking behaviour regardless of their engagement with WW4H, but that WW4H clients were more likely to have the confidence to apply for jobs and follow through with interviews.¹⁰¹

The programme enabled 5 people to get back into work and 10 people certifiably being retained in work. Applying health-related quality of life benefits from getting back into work to the 5 people who got back into work, and 74 who were already in work, (assuming these all retained their job as a result of the programme), the £9,556 cost per QALY gained is fairly low. This figure does not take into account

benefits to society and families and the reduced costs to the state in terms of work benefits paid. However, applying the QALY gains only to the 15 people who are currently known to have got back into work or been retained in work as a result of the programme, the cost per QALY gained is much higher at £50,333 and is higher than the NICE recommended threshold of £30,000 per QALY gained.³⁴

To confirm the success of the project over the medium to long-term will require the follow-up of a larger sample of clients over a longer period of time in comparison with a control group to minimise the potential sources of bias.¹⁰¹ Nevertheless, the service has won the “Excellence in Innovation” category of the Merseyside ‘Strictly Regeneration’ awards in July 2010.

<http://www.strictlyregeneration.co.uk/innovation.html>

For more information please contact: Dr Will Sopwith, Head of Research & Development, Wirral NHS. Tel: 0151 651 3935, e-mail: will.sopwith@wirral.nhs.uk

Holistic Services in NHS Knowsley

People with health problems often have multiple social and health issues. With this in mind, there is a need to offer holistic services that address the person and their needs – not the individual behaviours.

Health Trainers

Health Trainers take a whole person approach and are a good example of the provision of a holistic lifestyle service. An evaluation on the initial national pilot, of which Knowsley was included, found that the Health Trainers are accessible in community settings. They have been successful in working with some service users to facilitate behaviour change and that the service is perceived as approachable and user-friendly by those clients interviewed. Service users report that the intervention appears well-structured and clients receive clear information, including details of other services and have sign-posted clients on to appropriate services. The Health Trainers have identified unmet need for affordable exercise opportunities in the community which is an important barrier to developing a more active lifestyle in deprived communities.¹⁰²

In Knowsley, the service noted that many people appeared to find the title ‘Health Trainer’ confusing and rebranded the posts as ‘Lifestyle Advisors’, which appeared to be better understood. The overall management of the service also changed so that Lifestyle Advisors delivered services alongside the Community Health Development Team. Both teams fall within Health and Wellbeing Services, bringing together a wide range of health promotion activities across Knowsley.¹⁰²

Proposed one-stop shop lifestyle service

Knowsley are looking at how a ‘lifestyle’ type service can be offered as a one stop shop. This is on the basis that the key skills to help someone achieve behaviour change (e.g. assess current status, set goals, set out plans, access support and keep them motivated and informed) does not necessarily need specialist topic based skills at all stages. It isn’t just about having a single point of contact (e.g. phone numbers and referral points for all services) but it is the provision of the service to the patient that needs to be holistic. This means supporting the whole person to set

goals and achieve lifestyle changes rather than a topic focus requiring referral to separate services for weight management, stopping smoking, getting active etc.

Knowsley at heart programme

A good example of this holistic provision is with the Knowsley at heart programme. This is part of the NHS heart Health Check for 40-74 year olds. A community and GP practice programme offers 30 minute screens that help individuals identify which areas of lifestyle they need / would like to change and sign posts them into services, including a session with a Lifestyle Advisor. Most areas have started doing something similar as the Health Check is part of a national scheme.

Barriers to holistic working

The national focus for improving lifestyle risk factors has been on topic based strategies rather than healthy individuals and communities. This has led to targets around individual behaviours that has driven local programmes for stopping smoking, healthy weight etc. In the more deprived areas in the North West many of the topic based programmes and services all target the same people (e.g. the person who smokes, drinks heavily and is inactive etc). So, it makes sense to be person centred rather than programme focussed.

For further information please contact: Sue Drew, Director of Public Health, Knowsley.

Holistic Approach to Wellbeing in Sefton

NHS Sefton has commissioned a pilot programme **Wellbeing Sefton** that offers one to one consultations utilising a Life Balance Assessment tool. Clients self-identify their needs and prioritise them. The Wellbeing Sefton officer can then provide information and refer to relevant providers.

For example a person may prioritise housing, debt and welfare issues but also want to address weight management and anxiety needs. The Wellbeing Sefton officer can support all these issues as opposed to the client having to seek different routes of access.

The Wellbeing Sefton intervention forms part of the social prescribing offer in Sefton. Social Prescribing has arisen out of the mental wellbeing agenda but its interventions encompass a wide range of activities. For example the Relax & Revive programme combines physical activity, relaxation, social participation and inclusion.

Other social prescribing interventions on offer are bibliotherapy, arts on prescription, CAB Health Outreach, exercise on prescription, volunteering and green gyms.

Healthy Sefton 0300 100 1000 provides a single telephone contact for information on healthy lifestyles and can be utilised by health & social care professionals as well as the public. Clients can be referred or given information on the relevant services nearest to where they live.

Health Training

Training is provided by public health on healthy lifestyles, motivational interviewing and brief interventions in addition to the singular topic specialities. This training is provided for frontline staff across the voluntary and faith sector, NHS and Council staff. A network and e-newsletter keeps trainers and champions updated.

Barriers to holistic working

Referral patterns can be entrenched and behaviours can be hard to change. Health and social care professionals get bombarded with information and may overlook information on new service provision. Subsequently referrals and use of more holistic services can be slow to build.

It is considered that the evidence-base is solid for a more holistic approach but has not been put into SMART value for money/cost benefit language.

For further information please contact: Pat Nicholl, Deputy Health of Health Promotion, NHS Sefton, Tel: 0151 247 7000. e-mail: pat.nicholl@sefton.nhs.uk

Healthier Homes Healthier People Project – NHS Western Cheshire

NHS Western Cheshire, are working closely with partners across the public, private and voluntary sectors: including Chester and District Housing Trust, Cheshire West and Chester Local Authority and Cheshire Advice Partnership. They are piloting an initiative for the early identification and alleviation of barriers which may prevent an individual and/or their families from maximising their potential to achieve a sense of wellness, which can exacerbate health inequalities.

The project is largely based upon the former pilot “Health and Social Welfare Support Service” (H&SWSS), within the Ellesmere Port and Neston PCT now known as NHS Western Cheshire. Just like the previous pilot the “Healthier Homes Healthier People” (HHHP) project focuses upon the Primary Care team identifying issues which may be impacting upon their client’s health and wellbeing including: housing, debt, fuel poverty and other social welfare problems. However, the HHHP project differs in that there is now a central referral point: Cheshire Advice Partnership (CAP), which includes a wider “team” such as: housing staff from within Chester and District Housing Trust, colleagues from within the Local Authority working on the “Supporting People” agenda, homelessness and a local “live at home” project: “Anchor Staying Put”.

The following principles inform the HHHP project:

- A psychosocial model of health that recognises the influence of the work and home environment and strong social relationships.
- To reduce health inequalities the focus is on the broader determinants of health as illustrated in the Dahlgren and Whitehead model of health¹⁴ such as lifestyle and living conditions, which are related to the wider socioeconomic and cultural environment.
- A whole systems approach supporting collaborative working across all sectors.

All client facing staff will receive training around brief interventions for lifestyle factors. They will also be given additional support and training around a variety of “topic” areas such as alcohol, mental health, finances and so on, which enables staff to have the competence and confidence to raise what may be “difficult” issues in a non-threatening manner. For example: getting at the root cause of a problem such as: a tenant’s unkempt property which has previously been clean and tidy which may reveal a physical or mental health issue. Another problem could be rent arrears that might be a result of drinking problems, gambling or unemployment. If an issue is identified permission is sought from the client for a referral to CAP. The CAP will contact the client and keep the referrer informed of any outcomes.

Although in its very early stages, the project holds promise to impact upon health inequalities within NHS Western Cheshire footprint and will be fully evaluated in order to ensure the robustness of the project. Indeed, an evaluation of the H&SWSS¹⁰³ showed it provided a service of high quality which met the needs of those who accessed it, and contributed to improvements in mental health.

For further information please contact: Pat Johnson, Head of Health Improvement and Partnerships, Western Cheshire PCT. Tel: 01244 650455; e-mail: pat.johnson@wcheshirepct.nhs.uk

Wellness services outside Merseyside and Cheshire

Women’s Mental Health Demonstration Project at Bridgeton Local Health Care Cooperative, Glasgow

The Women’s Mental Health Demonstration Project (WMHP) was established in 2002 and aimed to develop a social model of care for women presenting within Primary Care with mild to moderate mental health difficulties. Based on best practice guidelines and evidence from across the UK and beyond, it aimed to develop and pilot a model of care within Bridgeton Local Health Care Cooperative and to influence wider mainstream policy and practice.

