Prioritising person-centred care

Promoting prevention

Summarising evidence from systematic reviews

National Voices
People shaping health and social care

Key themes

We compiled information from 308 systematic reviews and found that the top things that managers and clinicians can do to enhance health promotion and prevention are:

1. Reminding people why prevention is important:

- Opportunistic advice from health professionals
- Reminders to attend screening
- Educational programmes
- Mass media campaigns
- Routine health checks
- Parenting programmes

2. Providing support targeted towards the needs of specific groups:

- Targeted education interventions
- Proactive telephone counselling
- Motivational techniques
- Self-help programmes
- Online education
- Exercise programmes
- Smoking cessation
- Dietary support
- Peer support

3. Raising awareness within the wider population:

- Workplace-based interventions
- School-based interventions
- Mass media campaigns
- Targeted health promotion
- Social marketing campaigns
- Advice given by health professionals
- Banning tobacco advertising
- Smoke-free policies

The table overleaf signposts to evidence about what works best to enhance patient experience. Initiatives in bold have the most evidence to support them. The quantity of reviews is large, so only a selection of citations is provided.

Focus	Improves knowledge	Improves experience	Improves service use and costs	Improves health outcomes
Targets patients	• Educational packages[1,2,3] • Computer, internet and text initiatives[4,5] • Sports-based initiatives[6]	• Targeted education[7,8,9,10] • Collaborative care[11] • Social media[12]	• **Reminders**[13,14,15,16,17,18,19,20,21,22,23,24] • **Lay advice / peer support**[25,26,27] • **Work-based health promotion**[28,29,30] • Educational packages[31] • Relapse prevention initiatives[32] • Lifestyle programmes[33] • Home-based health promotion[34] • Self-help materials[35]	• **Smoking cessation, diet and physical activity programmes**[36,37,38,39,40,41] • **Work-based programmes**[42,43,44,45,46] • **School-based programmes**[47,48,49,50,51,52] • School policies[53,54,55] • Social marketing[56] • **Parental support and education**[57,58,59] • **Motivational initiatives**[60,61,62] • Health coaching[63] • **Proactive telephone support**[64,65,66,67,68] • **Computer-based programmes**[69,70,71,72,73] • Text messages[74,75] • Video games[76] • Printed materials[77] • Exercise prescriptions[78,79,80,81,82] • Risk scores[83] • Volunteering[84] • Financial incentives for patients[85]
Targets professionals	• Screening tools to identify disease and risks[86]	• Workforce development[87,88,89,90]	• Audit and feedback[91]	• Contracts between patients and professionals[92] • Cultural competence training[93,94] • Financial incentives[95]
Targets systems / organisations	• Media campaigns[96]			• **Media campaigns**[97,98,99,100] • Taxes[101,102] • Smoke-free policies[103]

Promoting prevention

Person-centred care involves placing people at the forefront of their health and care. This ensures people retain control, helps them make informed decisions and supports a partnership between people, families and health and social services.

Some of the core facets of person-centred care involve:

- supporting self-management
- supporting shared decision-making
- enhancing experience
- improving information and understanding
- and promoting prevention

We have a series of booklets for healthcare commissioners and health professionals summarising the best research evidence about what works in each of these areas. This booklet focuses on prevention and health promotion.

What is prevention and health promotion?

There is much that individuals can do to increase their chances of a healthy life. This includes exercising, eating well, avoiding health risks, not smoking and limiting the consumption of alcohol. Community initiatives and health promotion activities also complement individual efforts.

Health promotion involves enabling people to increase control over their health and its determinants, and thereby improve their health status. This may involve preventive activities such as screening for conditions such as cancer.[104]

Responsibility for promoting public health lies within many sectors of public and commercial life and spans the responsibilities of many government departments. The NHS and all who work within it have a clear and important role to play.

Why is this important?

1. There are inequalities in health status and outcomes in the UK

The greatest public health challenges in the UK include health inequalities, preventable deaths, mental illness, and high rates of smoking, obesity, teenage pregnancy and substance misuse.

There are still wide inequalities in health between social groups.[105] People in non-manual occupational groups can expect to live about three years longer than those in manual groups on average. Inequalities in life expectancy have increased over the last 30 years.

