Visram S, Thirlway F, Akhter N, Walton N, Lewis S.  
**Impact of an integrated health and wellbeing approach to addressing multiple lifestyle risks and reducing health inequalities:** a mixed methods study.  

**Copyright:**
This is the author’s manuscript of a paper that was presented at 61st Annual Scientific Meeting of the Society for Social Medicine (SSM), held 6-8th September 2017, Manchester, UK.

**Link to Conference website:**
[https://socsocmed.org.uk/events/annual-scientific-meeting/](https://socsocmed.org.uk/events/annual-scientific-meeting/)

**Date deposited:**
29/09/2017
Impact of an integrated health and wellbeing approach to addressing multiple lifestyle risks and reducing health inequalities: a mixed methods study

The return of public health to local government in England in 2013 created an opportunity to integrate preventive services with agencies that act on the wider determinants of health. A number of local authorities subsequently developed integrated health and wellbeing approaches, in recognition that the previous ‘silo’ approach to the provision of single-issue lifestyle services had made little impact on inequalities. These integrated services often involve targeting the most disadvantaged geographical and non-geographical communities locally. One example is the Wellbeing for Life (WFL) service in County Durham.

The impact of WFL was evaluated using a mixed methods study design, involving: i) ethnographic observations plus interviews and focus groups with clients (n=58), staff (n=47), volunteers (n=15) and external stakeholders (n=10); ii) secondary analysis of intervention monitoring data at baseline (n=1461 clients), three (n=1201), six (n=380) and 12 months (n=133); and iii) a value for money assessment. Primary outcome measures were the EQ-5D™ and short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS). Secondary outcome measures were BMI, fruit and vegetable intake, physical activity, alcohol consumption, smoking and self-efficacy.

Clients reported positive experiences of engaging with the service and described making lifestyle changes, such as reducing portion sizes or trying new activities. Many would have liked a longer intervention (usually 8-12 weeks) and staff agreed that the duration was often insufficient for those with more complex physical, mental and/or social needs. Pre/post analysis of the intervention data revealed significant improvements across all outcome measures, with the largest changes observed in clients with the least positive results at baseline. These changes were largely maintained at both follow-up periods. Furthermore, reductions in the differences in EQ-5D™ and SWEMWBS scores between clients from the 30% most deprived communities and all other clients at the six-month follow-up stage implied that inequalities had narrowed over time. The value for money assessment indicated an estimated cost per quality-adjusted life year (QALY) of £3900 and a social return on investment of around £3.59 for every pound spent on WFL.

An integrated health and wellbeing approach can be acceptable to members of the target communities, encourage them to make and maintain lifestyle changes, and potentially reduce health inequalities. The WFL service appeared to represent good value for money, although the reliance on self-report data and lack of a control group were limitations of the study design. Further research is needed to establish the effectiveness of this approach over other intervention models.