The project consisted of a single project worker with intermittent administrative support and a multi-agency steering group. Women presenting with mild to moderate mental health problems within Primary Care were offered the opportunity to be referred to the WMHP. The project worker case-worked women largely on an individual basis and over the course of the project a total of 181 women were seen from August 2003 to October 2005. All those assessed by the project worker described multiple problems of a psychosocial and social nature. Of those for whom a complete assessment was available (n=90), 65.5% were currently or had in the past experienced abuse. The majority had difficult relationships with members of their family or with friends, and high levels of sexual, physical and emotional abuse were reported. Those with a history of abuse had extremely high levels of mental health symptoms and health problems, low self esteem and poor support networks.

A significant finding was that 62% (n=59) of those who reported abuse were disclosing to a professional for the first time ever.¹⁰⁴

The project worker provided a wide range of services tackling problems from low levels of esteem and high levels of anxiety/depression to their social determinants (for example, housing problems, financial difficulties and issues of personal safety). The worker wrote a series of case-studies that served as useful practical demonstrations of a social model of health in action. Some practitioners working in the local area believed that the project had provided them with the knowledge and confidence to deal more holistically with their patients.

Women, and those who referred them, reported high levels of satisfaction with the project which demonstrated that significant impacts can be made in the lives and health of women with complex underlying problems in a relatively short period of time. Brief interventions, if composed of empowerment and advocacy and are underpinned by a broad understanding of the links between life circumstances and health, were found to make women feel more able to deal with their lives.

Cost-effectiveness

In the longer term, this may appear as a more cost effective approach than 'traditional' models since the evidence presented in this evaluation indicated that women have often been in contact with services for many years and yet the negative effects of abuse and gender roles have not been addressed. In addition to this, DNA rates (Do Not Attend) and cancellations were substantially lower than Primary Care Mental Health Team rates. This gives further **confirmation to service efficiency and client satisfaction**. Women commented on the flexible and understanding approach in this context, particularly valuing telephone contact and support, which may be linked to reduced DNAs.¹⁰⁴ Unfortunately, no formal cost-effectiveness or cost saving analysis was attempted.

For further information please contact: Noreen Shields, Planning and Development Manager, Corporate Inequalities Team, NHS Greater Glasgow and Clyde.

St. Peter's integrated health and leisure centre, Burnley



The St. Peter's Centre, is a combined leisure and primary care centre housed in one building, extending to nearly 20,000m² and costing some £29m. It was opened on 6th March 2006 and is located in the very heart of Burnley. The population of Burnley suffers from higher than average rates of long-term illness, life expectancy is

significantly lower than the national average and there are particular problems associated with teenage pregnancy rates, circulatory diseases and coronary heart disease. Many of these problems are associated with lifestyle.

The centre addresses these issues directly through a **holistic, one-stop shop approach**. The new building allows the provision of a more **integrated approach** to primary care, giving valuable links between healthcare and exercise. The council's '**healthy lifestyles**' team is accommodated within the GP area, which allows faster access and direct referral to services such as **exercise on prescription and smoking cessation**, which are consistently driving public health agendas throughout both the leisure and health elements of the building. The Atrium Café at the Centre has been given a glowing report by Lancashire Trading Standards service for providing healthy eating options in clean and hygienic surroundings.

It provides for the needs of patients, permits service provision and integration (including the provision of services previously provided by the Acute Trust) and provides dentistry and a 24-hour pharmacy. The scheme also houses new indoor leisure facilities for the 90,000 residents of Burnley, including a swimming pool, sports hall, squash courts and dance facilities.

The project forms part of the East Lancashire LIFT initiative and was started to raise the health and other needs of the local population, including the regeneration of the town centre. It is part of the NHS ten-year plan which identified the urgent need to improve primary care premises: these are particularly poor in Burnley and have resulted in problems of staff retention. This scheme was named Project of the Year at the RICS North West Awards in May 2007 and Building Better Healthcare Awards 2006: Special Commendation in Best Primary or Community Care Design.

For further information please contact: Mick Cartledge, Director of Community Services, telephone: 01282 477280, email: mcartledge@burnley.gov.uk
http://www.rossendale.gov.uk/teamlancashire/downloads/Microsoft_Word_-_St_Peters_Case_Study.pdf

Bromley by Bow Centre, East London



Introduction

In its 26th year the Bromley by Bow Centre is an exemplar for its social entrepreneurial approach to community regeneration. Its mission is to remove the label 'deprived' from the local area and create a healthy and enterprising community across Bromley by Bow and Tower Hamlets. Based in the heart of its local community it supports over 3,000 families, young people and adults each week to

learn new skills, improve their health and wellbeing, find employment and develop the confidence to transform their lives. At the core of its thinking is a belief in people and their capacity to achieve amazing things.

Living in Bromley by Bow

Bromley by Bow in Tower Hamlets, remains one of the poorest parts of London and one of the most deprived areas in Europe. Almost 80% of children in Tower Hamlets are living in poverty which is the highest rate of child poverty in London.¹⁰⁵ The links between poverty and health are increasingly well recognised.¹⁰⁶ Children born in Bromley by Bow are nearly twice as likely to die in infancy as those in wealthy areas.¹⁰⁷

Tower Hamlets has high rates of people in poor physical health and mental health is also a real concern. Chronic health problems such as asthma, coronary heart disease and diabetes are particularly high. Worklessness is also a real issue. In Tower Hamlets 53% of children live in families who are surviving on welfare benefits.¹⁰⁵ For many young people there is a lack of positive role models and a challenge in being able to envisage a positive future. Levels of drug misuse and violent crime are also high.¹⁰⁸ Despite the ongoing challenges the Bromley by Bow Centre continues to be a success story making a real difference in the heart of its community.

The Bromley by Bow Centre

The Bromley by Bow Centre is a local charity with an international reputation for helping to transform its community over the last 26 years. It has pioneered a social entrepreneurial approach to community regeneration and become an exemplar for others across the UK. Yet it remains at heart a local community organisation that local people and families can turn to in times of need.

We support over 3,000 people each week to resolve their immediate problems, gain new skills; look after their health and family needs and to find work or set up in business. We also work to create jobs and generate wealth with the ultimate aim of removing the label deprived from the local area. We work with families, young people, vulnerable adults and elders from all sections of the community. At the core of our thinking is our belief in people and their capacity to achieve amazing things. We use the arts to tap into everyone's inbuilt creativity and resourcefulness, instill self-confidence and open people's eyes to learning and the opportunities that follow.

We offer people a holistic programme that helps them to overcome the barriers that stop them moving forwards in life to create a more positive future for themselves and their families and to achieve their full potential.

We:

1. Support people to develop good health & wellbeing

The Bromley by Bow Healthy Living Centre opened in 1997 with a radical and holistic approach to tackling chronic illness. We work in partnership with our team of onsite GP doctors to provide a range of programmes designed to be welcoming and accessible for everyone and which are delivered in a stimulating, rewarding and high quality environment. This includes;

- A health trainers' programme which works with over 1,000 vulnerable people each year supporting them to eat more healthily, lose weight and quit smoking and also helping to reduce isolation. For example we provide walking clubs, yoga classes or dance for example.
- Our Children's Centre provides support for parents with young children and also teenage parents. It helps parents to teach their children new skills and supports those who may be struggling with parenting.
- Our social and therapeutic horticulture programme works with adults and young people with mental health problems. Through the programme people learn new skills, develop a sense of confidence and improve their wellbeing

2. Provide advice and support to help people manage their household

We provide a one-stop shop drop-in service for people who need advice and support on a range of issues including benefits, rent arrears, debt counselling and housing issues. We also offer a legal advice clinic. For many people resolving the fundamental money worries is the first step in beginning to make positive changes in their lives. Our debt, housing and welfare benefits advice service helped 575 people in 2009/10 to increase their income, reduce debt and manage their families' finances.

3. Enable people to learn new skills

Many people living in our community left school with little or no qualifications. Also with a large Bangladeshi community some community members have never been to school. The Centre provides a range of learning opportunities which as well as encouraging people to learn new skills help people on the road to employment. We have over 700 learners this year enrolled on a range of courses including;

Skills for life (literacy, numeracy, English language) – for many local people these are the key barriers to finding employment and also to taking part in wider community activities and leads to people being isolated and excluded.

Vocational training (childcare, customer service, health and social care, business administration) – for many of our learners this leads directly into employment

A BA Honours degree in Social Enterprise delivered in partnership with University of East London. This innovative course is the only BA in Social enterprise in the UK and many of those who enrol did not do well at school and are turning to education later in life.