2. Many conditions or adverse outcomes are preventable

Cancer and circulatory disease are the most common causes of death. Many premature deaths from these conditions are preventable. Coronary heart disease is the leading single cause of death in the UK. It claims the lives of one in five men and one in six women and can cause years of disability and ill health. Heart disease may cost the UK economy £29 billion a year. Britain spends more of its health budget on heart disease than any other EU country.

There are many other things that can be targeted for prevention and health promotion activities. For example, smoking is the single greatest cause of preventable illness and early death from a wide range of illnesses, including cancer, respiratory disease and heart disease. In 2007, 22% of adults were smokers, a decrease from 1974 when 45% of adults smoked.

In 2008, around 83,900 (18%) of deaths in England among adults aged 35 and over were estimated to be caused by smoking. This includes, in this age group, 35% of all deaths due to respiratory diseases, 29% of all cancer deaths and 14% of deaths due to circulatory diseases. A larger proportion of men (23%) are estimated to die than women (14%) from smoking-related diseases.

The UK also has the highest prevalence of obesity among adults in Western Europe. Obesity is related to a number of conditions, including coronary heart disease, stroke and diabetes. In 2007, 24% of adults (aged 16 or over) in England were classified as obese (a 15% increase from 1993). Almost a third (30.4%) of children aged 2 to 15 were classed as either overweight or obese. In 2007, only 27% of men and 31% of women consumed five or more portions of fruit and vegetables a day.

UK Government recommendations are that adult men should not regularly drink more than 3–4 units of alcohol a day and adult women should not regularly drink more than 2–3 units a day. 'Heavy' or 'binge' drinking is defined drinking more than 8 units (men) or 6 units (women) on the heaviest drinking day in a week. Statistics for England suggest that around two fifths of men and one third of women report drinking more than the recommended limit at least one day per week. There are more than 200,000 hospital admissions every year for diseases or injuries that are wholly attributable to alcohol consumption and alcohol misuse and related harm are estimated to cost the NHS in England £2.7 billion.

In England and Wales, suicide is the second most common cause of death of men aged 15 to 34 years, and the third most common cause of death among women in the same age group. In 2008, there were 5,706 suicides among adults aged 15 and over in the UK. Suicide rates were 17.7 per 100,000 for men and 5.4 per 100,00 for women. Both UK rates are higher than in 2007, reversing a downward trend over the previous decade. England's national suicide prevention strategy aims to reduce the death rate from intentional self-harm and injury/poisoning of undetermined intent in England by 20%, from a baseline of 9.2 deaths per 100,000 in the three years 1995-7 to 7.3 deaths per 100,000 in 2009-11. Data for 2005-7 show a rate of 7.9 deaths per 100,000 in England, a 13.9% reduction from baseline. Suicide in young men, which more than doubled between the 1970s and the 1990s, remains higher than for other demographic groups, but fell steadily to 2006. In 2008, suicide rates in England were 15.9 per 100,000 for men and 4.7 per 100,000 for women. Both rates are higher than in in 2007. The 2008 suicide rate for males aged 15 to 44 was 24.0 per 100,000. The suicide rate per 100,000 mental health service users in England in 2006 was 141.6. There were 141 suicides among mental health service in-patients in 2006, compared to 219 in 1997.

Forty per cent of older people attending GP surgeries, and 60% of those living in residential institutions are reported to have 'poor mental health'. People with severe mental illness are 1.5 times more likely to die prematurely than those without; partly due to suicide, but also due to death from respiratory and other diseases. Depression has consistently been linked to mortality following a myocardial infarction. It increases the risk of heart disease fourfold, even when other risk factors like smoking are controlled for. People with severe mental illnesses are also more likely to have a poor diet, be obese, smoke more, attend routine health checks less frequently and get less health promotion input than the general population.

Sexual health is recognised as an important component of individual physical and mental health and wellbeing. Rates of sexually transmitted infection and of unintended and unwanted pregnancy are also a public health priority, with health promotion initiatives focused on reducing sexually transmitted infection (STI) rates, especially among young people, countering stigma and discrimination associated with STIs, reducing rates of unintended and unwanted pregnancy, minimising the risks of exclusion and disadvantage associated with pregnancy and parenthood for women aged under 18 and reducing inequalities - in sexual health, and in access to sexual health information, advice and high quality services.