Signs of Life is our specialist arts enterprise working with young people from 12 upwards to create public works of art. It creates a positive and creative environment for young people and encourages them to develop aspirations for their future.

4. Work hard to create an enterprising community

Key to helping the community move forwards is to reduce grant dependency and support people to develop the confidence and skills that they need to unlock their potential and find work. Our team of employment advisers helps people to find employment through providing training and support in areas like cv writing, interview techniques and job searches for example. We also help people to get onto other courses to improve their employment chances and to do work placements. The Centre also helps local people to improve their economic situation by setting up community enterprises which will become sustainable local businesses.

- We have helped local people, many of whom were previously unemployed to set up 33 new social enterprises across Tower Hamlets including a bicycle business and a florist through our Beyond the Barn programme and we provide ongoing business support. This has created over 200 local jobs.
- Last year we helped over 100 people to find employment. Many had never worked before.

Our own social enterprises turnover almost £1m and also give practical training to local young people in landscaping, graphic design and creating public art.

Case study 2: Bromley by Bow Centre supports Shamim to set up a social enterprise

“I came here very young and married at 16 so didn’t get chance to study. I took a degree in Social Enterprise at the Bromley by Bow Centre. The Centre really inspires me – it listens to the community and make things happen. After the degree I was lucky to get start up to set up my own enterprise - Community Cleaning Services. I wanted to provide opportunities for local Bengali women. Many are isolated and don’t work. Bengali women face barriers but I work with the families to help them understand that women need some independence. You should see the women’s faces when they get their first pay cheque. They say “Nobody would ever give me a job and you have given me that opportunity”. That’s what I want to do. I want to create opportunities so that people who are excluded can get into the labour market. I use a business model providing a high quality service and creating jobs for local people.”

The future

The Bromley by Bow Centre has worked effectively with many people to change their lives over the years, and we are proud of the safety net of support we can offer. Yet we know from our volunteers and staff members, many of them local, that there are still people who are receiving no help, and unmet needs among those who come. These are people with chaotic lives or those isolated at home, who may just need someone to talk to before they feel ready to seek specialist help. Our existing team do what they can, yet with additional resources we could ensure that nobody falls through the cracks and people receive the full support they need.

And the time is ripe for change. The Bromley by Bow Centre sits on the edge of the 2012 Olympics site. This is the most diverse community ever to host the games and there is a real opportunity to maximise the impact for East London and create a long-term legacy. Our 3-year vision “Seizing the Opportunity” focuses on inspiring and motivating local people, particularly those facing the greatest disadvantages, to make the most of these possibilities and to lift themselves out of poverty through better health, jobs, training, leisure activities, and influencing the physical development of their area.

Our challenge is to ensure that we work with partners to support our community to make the most of the opportunities available. The Bromley by Bow Centre achieves amazing things. But we can only continue to do so with support. While we receive some government funding many of our most innovative and dynamic projects can only take place with backing from independent funders including foundations, corporate funders and individuals. We work closely with private funders to help ensure that their money makes a real difference and we keep funders updated with the difference they have made, through invitations to events, regular funding reports and the chance to meet members of the Community.

Evaluation work

In 2009 the centre started a three year evaluation project on the impact of its work. The project has three main components:

1. Measuring the centre’s social return on investment (SROI)

2. Building the capacity of services and projects to show how they make a difference
3. Benchmarking the Centre's services

Further details of the evaluation can be found on the Bromley by Bow Centre website:

<http://www.bbhc.org.uk/pages/impact-measurement.html>

For Further information please contact: Helen Goodier. heleng@bbhc.org.uk

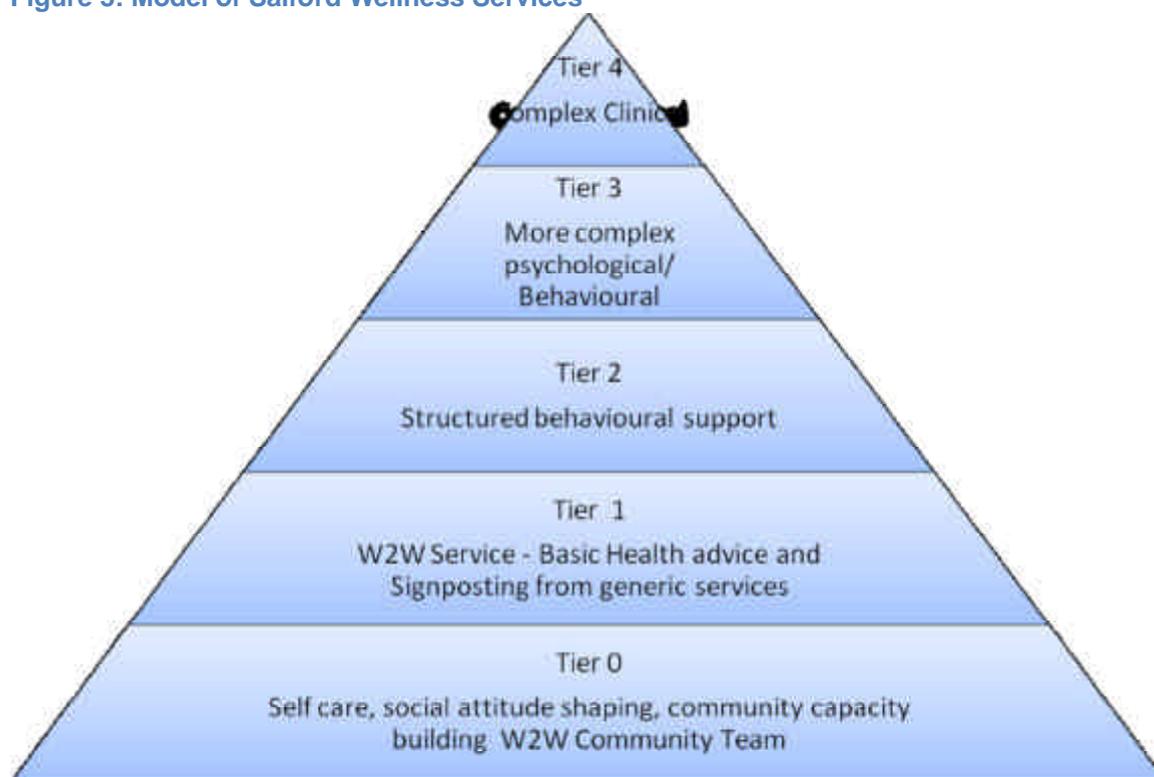
A Wellbeing Service Model - Salford

Currently Salford PCT in collaboration with Salford City Council is working on a radical re-design of its lifestyle services to unify them within a single "Way to Wellbeing service" (W2W service). The work will:

- Integrate the health improvement, work and skills and neighbourhood teams
- Provide a clear specification for the new integrated provision (which will have a focus largely on the adult service provision) with clear performance management built around defined outcome areas
- Develop and deliver a clear plan for implementation of the new integrated service
- Develop a clear operating framework/pathway to govern the operation of the new service

The service model has been designed around the tiers of service commonly used within the NHS but incorporates an additional tier 0 which introduces community based activities as an integral part of the system ensuring they are resourced and managed as part of the system and not viewed as separate or distinct.

Figure 3: Model of Salford Wellness Services



Source: A Wellbeing Service for Salford¹⁰⁹

Table 4: Components of the Salford Wellness Service

<i>Level</i>	<i>Description</i>
Level 0	<p>Wider strategic activity to engineer supportive environments</p> <p>Actively building capacity within local communities enabling local people to find solutions to wellbeing issues and work with service providers as partners.</p> <p>Developing a range of interventions and groups that can provide support and activity in the community. Activities which are self sustaining and therefore reduces level of intervention and avoids dependency</p> <p>Enables those who can to self treat/manage using a wide range of self care tools in a variety of formats.</p> <p>Developing the necessary skills to support and enable people to change aspects of their life without additional support</p> <p>Social advertising to build health aspirations layered with specifically targeted campaigns for key issues and audiences</p> <p>Informal social support networks with buddying schemes offering support for first visits to W2W service and other community groups or services</p> <p>Low level peer mentoring to support self care approaches and engage local communities in both utilising and delivering aspects of the service system</p> <p>Stimulation of the local economy/community to respond to expressed local</p>

	need for supportive activities
Level 1	<p>Single point of entry way to the Way to Wellbeing (W2W) service which provides:</p> <ul style="list-style-type: none"> • Holistic first assessment • Tailored programme of support across a range of wellbeing issues as appropriate based on clear protocols • Referral on to those relevant higher tier services and community based activities • Referral on to a wide range of other support services as necessary, e.g. those for employment, training, debt advice etc • Structured support services in community settings e.g. Health trainers and Telephone support • Return point to “capture people exiting higher levels of services requiring ongoing support • Effective and seamless links to the community based interventions identified in Level 0 <p>Opportunistic routine health advice and signposting to the W2W service from a wide range of generic services which will be undertaken as a routine part of their normal work role</p>
Level 2	<p>Structured brief intervention support with a mix of provision tailored to key population groups e.g.</p> <ul style="list-style-type: none"> • Under 25s • Young families • Middle to later ages • Older age <p>The service is heavily incentivised to identify and support clearly defined priority groups e.g. C2DE males aged 18-25</p> <p>Level 2 services utilise practitioners who are able to offer support across all lifestyle issues, people are not referred to different services but receive advice about the subject they prioritise but with the possibility of additional support for other issues as they are explored</p> <p>Access is solely through the W2W service to ensure people are effectively assessed and provide the holistic package required</p> <p>Where necessary additional support activity can be linked in e.g. for dietary support a link to specifically commissioned activity programmes</p> <p>Level 2 services will be able to search and book the required range of services online with the client at the time of first visit</p> <p>Clients exiting level 2 after successfully changing their behaviour will be referred back to W2W for linking back into local activities where appropriate or ongoing support offer</p> <p>There is active follow up to maintain contact with beneficiaries through a network of graduate mentors through level 0 provision</p> <p>People will be offered a maximum number of sessions in any given lifestyle advice programme before review and possible referral on to level 3 services where progress is not sufficient.</p> <p>Level 2 services will wrap around General practice provision, initially this may be a mixed economy with some parts provided by General practice and others by alternative providers, but the future model should be fully integrated into primary care provision</p>

Level 3	<p>More specialist behavioural / psychological support e.g. community detox and specialist group therapy for alcohol, or more clinically based dietary interventions for weight management e.g. very low calorie diets</p> <p>Interventions at this level are more specifically tailored to the issue</p> <p>They utilise specialist staff with a degree of specialist expertise but medical input is limited if used at all</p> <p>Referral to level 3 is from either level 1 or level 2</p> <p>Where services require prescribing support this is provided from a primary care practitioner</p> <p>All clients successfully completing level 3 return to W2W service There is active follow up to maintain contact with beneficiaries</p> <p>Level 3 acts as the gatekeeper for Level 4 – no one can access level 4 with a clinical assessment at this level first</p>
Level 4	Clinical services e.g. Bariatric, inpatient detox for alcohol etc

Key principles of the wellbeing service

The holistic approach will ensure both that people’s health issues are dealt with in the context of the wider social context in which they arise, and also that common approaches and skill sets apparent in the variety of services covered by the work are managed more effectively. The W2W service will be linked into City Council service re-design to ensure that socio economic inequalities such as worklessness which underpin many health inequalities are able to be addressed. The future service will be targeted and based in the communities where the needs are greatest and health is poorest. Service providers will actively seek out and engage with those who find it hardest to change their unhealthy lifestyles and will reach out into local communities to build on existing capacity to support lifestyle change. It will use local people wherever possible, both to ensure NHS Salford is maximising the impact on the worklessness agenda but also in acknowledgement of insight intelligence, which suggests that Salford people are better able to make changes when helped by ‘people like us’.

Cost-effectiveness

Earlier targeted interventions that promote health, independence and well-being improve outcomes and are therefore more cost-effective. The wellbeing service through its community engagement approach builds on what individuals themselves identify as supporting them to improve wellbeing. It recognises people as contributing to their own health and wellbeing and not purely as receivers of costly services/interventions. The model supports and recognises communities as contributing to improving health through community, voluntary run schemes. It recognises the skills and experience of non clinical staff and volunteers in supporting health improvement. Therefore, the demand for complex health and social care services will be reduced.

Behavioural approaches which underpin lifestyle interventions are largely the same. The model acknowledges that lifestyle factors are interconnected: a person who wishes to quit smoking may also require dietary support to avoid putting on weight

and someone wanting to lose weight may also require help to manage their alcohol intake which is contributing to their calorie intake. It can motivate behaviour change and by experiencing this change, the person can often see other possibilities for changing their other aspects of their lifestyle. Therefore providing an integrated holistic lifestyle person-centred service is potentially more cost-effective: aligning services thus reducing duplication of service support structures, including buildings and staff.

For further information please contact: David Herne, Consultant in Public Health. Tel: 0161 212 5693; e-mail: david.herne@salford.nhs.uk

The creation of a 'Centre for the Third Age' in Cockermouth

In Cockermouth the number of over 85s will increase 130% in the next 20 years – that's 6% per year every year for 20 years. In response to this challenge health groups, social care agencies and charities will work alongside the town's Community Hospital on a project called the Centre for the Third Age

www.centreforthirdage.blogspot.com

It is heavily influenced by the work of Professor John McKnight from Chicago's Asset Based Community Development (ABCD) Institute. The concept of health being the 'connector' or enabler for development of community assets is gaining ground within the NHS. It is a 'glass half full' view of the community - full of strengths, skills and assets rather than full of needs, problems and deficits.

This idea has been developed by Dr John Howarth, a local GP, in discussion with a wide number of community leaders and inspired by the community response to the devastating floods of November 2009 when over 800 people lost their homes.

A key aim will be to use the combined resource of health, social care and the assets of the community to deliver care closer to home, reduce admissions both to hospital and residential care and improve health and wellbeing rather than just treat illness. The centre brings together a large number of services such as befriending, social events, exercise classes, the 'Street Angels' - a network of community activists each looking after a section of the town together with memory clinics and other services for dementia. A senior district nurse is attached to the centre and brings with her a list of the town's most vulnerable elderly (a risk stratified population). Early partners in the centre are Age UK, Alzheimer's society and the local University of the Third Age which has over 600 members and 38 activity groups. A software ('Slivers of Time') enabling exchanges of skills and services is being developed.

Benefits to patients

This should result in much better use of local resources with better integration between health, social care and the voluntary sector. Resources will be better targeted and the whole approach is one of empowerment of local groups and citizens rather than just being passive recipients of care. It is an interesting synthesis of a primary care and public health approach. Local doctors and nurses are active leaders in their community, nurturing and developing the community assets to help

meet the goal of delivering more care closer to home and a healthier elderly population living at home with dignity.

Cost-effectiveness

Cockermouth is an Integrated Care Pilot with a 'one team' approach to care in the town. The GPs are already managing most of the town's health budget of £22m. We expect that the small investment (providing free accommodation and project management) is likely to represent excellent value for money. In the first 3 months of this year (while the centre was in the early stages of set up) we had 145 fewer emergency admissions in the town compared to the previous year – a saving of circa £250,000.

Further information please contact: Dr John Howarth, GP and Clinical Director Adults, NHS Cumbria

The Green Dreams Project - NHS East Lancashire

The aim is to tackle social exclusion, worklessness, substance misuse, low self-esteem, life skills and educational difficulties using an **individual case management approach** and involving the whole community. Uses a monitored and results driven approach to foster new skills and overcome unhealthy lifestyles.

The innovation is the proposed change in the traditional GP Care model to tailored, coordinated care along the lines of the PACE model¹ from Healthier Horizons but with the widest of inclusion criteria for tackling all problems contributing to the reduced quality of life.

By employing a community health coordinating officer using this funding, the project will be able to help those groups of patient who have never been helped before, but also augment general medical care. This is a radical, but simple shift in thinking. By utilising and linking all voluntary or non-voluntary health providers for each individual patient, they will provide the motivation needed for change, and the help. This will tackle the problem at the cause. It will also create vibrancy and activity in the community which in many areas has become lost.

Part of the idea came from Bromley By Bow healthy living centre, but the model is different to theirs because we are concentrating on productivity, social isolation and dysfunction with less emphasis on the creative approach adopted by them. This should make the project cheaper to start and to maintain.

Benefits

The patients will benefit from increased life skills, better well-being, reduced medication usage, reduced usage of alcohol and recreational drugs, reduced isolation, better self understanding and a more thriving and enterprising community.

¹ Personalised, Advanced, Care Environment is a model giving a patient with needs care from across a number of sectors, a tailor-made service, using the latest technology in a way that is convenient for them.

There will also be increased opportunities for self-improvement and widening knowledge. There will be other preventative arms looking at cooking, healthy eating, life skills, parenting, and aspirations.

The NHS will benefit from reduced medication costs, reduced burden on the mental health and drug services costing an estimated £2000 per family per year.