Substance misuse is associated with significant health risks including anxiety, memory or cognitive loss, accidental injury, hepatitis, HIV infection, coma and death. It may also lead to an increased risk of sexually transmitted infections. In England and Wales class A drug use is estimated to cost more than £15 billion in economic and social terms. In 2007/8, a third of people (35.8%) surveyed reported ever using illicit drugs, one in ten reported using in the last year (9.3%) and one in 20 in the last month (5.3%). Among 16 to 59 year olds, reported use of illicit drugs fell from 10.0% to 9.3% between 2006/07 and 2007/08, and it fell from 24.1% to 21.3% among 16 to 24 year olds. Class A drug use was much less commonly reported, with 13.9% reporting having used a Class A drug at least once, 3.0% in the previous year and 1.3% in the previous month. Reported use of Class A drugs use among 16 to 24 year olds in 2007/8 was the lowest reported use since 1995.

3. Policy suggests there is potential for significant improvements

NHS staff can make an impact by providing advice on health-related behaviours. However, findings from recent national surveys of people using primary care suggest that many opportunities to provide such advice are being missed. Thus there is much room for improvement.

The Department of Health has set out a strategy for improving public health and this is supported by the NHS Operating Framework and the NHS Constitution.

Regulators and other bodies also expect health professionals to play a part in promoting health. The General Medical Council (GMC) and the Nursing and Midwifery Council both emphasis the increasing importance of population health.

What works?

308 systematic reviews published between 1998 and 2013 have summarised the best research evidence about prevention and health promotion. This section outlines key findings about what works so commissioners and health professionals know the most useful and cost-effective interventions to invest in.

The appendix describes how we identified and analysed the research evidence.

What has been tested?

Systematic reviews have compiled evidence about the following interventions:

Community education and adult learning

- Group education
- One-to-one education
- Videos and interactive multimedia programmes
- Cultural competence training
- School and home-based programmes

Targeted health promotion and social marketing

- Tracking/reminder systems
- Leaflets and hand-outs
- Advice from hospital staff
- Exercise and fitness programmes
- Invitations and reminders
- Individual counselling
- Telephone counselling
- Financial incentives
- Self-help packages
- Home visits
- Risk assessment
- Advice in primary care
- Contracts
- Workplace initiatives

Mass media campaigns

- Television and radio
- Newspapers and journals
- Point-of-sales measures
- Advertising

What are the impacts?

Improving knowledge

Education

There is evidence that **educational packages**, videos/dvds and multi-media programmes can help to improve knowledge among low literacy populations.[106] However, short-term group-based didactic teaching is of limited value for these groups.[107,108,109,110]

There is evidence that occupation- and activity-based mental health promotion interventions for young people can increase knowledge, including programmes that focus on social-emotional learning; school-wide bullying prevention; and after-school, performing arts, suicide prevention and stress management activities.[111,112]

Preventive or disease specific education has also been found to improve knowledge in people with many types of conditions.[113,114]

Using technology

A review of text messages, the internet and social media found that these technologies could be used to increase knowledge about sexual health issues among young people.[115] Other reviews suggested that computerised interventions improved knowledge and sexual health outcomes more than face-to-face interventions.[116,117]

Initiatives with professionals

A number of tools are available to help professionals screen, support decisions and measure the extent to which people are receiving the help they need.[118] These tools may increase practitioners' knowledge about which individuals to target for further support.

Media campaigns

Media campaigns have been found to improve knowledge and awareness.[119]

Other initiatives

Sports-based initiatives have been found to improve knowledge of issues such as sexual health.[120]

A review of studies investigating people's attitudes towards the content, source, tailoring and comprehension of dietary guidelines found that people thought that guidelines were confusing.[121]

Another review found that providing information about 'ultraviolet index' did not improve people's knowledge or attitudes about sun protection.[122]

Improving experience

Education

People's demographic characteristics can influence their attitudes and behaviours, so targeted programmes may be worthwhile.[123,124] **Targeted interventions** for people from minority ethnic groups and cultural competence training can improve patient satisfaction.[125,126,127,128] Specific health promotion activities for people with intellectual disabilities have also been found to heighten people's experience.[129]

Programmes to increase physical activity in older people that contain cognitive behavioural elements have been found to improve self-efficacy,[130,131,132] as have educational interventions for people with heart failure[133] and the general population.[134]

Educational and supportive programmes for youth have also been found to improve experience, skills, confidence and leadership.[135,136,137]

Support

Collaborative care has been found to improve experience and engagement in healthcare, particularly amongst minority ethnic groups.[138]