The wider economy will benefit up to £15000 per family in those cases where worklessness is an issue. The benefits will start to be measurable after about 4-6 months.

Further information please contact: Dr. James Fleming, GP, Padiham Group Practice, Burnley.

Guthrie House: a rural community organising for wellness, British Columbia

The Guthrie House community wellness centre described by Halseth and Williams (1999),¹¹⁰ demonstrates tremendous innovation in rural health care delivery. Guthrie House in Elgin, Ontario is managed by local volunteers that support services formerly provided by mobile units. Without voluntary organisation, many of the services housed there would not be available in this rural place.

The impetus for change came as the village of Elgin in rural Ontario like other rural settlements with a relatively small local population, failed to generate the critical mass required for the provision of many services with a high delivery cost. This situation was exacerbated by Ontario's challenging economic situation that put the government under pressure to reduce the public sector budget as a result the village suffered from inequalities in health care provision. Furthermore, the Elgin community recognised the current and long standing social and health problems which the community wanted addressed and the lack of resources within the community, which could enhance local health and social well-being. This mobilised the community to develop locality-suitable care alternatives.

The initial efforts of five volunteers generated strong community support (in terms of volunteering time and financial commitment) and the formation of the North Leeds Community Development Corporation. This umbrella body remains the corporate entity through which fundraising and organisational efforts are managed. In 1989 'Guthrie House' was established, with the financing for the purchase and renovation coming entirely from local residents. Since that time operating revenue has come from rental fees from service agencies and groups using the facility. Many services are also supported from government core funding that provides a measure of financial stability. Annual community fundraising efforts also assist with the operation of Guthrie House, as does the steady supply of goods and materials donated by local residents.

As the following show, services and programmes offered through Guthrie House interpret community health and wellness in its broadest sense including:

- Toy lending for children,

- teen counselling,
- services to keep seniors comfortable in their own homes,
- mental and emotional counselling,
- job skills, adult literacy programme,
- outreach service – incorporates concerns for the health of seniors with concerns for the well-being of the broader community,
- violence against women education
- assessment and professional referral services

These are all part of a conceptualisation of community health which is not limited to medical intervention. Instead, community health is intimately connected to personal and family welfare and well-being. One of the reasons for this broad interpretation is the involvement of residents in defining local community needs.

Beyond the broad range of tenants operating in this community resource centre, the facilities also provide a base for other service agencies or organisations. For example: Alcoholics Anonymous, the Diabetes Association, a Smoking Cessation Programme and a Fibromyalgia Support Group. The North Leeds Abuse Task Force also has office space there to assist with its work, while the South Crosby Non-Profit Housing Corporation uses Guthrie House as their local base of operations. The use and expansion of services is testament to the previously unmet needs within the Elgin community.

Guthrie House project provides a successful example of community participation. As health care policy strategies for increased cost-efficiency continue to threaten the few remaining services in what are already underserved areas, government should be looking to more fully support this kind of community development rather than continue to encourage a few community representatives to sit on state-defined health care institutions.

For further information see: Guthrie House: a rural community organizing for wellness¹¹⁰

Conclusions

A Wellness Service provides support to people in order to improve their health and well-being. The service aims to build people's capacity to live healthy lives by addressing the factors that influence health and wellbeing.

The examples of best practice in this report confirms that many service leads within Cheshire and Merseyside and in other counties are already exploring innovative ways of providing wellness services that offer more than one service at point of contact.

The benefits to the service user

This review has identified the following benefits to service users from Wellness services:

- Promote positive health that can empower individuals, enabling them to maintain and improve their own health.
- Providing, safe, natural means to boost physical and mental health without unpleasant side-effects. For example: tools, techniques, assistive technology and education.
- Wellness services can work in conjunction with traditional medical services or prevent or reduce the need for medical interventions
- Where necessary services and programmes facilitate lifestyle adjustments to enable individuals to gain wellness.
- The focus is on promoting quality of life not just length of life.
- Rather than considering just the diseased part the service considers the whole person: mind, body and spirit and the wider determinants of health such as lifestyle, social environment, living conditions and so forth where there can be imbalances in an individual's life – that are preventing them from reaching their optimum health.
- Wellness services take into consideration inequalities of health and where possible actively seeks out those individuals that do not usually benefit from mainstream health services. However, some services reviewed found it problematic to access the "hard to reach groups" – this has implications for equity.
- Specific wellness services can increase patient choice by linking patients up to non-medical facilities and services available in the wider community that can address psychosocial factors that influence wellbeing.
- There have been a range of reported positive mental health outcomes including: enhanced self-esteem, improved mood, opportunities for social participation, increased self-efficacy, various transferable skills and greater confidence that all enhance quality of life.
- Some of these wellness services can make available new opportunities for patients for meaningful activities.

- Preventive health programmes based on Occupational Therapy may mitigate against the health risks of older adulthood.
- Wellness services can provide contact with others facing similar challenges. This provides a sense of not being alone and opportunities to learn from others' coping strategies.
- Peer support or “buddying” can provide on-going mutual support for self help strategies beyond the professional intervention.
- Some services can enable some individuals to improve self-management of a long-term health condition and return to work.
- By tackling the causes of ill-health, wellness services have demonstrated a broad understanding of the links between life circumstances and health. For example “the Women’s mental health demonstration project” in Glasgow, has found that significant impacts can be made in the lives and health of women with complex underlying problems in a relatively short period of time
- Improved outcomes for older people appear to be achieved through integrated, co-located health and social care teams.
- Appendix 2 also illustrates the benefits from some existing models of integrated lifestyle services.

Evidence of cost-effectiveness

In cost-effectiveness analysis there is often considerable uncertainty associated with the findings as a result of the assumptions and parameters used, therefore even when a sensitivity analysis is undertaken a degree of caution is required when reading the results.

Nevertheless, the majority of services reviewed, that considered costs, were found to be cost-effective and have shown the potential to bring a return on investment and to save on future costs of ill-health through early intervention.

The majority of services reviewed that have considered costs are cost-effectiveness and have shown the potential to bring a return on investment and to save on future costs of ill-health through early intervention. They can provide significant ‘value for money’ in return for the resources that they consume. For instance, the examples of good practice in the report using a case management approach show potential to reduce medicine and health service and business costs by tackling worklessness (used to describe individuals who are out of work but who would like a job).

By taking into consideration the wider determinants of health such services can potentially provide an effective response to frequent attenders in primary care, whilst tackling the underlying causes of their visits. Many services such as those involving social prescribing and psychological well-being have little or no cost compared to medical treatment. Indeed, they help individuals manage the triggers to their own distress. Relatively inexpensive mind-body interventions, such as stress management techniques, can improve health outcomes, while reducing the need for more expensive medical treatments and without any adverse effects. Furthermore, there are many indications that mind-body interventions can actually prevent the occurrence of disease as perceptions, thoughts and feelings can influence immune and hormonal systems in both adaptive and maladaptive ways.

Wellness services for the older generation and physically disabled adults, such as: OT and Partnerships for Older People Projects (POPP), can be cost-effective and make considerable savings in care costs while at the same time improving quality of life, enabling individuals to live independently. OT can often include “low tech” inexpensive applications such as assistive technology. A strong financial case exists for substituting and/or supplementing formal care with assistive technology, even for individuals with quite disabling conditions. Although needs and hence the cost of provision rise with an increasing level of disability, the savings in care costs accrue quickly and major savings are feasible. Economic factors reinforce the importance of the principle of parsimony in guiding treatment selection” utilising the most rapid and less complex (therefore least costly) methods first and using other methods only when less complicated methods have proved unsuccessful.

Wellness services that facilitate true community engagement can build on what individuals themselves identify as supporting them to improve wellbeing. It recognises people as contributing to their own health and wellbeing and not purely as receivers of costly services/interventions and also recognises the skills and experience of non-clinical staff and volunteers in supporting health improvement. Therefore, the demand for complex health and social care services will be reduced. Guthrie House project provides a successful example of community led participation and shows the power of the community to identify and deliver cost-effective services to a previously underserved village.

Lifestyle services providing health trainers and food workers can also be cost-effective by saving costs on staff budgets releasing more costly professionals to perform strategic and clinical duties. As lifestyle factors are interconnected, providing an integrated holistic lifestyle person-centred service is potentially more cost-effective, by aligning services thus reducing duplication of service support structures, including buildings and staff. Wellness services to families or groups could be more cost effective than one to one services as well as the integrated, co-location of health and social care teams.

Recommendation:

- Establish clear principles to inform the development of wellness services, based on the guidelines and standards in Appendix 3 and 4.