Social media

A review of using social media for health communication found benefits including increased interactions with others, increased accessibility to health information, more readily available tailored information and social / peer / emotional support.[139]

Initiatives for professionals

Workforce development may need to go hand in hand with interventions targeting patients.[140,141,142] Health promotion education targeting professionals has the potential to improve people's experience, as patients report being influenced by professionals' advice regarding screening, vaccinations and behaviour change.[143,144,145] Reviews have found that the attitudes of professionals regarding things like alcohol use, smoking and sexual health influence the extent of their health promotion behaviours.[146,147,148,149]

A review found that medical students can learn behaviour change counselling through active, realistic practice, plus reminder and feedback systems within clinical practice settings.[150]

One review suggested that models which incorporate community support and empowerment can help to improve people's experience and health literacy. This may include working in partnership with community groups.[151]

Improving service use and costs

Reminders

Various types of reminders, such as postcards, **letters**, telephone or automated phone calls, educational interventions, mass media campaigns and periodic health evaluations have been found to improve the uptake of screening, immunisations, blood donations and other preventive procedures.[152,153,154,155,156,157,158,159,160,161,162,163,164] However, not all evidence is positive. One review found little impact for targeted screening reminders in minority ethnic groups[165] and another found little evidence that breast screening reminders influenced uptake rates.[166]

One review found no difference between email reminders and standard reminders for increasing the rate of screening uptake or health status and wellbeing.[167]

Education

One review found that patient education about the management of heart disease can reduce hospital admissions, leading to reduced healthcare costs.[168]

Education initiatives have not been found to increase immunisation for seasonal influenza amongst health professionals.[169]

Targeted programmes

There are also findings relating to specific conditions. For example, **motivational** communications and support from trained **lay volunteers** may be a cost-effective way of providing cardiac rehabilitation programmes.[170] Some cardiovascular risk prevention programmes have been found to be cost-effective.[171] A review of diabetes prevention interventions found the following to be cost-effective: medication to reduce risk factors, multicomponent lifestyle programmes to reduce risk, universal screening over a certain age and smoking cessation programmes.[172]

Relapse prevention initiatives have been found to be cost-effective in smoking cessation services.[173]

There is emerging evidence that **home-based nurse-led health promotion** for older people may reduce health and social care costs.[174]

Most programmes to increase **physical activity** have been found to be cost-effective, especially when they do not require direct supervision.[175]

Some reviews report good return on investment, reduced costs, reduced absenteeism and increased productivity from **work-based health promotion** programmes,[176,177,178] However not all evidence is positive.[179]

Materials

Self-help materials may be more cost-effective than advice from a specialist dietician in reducing blood cholesterol as they produce similar outcomes at lower cost.[180]

Providing smoke alarms, home inspection and education combined may be the best way to increase uptake of using smoke alarms.[181]

Support from peers

Reviews suggest that advice from lay health workers can increase immunisation rates in children[182] and screening for HIV and cancer[183,184] as well as treatment adherence.[185] However, another review of the cost-effectiveness of health-related advice provided by peer or lay workers found limited evidence of cost-effectiveness in terms of changing health-related knowledge, behaviours or health outcomes. Lay advisors may only be cost-effective when they target behaviours likely to have a large impact on overall health-related quality of life, such as diabetes.[186]

One review found that involving churches, housing projects and centres for older people may help to increase the uptake of cancer screening.[187]

Interventions for professionals

Audit and feedback interventions for professionals have been found to improve the uptake of cancer screening.[188]

Other initiatives

Having mobile dental units on school premises has been found to increase the use of dental services among young people.[189]

Improving health behaviour and outcomes

Targeted programmes

Targeted health promotion programmes and social marketing can reduce health risks in certain groups, but there is little evidence about the extent to which they reduce health inequalities between groups.[190,191,192,193,194,195,196,197,198;199;200;201,202,203,204,205,206,207,208,209,210,211,212,213,214,215,216,217,218,219,220,221,222,223,224,225,226,227]

Reviews have focused on a wide range of public health issues. For example:

- A number of reviews have focused on **smoking cessation**.[228,229,230,231,232] There is evidence that counselling, including telephone calls, and pharmacotherapy through, for example, nicotine patches, either alone or in combination, can encourage smokers to quit.[233,234,235,236,237,238,239,240,241] Smoking cessation interventions may more effectively reach disadvantaged groups when integrated into other health services and settings, including pharmacies and the workplace.[242] Advice from health professionals in hospital, primary care and the workplace can also encourage smoking cessation.[243,244,245,246,247,248,249] A review found that doctors may be more effective in promoting attempts to stop smoking by offering assistance to all smokers than by advising smokers to quit and offering assistance only to those who express an interest in doing so.[250] Individualised self-help interventions, including internet programmes, have a small effect on reducing smoking.[251,252,253,254] However, not all interventions have been found to reduce smoking.[255]

- **Dietary education** and motivational interventions such as individual counselling, group nutrition classes and social support can be effective in increasing fruit and vegetable intake and diary consumption and reducing fat consumption.[256,257,258,259,260] Targeted programmes have been found to be effective for minority ethnic groups,[261,262,263,264,265] young people[266,267,268,269] and others.[270,271,272,273] Programmes that combine physical activity and healthy eating may be beneficial,[274,275] as may those that supply samples of food for people to taste[276] and use component such as training of health professionals prior to delivery, behaviour change principles, counselling, education, written resources and tailoring the intensity to the individual.[277] Commercial weight loss programmes have been found to be effective.[278]

- **Exercise programmes** can help to enhance older people's mental wellbeing and reduce falls.[279,280,281] Reviews have found that programmes to improve physical activity in older people might include cognitive behavioural-based components, personalised coaching, goal setting, peer support groups, technology, physical activity monitors and follow-up support to most effectively increase the level of physical activity.[282,283,284,285]

Drawing on community resources, family members and other social networks may help to make exercise seem 'normal.'[286] Targeted support for minority ethnic groups has shown promise.[287,288,289,290] Programmes specifically for women or men, young people or those from disadvantaged social groups have also been tested, though not always successfully.[291,292,293,294,295,296,297] Amongst the general population, interventions to increase physical activity have been found to work well,[298] especially when they prompt self-monitoring of the behaviour, include group support, such as walking in groups, and last for a longer period.[299,300,301,302] These programmes can be offered in primary care.[303] Reminder signs to use stairs may also impact on behaviour. These are known as 'point of decision prompts.'[304,305]

- **Parental support** and educational programmes for parents can help to reduce health risks among children, including preventing and treating obesity, though not all evidence is positive.[306,307,308,309,310,311,312] They can also help to reduce substance misuse among adolescents.[313] Peer and professional support and structured educational programmes and community initiatives can encourage breastfeeding in some circumstances.[314,315,316,317,318,319]

- Reviews have examined programmes aiming to prevent specific types of conditions too. For example, diabetes prevention programmes have been found to reduce risk factors such as weight.[320]

- There is no evidence that breast self-examination has a beneficial effect on mortality from breast cancer.[321]

Targeted interventions have been tested in a wide range of contexts. For instance, prevention and health promotion programmes run at people's **place of work** have been found to improve health behaviours and outcomes, including physical activity.[322,323,324,325,326,327,328,329,330,331] Not all workplace-based interventions have been found to improve health behaviours and outcomes.[332,333,334] Workplace interventions may be most effective when they include weekly contacts and multicomponent interventions.[335,336,337] Other useful components include individualised risk assessment and reduction,[338,339] providing practical resources such as pedometers[340] and social activities.[341]

School-based programmes can improve children's social and emotional wellbeing[342] as well as potentially diet, physical activity and other behaviour, usually to a small extent.[343,344,345,346,347,348,349,350,351,352,353,354] There is some evidence that classroom-based education may help to reduce alcohol and cigarette consumption among young people.[355,356,357] School-based life skills and resilience programmes have been found to have positive effects on young people's self-esteem, motivation and self-efficacy. Community-based interventions, including those linked to schools, may impact on youth mental health, activity and social wellbeing, though the evidence is equivocal.[358,359,360,361] Some reviews suggest that physical activity interventions for young people, whether at school or in the community, have small or negligible results.[362,363,364] Programmes that include schools as one component of broader interventions may be more effective for preventing substance abuse and risky sexual behaviour.[365]

Community prevention programmes have been found to reduce cardiovascular risk and may be effective for diabetes prevention.[366,367]

Many other reviews of specific targeted health promotion and prevention initiatives are available.[368,369,370,371,372,373,374,375,376]