Appendix 1: Glossary of Terms

Bio-psychosocial model BPS	This model of health considers not only the body-focused biological components of health, but also the individual and societal contexts of the person's experience of health. ⁴ Despite a recent review founding the BPS perspective to be synonymous with best practice there is a deep-rooted dominance of the biomedical model in medical practice. ⁸
Cost-benefit analysis (CBA)	Analytical procedure for determining the economic efficiency of a program, expressed as the relationship between costs and outcomes, usually measured in monetary terms. ¹¹¹
Cost-effectiveness analysis (CEA)	The efficacy of a program in achieving a given intervention outcomes in relation to the program costs. ¹¹¹ Health benefits are measured in natural units: life years saved or functional status. Incremental cost effectiveness ratio can compare two alternatives, but only when outcomes are measured in the same natural units. ¹¹²
Cost-effectiveness acceptability curves (CEAC)	A method for summarising information on uncertainty in cost-effectiveness. A CEAC shows the probability that an intervention is cost-effective compared with the alternative, given the observed data, for a range of maximum monetary values that a decision-maker might be willing to pay for a particular unit change in outcome. ¹¹³
Cost-minimisation analysis	If health effects are known to be equal, only costs are analysed and the least costly alternative is chosen.
Cost-utility analysis	A form of cost-effectiveness analysis that compares the costs associated with two or more strategies based on a measure of utility such as quality adjusted life years (QALYs). The results are expressed in terms of cost per QALY gained. ¹⁰
Costs	The economic definition of cost (also known as opportunity cost) is the value of opportunity forgone, strictly the best opportunity forgone, as a result of engaging resources in an activity. Note that there can be a cost without the exchange of money. Also the economists' notion of cost extends beyond the cost falling on the health service alone, e.g., includes costs falling on other services and on patients themselves. In considering the production process, costs may be differentiated as follows: Average costs - equivalent to the average cost per unit; i.e., the total costs divided by the total number of units of production. Fixed costs - those costs which, within a short time span, do not vary with the quantity of production; e.g., heating

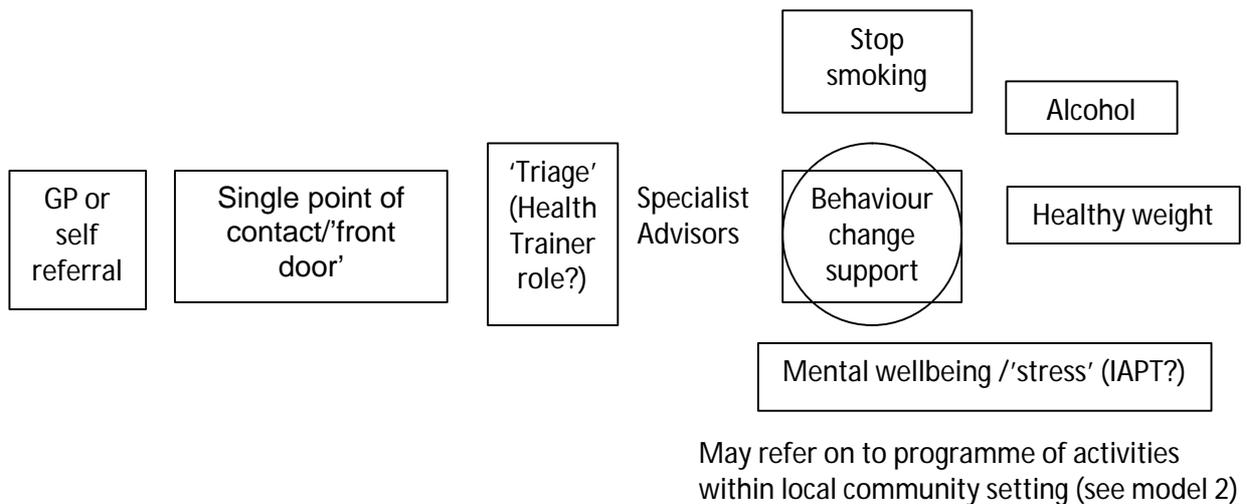
	<p>and lighting.</p> <p>Incremental cost - the extra costs associated with an expansion in activity of a given service.</p> <p>Marginal cost - the cost of producing one extra unit of a service.</p> <p>Total costs - all costs incurred in the production of a set quantity of service.</p> <p>Variable costs - those costs which vary with the level of production and are proportional to quantities produced.</p> <p>In considering health problems, costs may be differentiated as follows:</p> <p>Avoided costs - costs caused by a health problem or illness which are avoided by a health care intervention.</p> <p>Direct costs - those costs borne by the healthcare system, community and patients' families in addressing the illness.</p> <p>Indirect costs - mainly productivity losses to society caused by the health problem or disease.</p>
Discrete choice experiment (DCE)	It is one method to elicit stated preferences by asking respondents to choose between scenarios. Rather than examine the entire scenario as a package, the choice experiment allows the researcher to break down the relevant attributes of the situation and to determine preferences for different attributes that are mutually exclusive. As the choice is discrete only one alternative can be chosen and the respondent is forced to make trade-offs. ¹¹⁴
Economic democracy	Economic democracy exists when the units of economic organisations are owned and controlled by the people who work in them, and/or by those who use their services. ¹¹⁵
Ecotherapy	Encompasses a broad range of nature-based methods of psychological healing, grounded in the crucial facts that people are inseparable from the rest of nature and nurtured by healthy interaction with the Earth. Thus it recognises our relationship with the natural world as inherently healing and facilitates deeper connection with our environment. ¹¹⁶
Health (WHO definition)	Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. ⁵
Holistic model of health	This encompasses the physiological, mental, emotional, social, spiritual and environmental aspects of health. Holistic health is a state of optimum or positive wellness, emphasising the unity of the mind, body and spirit. ¹¹⁷
Incremental cost effectiveness ratio (ICER)	The difference in costs between one intervention and an alternative, divided by the difference in outcome such as life year gained. The ICER is the cost to generate each additional life year gained.

Motivational Interviewing	A directive, client-centred counselling style for eliciting behaviour change by helping clients to explore and resolve ambivalence (a conflict between two courses of action). Compared with nondirective counselling, it is more focused and goal-directed. The examination and resolution of ambivalence is its central purpose, and the counsellor is intentionally directive in pursuing this goal. ¹¹⁸
Opportunity costs	The value of health care opportunities foregone because of an intervention ¹¹¹
QALY	Stands for Quality Adjusted Life Year. A measure of the state of health of a person or group in which the benefits, in terms of length of life, are adjusted to reflect the quality of life. One QALY is equal to 1 year of life in perfect health. QALYS are calculated by estimating the years of life remaining for a patient following a particular treatment or <i>intervention</i> and weighting each year with a quality of life score (on a zero to one scale). It is often measured in terms of the person's ability to perform the activities of daily life, freedom from pain and mental disturbance. ¹¹⁹
Social prescribing	A basic model of social prescribing seeks to link patients up with the non-medical facilities and services available in the wider community that they can access to address the factors that influence their wellbeing such as offering on prescription: arts, books, exercise, learning and information on prescription ³⁶
Wellness	Wellness is an active process of being aware of and making better choices towards a healthier, more meaningful and successful existence.
Wellness Services	Lifestyle services that take a whole person approach to supporting participants in more than one lifestyle area that also incorporates mental wellbeing as part of the assessment criteria. Services that specifically promote health and wellbeing, rather than treat illness, through lifestyles and psychosocial interventions for individuals, families or groups. This might include a combination of smoking cessation, weight management, alcohol brief interventions, physical activity pathways, health trainers, social prescribing/referral, psychological well-being interventions e.g. mindfulness, stress management.
Willingness to pay (WTP)	A technique which aims to assign a value to health benefits by directly eliciting individual preferences in the views of samples of the general public who are asked how much they would be prepared to pay to accrue a benefit or to avoid certain events. ¹²⁰

Appendix 2: Existing models of integrated lifestyle services

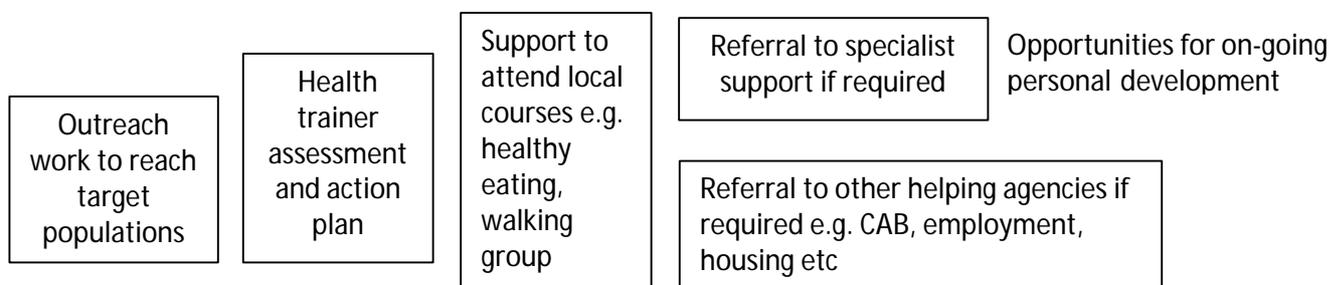
Some existing models of integrated lifestyle services to inform development of 'wellness services'

Model 1: Integrated lifestyle services (plus mental wellbeing) for individuals (clinical model)



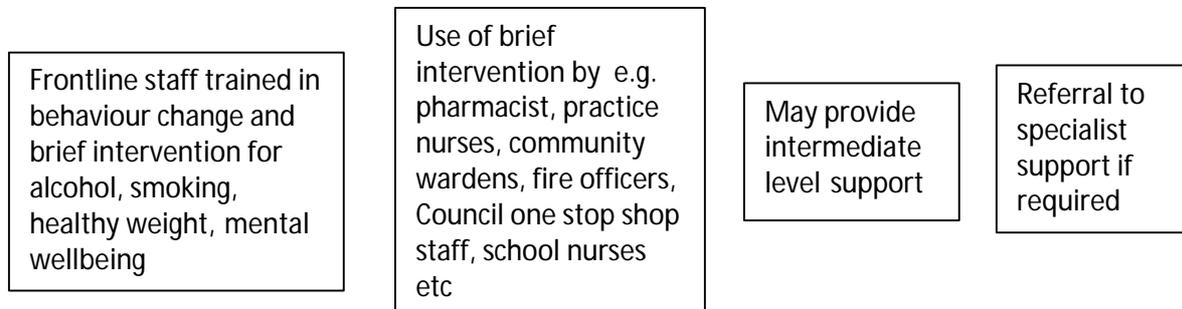
Benefits: use of GP referral enables systematic industrial scale targeting (linked to 'health check')

Model 2: Integrated lifestyle services within a community setting (community health development approach)



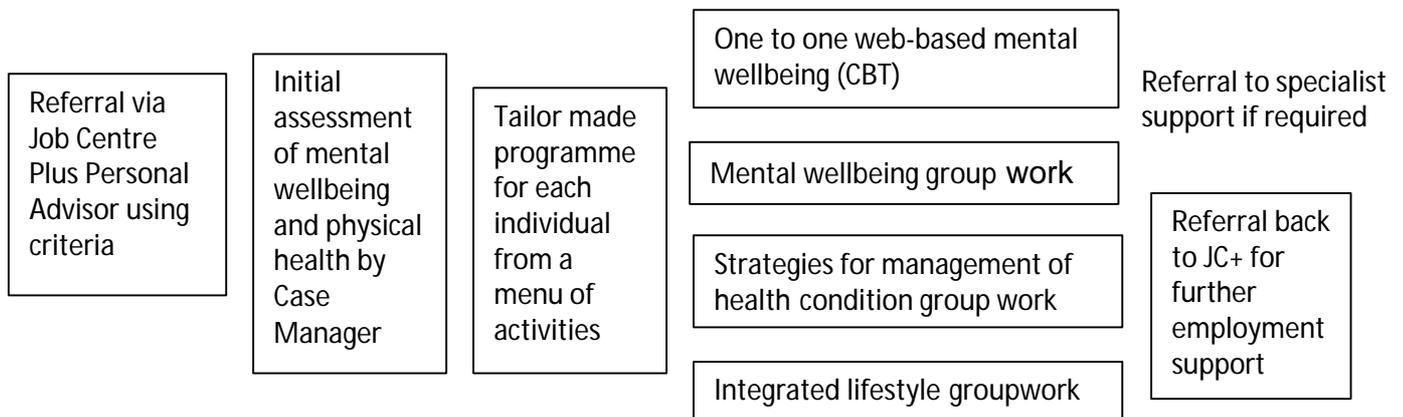
Benefits: family, and/or friends' approaches; peer support available; links to wider determinants; use of social marketing techniques; in the home or street level interventions
 Services 'wrapped around' everyday life e.g. local shops, local champions, children's Centre, door knocking, web-based, local pubs, supermarket etc. (e.g. Wirral smoking programme)

Model 3: Basic support for lifestyle change within other service



Benefits: opportunity for integration of lifestyle change into wider determinants workforce; opportunistic use with target populations; potential for further development following public health integration with local authorities

Model 4: Case management approaches (e.g. Job Centre Plus – Condition management programme)



Benefits: Lifestyle groupwork support within the context of health related worklessness; ongoing peer support helps to overcome social isolation; individual assessment of outcomes up to 6 months following programme; on-going support through programme by Case Manager (clinically trained and JC+ Personal Advisor. NB funding from JC+ ceases April 2011

Appendix 3: Guidance for wellbeing/Lifestyle services

Please note this guidance relates to those public health and wellbeing services that are currently provided by *PCT provider services only*. The scope includes services that *specifically* promote health and well-being, rather than treat illness, through healthy lifestyles and psychosocial interventions for individuals, families or groups. This might include smoking cessation, weight management, alcohol brief interventions, physical activity pathways, health trainers, social prescribing, psychological well-being interventions e.g. mindfulness, stress management.

	No.	Test	Supplementary Guidance - Areas to be assured by NHS Northwest specific evidence required for Wellbeing Health Services
Quality Improvement	1	Improving Outcomes	
		Will it meet patient needs and deliver improved local health outcomes as identified in the PCT strategic commissioning plan and Local Area Agreement (LAA), plus significantly better patient experience (including convenience and choice)?	<p>Is there evidence to demonstrate PCT understanding of the needs of the community? e.g. reference to JSNA etc</p> <p>Are the proposed services based in the communities where the needs are greatest?</p> <p>Is there evidence of a clear vision for these services including supporting the broader skills and capacity building in individuals and communities to support wellbeing and sustainability, beyond individual risk factor management?</p>
	2	Improving Quality	
		Will it deliver significant improvements in quality of service and outcomes delivered?	<p>Has the PCT demonstrated that the proposed provider model takes into account value for money?</p> <p>Is there evidence that PCT has ensured the new provider will be a genuine health promoting organisation in its day to day delivery of all services?</p> <p>Is there evidence of a clear commitment to increasing self-care, self-efficacy and co-production of health?</p> <p>Does the proposal clearly detail the monitoring and performance management of quality measures?</p>

	No.	Test	Supplementary Guidance - Areas to be assured by NHS Northwest specific evidence required for Wellbeing Health Services
	3	Service Integration	
		Will it delivery significant improvements in service integration and quality of health and social care?	<p>Is there an opportunity to improve integration/coordination of services such as smoking, alcohol, weight management, or other relevant community services?</p> <p>Is there evidence of a single point of access for lifestyle and well being services?</p> <p>Are social prescribing and mental well-being services integrated with lifestyle services with clear access routes from wellbeing to intensive specialist support for lifestyle risk factors?</p> <p>Have opportunities to integrate wellness services with wider determinates work such as worklessness, training and education, housing benefit advice etc been explored?</p> <p>Is it clear how the proposed provider will relate to other key NHS and non NHS service providers if not provided by the NHS, e.g. to health trainers, low level mental health services in the voluntary sector?</p>
Quality Improvement	4	Stakeholder Engagement	
		Has it got the engagement and support of key stakeholder groups?	Does the PCT submission make clear reference to GP consortia and local authority and third sector partners and partnership infrastructures?
	5	Efficiency Improvements	
		Will it deliver substantial improvements in the technical and allocative efficiency of the services being delivered?	<p>Has the PCT outlined how these initiatives contribute to the overall efficiency of wellbeing programmes including</p> <ul style="list-style-type: none"> • The cost of the proposed model of provision • The wider fit with local pressures in the health and social care economy e.g. as alternatives to prescribing? • Addressing psychosocial well-being as a key determinant of health, alongside individual health lifestyle management

	No.	Test	Supplementary Guidance - Areas to be assured by NHS Northwest specific evidence required for Wellbeing Health Services
			<ul style="list-style-type: none"> Releasing funding from existing services to meet unmet need, closing health inequalities gaps, and dealing with emerging threats
	6	Infrastructure Utilisation	
		Will it maximise utilisation of own (and any integration partners) estate and infrastructure?	
Sustainability of Solution	7	Sustainability	
		Will it be clinically and financially sustainable?	<p>Does the vision promote sustainability through a single integrated approach to people with a range of well being and lifestyle needs?</p> <p>Has there been due consideration of a footprint greater than the PCT?</p>
	8	Whole System fit	Does a single local provider solution provide sufficient critical mass for financial and clinically effective delivery and have other options been considered including the private sector and voluntary sector agencies?
		Will it fit into and enable delivery of wider health economy service transformation and shifts in care?	Have region-wide solutions been considered, where appropriate? Is there a clear rationale as to why this is not appropriate?