Motivational initiatives

Initiatives using approaches such as **motivational interviewing**, cognitive dissonance, cognitive behavioural therapy and other psychosocial approaches have been found to support behaviour change,[377,378,379] including increased physical activity.[380,381,382] However one review concluded that achieving and sustaining changes such as fruit and vegetable intake cannot be achieved through motivational behaviour techniques alone.[383]

One-to-one counselling can help to reduce sexually transmitted infections and teenage pregnancies.[384] When provided by health professionals, it has also been found to improve physical activity in older people.[385] In general, face-to-face provision of tailored messaging has been found to improve health behaviours.[386] In fact, one review of reviews found that the most effective behaviour change interventions were advice from doctors or one-to-one counselling, and workplace or school based initiatives.[387]

A review of **health coaching** found significant improvements in nutrition behaviours, physical activity, weight management and medication adherence, though findings were mixed. Common features of effective programmes included goal setting, motivational interviewing and collaboration with health professionals.[388]

There is no clear evidence that peer support improves health outcomes universally,[389] though some reviews indicate positive findings.[390] In some instances, peer-based interventions have been found to facilitate important changes in health-related behaviours, including physical activity, smoking, and condom use, with a small to medium-sized effect.[391]

Telephones and technology

Proactive telephone support can be an effective way of improving health behaviour among disadvantaged groups.[392,393,394,395,396] Women who are pregnant may also benefit from proactive telephone support with things like nutrition, smoking relapse and breastfeeding.[397] There is a smaller amount of evidence that telephone and internet interventions for the secondary prevention of coronary heart disease may improve levels of physical activity and mental wellbeing.[398]

A review of delivering dietary and exercise interventions by telephone found improved health behaviours.[399]

A review of **text message-based interventions** for health promotion found improvements in health behaviours, particularly smoking cessation and increased physical activity. The most effective interventions used personalised and tailored messages, and decreased the frequency of messages over the course of the intervention.[400] Other reviews have also suggested positive findings,[401] though the evidence for mobile phone technologies is only just emerging, so it is not possible to draw firm conclusions.[402]

Computer-based health promotion and risk reduction interventions can have a positive impact on diet and eating behaviours, smoking and drug use, safer sex and general health attitudes and behaviours,[403,404,405,406,407] particularly among young people.[408,409,410,411] Often the effects are short term or small.[412,413,414] One review found that online programmes could impact on weight control.[415] However not all reviews have positive findings.[416] The most effective initiatives may include opportunities for peer support, contact with health professionals, regular updates and tracking and simultaneous use of other initiatives such as text messages.[417,418]

Video games can increase physical activity in laboratory settings, but gains may not last in the longer-term.[419]

Documents and tools

Tailored print interventions have been found to promote physical activity in adults.[420]

Risk scores have been found to be a useful mechanism for targeting people to take part in prevention programmes. For example, cardiovascular risk scores can help select people for inclusion in multifactorial interventions that lower cardiovascular risk and mortality.[421]

Contracts between patients and professionals may help to improve adherence to preventive measures, but the evidence is limited.[422]

Exercise prescriptions and advice from primary care practitioners may help to increase levels of physical activity.[423,424,425,426,427]

Media campaigns

Media campaigns can take a variety of forms including combinations of television, radio, newspapers, billboards, posters, leaflets, booklets and online. **Mass media campaigns** can encourage people to do things such as eat healthy or take part in disease screening. For example, media campaign have been found to increase screening for conditions such as cancer and HIV.[428,429,430,431]

Well-designed mass media campaigns can also encourage people to stop unhealthy behaviours.[432] For instance there is evidence that campaigns can help to reduce smoking rates among adults and young people.[433,434,435,436,437,438,439] Culturally targeted campaigns have been found useful for minority ethnic groups.[440] However, media campaigns have generally not been found to be effective for reducing illicit drug use.[441]

Some reviews suggest that standalone media campaigns are less likely to be effective than campaigns combined with other initiatives.[442,443] The most effective campaigns and health promotion materials may use 'scare tactics' and emphasise the things people will lose,[444,445] though some reviews suggest focusing on what people gain is more useful.[446]

Social marketing uses marketing techniques to achieve a social or health-related goal. This includes customer orientation, insight, segmentation, behavioural goals, exchange, competition, methods mix, and theory base.[447] A review found that social marketing can change attitudes and behaviours related to alcohol.[448]

Interventions with professionals

Cultural competence training for professionals may help to promote engagement in health-promoting behaviours among people from minority ethnic groups, but the evidence is limited.[449,450]

Evidence about the benefits of **financial incentives for professionals**, such as through the Quality and Outcomes Framework, is limited, One review found mixed results of financial incentives for professionals on patient quit rates and longer-term abstinence.[451]

Other initiatives

Volunteering may help to improve physical and mental health. A review found that volunteers had better wellbeing and higher survival rates than people who did not volunteer. The reviewers suggested that volunteering could be promoted as a public health intervention.[452]

Reviews have also examined interventions targeting system or policy levels.[453,454,455,456] It is estimated that **taxes** on carbonated drinks and saturated fat, higher fast food prices and subsidies on fruits and vegetables would be associated with beneficial dietary change, with the potential for improved health.[457,458] Financial incentives for patients may also have a role in increasing physical activity.[459]

Smoke-free policies at workplaces or in the community have been found to reduce tobacco use.[460]

There is also evidence that establishing specific **physical activity policies for schools** and making sure that equipment and time is available can influence behaviour and health outcomes.[461,462,463]

Policies to promote establishing **home gardens** may influence food consumption, but the effect on health outcomes remains uncertain.[464]

What should we invest in?

Taking all of the evidence together, commissioners and providers wanting to enhance experience should consider investing in the initiatives listed below.

Improvement initiatives	Expected return on investment
Opportunistic advice from health professionals in hospital, primary care and workplace	• Reduced smoking • More physical exercise • Better diets • Reduced alcohol consumption • Increased uptake of preventive procedures
Targeted health promotion / social marketing programmes	• Reduced risk factors • Increased uptake of screening, immunisation and other preventive procedures • *May* reduce risk factors among disadvantaged groups
Proactive telephone counselling using motivational techniques	• Increased uptake of screening, immunisation and other preventive procedures • *May* reduce risk factors among disadvantaged groups
Self-help programmes and websites	• *May r*educe smoking rates • *May* improve diets • *May* reduce other risk factors
Mass media campaigns	• Reduced smoking rates • Increased uptake of screening
Parenting programmes and home visits	• Reduced health risks among children • Reduced substance misuse among adolescents
Health education in schools including attention to social and emotional wellbeing	• *May r*educe smoking rates • *May* reduce alcohol consumption • *May* improve social and emotional wellbeing
Coordinated sexual health strategies including one-to-one counselling	• *May* reduce incidence of sexually transmitted infections • *May* reduce teenage pregnancies
Physical activity programmes for older people	• *May* enhance mental wellbeing

Although the range of interventions studied is very wide, the evidence suggests that the top three things to focus on include:

1. Reminding people why prevention is important

There is good evidence that opportunistic advice from health professionals (in primary care, hospital and the workplace) can help to reduce risk factors (smoking, exercise, diet, alcohol). A variety of methods - reminders, educational programmes, mass media campaigns and routine health checks - can help to increase uptake of screening, immunisation and other preventive procedures. There is good evidence that parenting programmes and home visits can help to reduce health risks among children. They can also help to reduce substance misuse among adolescents. Coordinated sexual health strategies including one-to-one counselling can help to reduce sexually transmitted infections and teenage pregnancies.

2. Providing support targeted towards the needs of specific groups

There is good evidence that well-designed, carefully targeted interventions can reduce health risks among disadvantaged groups. The extent to which they reduce inequalities *between* socio-economic groups has not been well studied. There is some evidence that proactive telephone counselling using motivational techniques can reduce health risks among disadvantaged groups. There is some evidence that self-help programmes, including those that are internet-based, can help some smokers to quit. Exercise programmes can help to enhance older people's mental wellbeing.

3. Raising awareness within the wider population

Mass media campaigns, targeted health promotion and social marketing campaigns and advice given during contact with health professionals have all been found to be beneficial for raising awareness and potentially changing behaviour. There is reasonably good evidence that well-designed mass media campaigns and banning tobacco advertising can help to reduce smoking rates.

Learn more

You can access the abstracts of all the systematic reviews of evidence by clicking on the hyperlinks in the references section of this document.

There are a number of other resources available, such as:

- Public Health England produces information, data and intelligence on people's health and healthcare for practitioners, policy makers and the wider community. Their health profiles provide a summary of key health indicators for each local council in England. They are designed to help local councils and the NHS decide where to target resources to tackle health inequalities in their local area.