Source: NHS NW - Transforming Community Services Assurance Process Guidance

WELLNESS SERVICE STANDARDS

A Wellness Service provides support to people to live well, by addressing the factors that influence their health and well-being and building their capacity to be independent, resilient and maintain good health for themselves and those around them.

These standards provide a benchmark for the provision of a Wellness Service.

A. Improving Outcomes

1. The Service measures the achievement of outcomes in relation to:
 - Population health, well-being and inequalities
 - Customer defined health & well-being
 - Cost effectiveness
2. The Service has been developed following consultation with the public on their needs and preferences for delivery and assets for healthy living.
3. An equity audit has been undertaken to ensure that services are targeted at and accessed by those in greatest need.
4. Services are provided and tailored to particular excluded groups or those facing multiple challenges e.g. people with severe and enduring mental health conditions.
5. The service supports broader skills and capacity building for health and well-being, beyond individual risk factor management, to enable independence and resilience in individuals, families and communities to live well and care for themselves.
6. The service builds the role, skills and knowledge of all practitioners to affect the health and well-being of individuals, families and communities, so that every patient/ client contacts is a health promoting opportunity.

B. Improving Quality

1. The service measures the achievement of quality in relation to:
 - Service standards
 - Customer satisfaction

- Equality & Diversity
2. The Wellness service has integrated data collection, data exchange and clear communication between providers.
 3. The service uses NICE guidance and other quality standards to continually improve delivery.
 4. The service provider is a health promoting organisation that adds health and social value through its business, as reflected in its organisational mission statement and plan:
 - With a clear organisational Health & Well-being Strategy
 - With wellness services provided to staff
 5. The wellness service demonstrates a clear commitment to increasing self-care and co-production of health.
 6. The service uses strengths based approaches that acknowledges and builds the strengths, skills and capacities of people to live healthy lives alongside the assets within the local community.
 7. There are opportunities for community members and users to be involved in local delivery, monitoring and improvement.
 8. The service is easily accessible and flexible and uses social marketing approaches to enable better uptake.

C. Service Integration

1. The wellness service offers a single integrated and coherent approach to supporting people to live healthy and well.
2. There is a single point of access, with a central booking and triage system.
3. There is seamless integration of different wellness services through clearly defined pathways and co-ordinated community referrals/ social prescribing across the system.
4. There is a common, holistic assessment that incorporates psychosocial well-being, physical health and lifestyle behaviours.
5. Generic wellness services are provided with access to specialist interventions.
6. Well-being is an explicit component of all the wellness service interventions. This addresses the psychological factors for healthy living and capacities to make and sustain health change e.g. sense of control, coherence, self-efficacy, motivation, self determination, self value; and the social factors for

health living and behaviour change e.g. social networks and support, access to healthy living environments.

7. A range of delivery models are used, determined by community preference. For example:

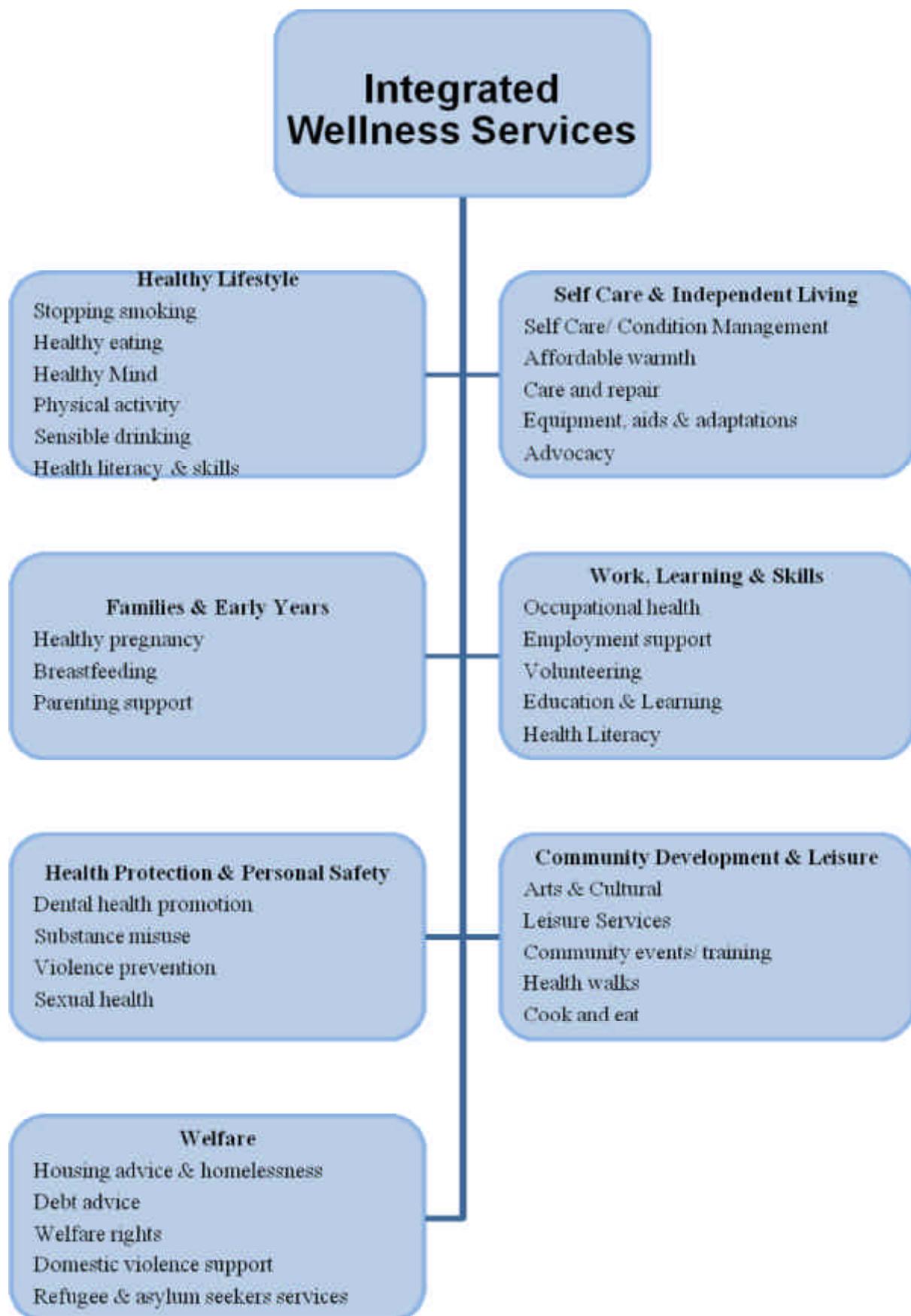
- Information provision
- Health assessment
- Computerised support
- Brief advice and coaching
- Brief intervention
- Intensive behaviour change support
- Peer support/ buddying
- Group specialist support
- Self help/ supported self help
- Signposting
- Social prescribing
- Community development
- Community education and training
- Pro-active outreach
- Social marketing

8. Services are provided in the most accessible and preferred places though face to face and digital contact using new technologies. Places that face to face are provided could include:

- Streets
- Neighbourhoods/ Communities
- Workplaces
- Public Services

9. The wellness service includes support for people in relation to a range of issues as exemplified in diagram 1 below:

Figure 4: Integrated Wellness Services Model



D. Stakeholder Engagement & Whole System Fit

1. There is a strategic plan and joint vision for wellness services within the locality.
2. There is a multi-agency wellness service partnership that oversees partnership alignment and development.
3. The service is informed by and linked to GP consortia, local authority, public health service, community service providers, voluntary and community sector and partnership infrastructures.
4. The wellness service is jointly commissioned by relevant partners and has joint outcome accountability.
5. The wellness service is developed as part of the overall system and infrastructure for health improvement.

E. Efficiency Improvements

1. Cost efficiencies have been modelled and will have ongoing monitoring e.g. releasing efficiencies through streamlining services, reducing the number of admissions to secondary care, reducing prescribing
2. Value for money is ensured through benchmarking the service with other areas.

F. Sustainability

1. The service vision promotes sustainability through addressing the determinants of health and ill-health.
2. The service tracks the sustainability of outcomes through appropriate follow-up.
3. The service trains other front line workers in providing health promoting contacts.

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