- The Health Poverty Index provides summaries for every local authority area across a range of factors underpinning health inequalities. The HPI tool allows groups, differentiated by geography and cultural identity, to be contrasted in terms of their 'health poverty'. A group's 'health poverty' is a combination of both its present state of health and its future health potential or lack of it.

- The National Social Marketing Centre aims to increase the impact and effectiveness of health promotion programmes and campaigns at national and local levels, by ensuring that social marketing principles are adopted and systematically applied.

- The Public Health Outcomes Framework includes a number of indicators on health promotion that can be used to track progress over time.

- A number of NICE public health guidance documents relate to the issue of health promotion, including PH2: Four commonly used methods to increase physical activity; PH7: School based interventions on alcohol; PH9: Community engagement; PH12: Social and emotional wellbeing in primary education; PH13: Promoting physical activity in the workplace; PH16: Mental wellbeing and older people; PH17: Promoting physical activity for children and young people; PH20: Social and emotional wellbeing in secondary education; PH22: Promoting mental wellbeing at work; PH23: School-based interventions to prevent smoking; PH35: Preventing type 2 diabetes – population and community interventions.

- The World Health Organisation (WHO) aims to encourage consumer behaviours that optimise health (physical and psychosocial) through providing health information, preventive programmes, and access to medical care. It has a wide range of resources online.

- The Mental Health Foundation provides information, carries out research, campaigns and works to improve services for anyone affected by mental health problems. It examines what makes and keeps people mentally well, communicates its findings, and turns research into practical solutions that make a difference to people's lives.

Appendix: identifying evidence

Commissioners and professionals need accessible and accurate information upon which to make decisions. High quality research is one of the things that might be used to help guide decisions. This appendix describes how we compiled the highest quality research to support decision-making.

What type of evidence is included?

To find out what works best to prioritise person-centred care, we drew on systematic reviews. 'Systematic reviews' have traditionally been regarded as the best standard of evidence because they bring together the results of all relevant studies that meet specific quality criteria. A systematic review starts with a specific question or set of clearly defined questions and then identifies, appraises, selects and synthesises all high quality research evidence relevant to that question. Tried and tested methods are used to perform a thorough search of the literature and critical appraisal of individual studies to identify valid and applicable evidence.

Some groups, such as the Cochrane Collaboration have agreed a set of standards for gathering, analysing and reporting evidence, though not all reviews conform to these standards.

By drawing together the findings of systematic reviews, we compiled the highest quality evidence to support healthcare planners and practitioners. We focused on the extent to which interventions impacted on people's knowledge, people's experience, service use and costs and health outcomes and behaviours.

Identifying research

Two reviewers independently searched bibliographic databases to identify relevant systematic reviews and other high level narrative reviews. The databases were Medline / Pubmed, Embase, CINAHL, the Cochrane Library and Google Scholar. Specialist websites and the reference lists of identified articles were also searched. The databases were searched for systematic reviews published in English language journals between January 1998 and December 2013.

Reviews were eligible for inclusion if they focused on interventions designed to enhance the active role of patients and lay people. Reviews where patients were solely the 'objects' of an intervention that targeted professionals were excluded. Two reviewers independently assessed the relevance and quality of each review, first based on the abstracts and titles of identified studies and then based on full-text. Any review which focused on a relevant topic and outcome was included.

More than 40,000 studies were screened and a total of 779 systematic reviews were identified for inclusion, broken down into the following categories:

- supporting self-management (228 reviews)
- supporting shared decision-making (48 reviews)
- enhancing experience (110 reviews)
- improving information and understanding (85 reviews)
- and promoting prevention (308 reviews)

Things to remember when interpreting the findings

The evidence base is substantial and significant, but it is not perfect. It will not help to answer all questions about how best to prioritise person-centred care. Some interventions, such as education for self-management, have been very well studied. Others initiatives have been less well investigated, and few studies have examined the longer-term effects of interventions.

Much of the research is from North America, so commissioners and health professionals need to think about whether the findings translate easily to the local context.

Although there is good evidence that some things make a difference to how people feel and what people do, analysis of cost-effectiveness is sometimes lacking.

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Exploring the evidence

You can click on the hyperlinks to explore the evidence further.

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