

# New Deal for Communities

## The National Evaluation

### Research Reports

#### **Complementary and Alternative Therapies in New Deal Communities**

Research Report 32

The Neighbourhood Renewal Unit is currently sponsoring the 2002-2005 national evaluation of New Deal for Communities. This evaluation is being undertaken by a consortium of organisations co-ordinated by the Centre for Regional Economic and Social Research at Sheffield Hallam University. The views expressed in this report do not necessarily reflect those of the Neighbourhood Renewal Unit.

Those wishing to know more about the evaluation should consult the evaluation's web site in the first instance  
<http://ndcevaluation.adc.shu.ac.uk/ndcevaluation/home.asp>



*Sheffield Hallam University*

# **Complementary and Alternative Therapies in New Deal Communities**

Research Report 32

## **Authors:**

Lindsay Blank  
Libby Ellis  
Elizabeth Goyder  
Jean Peters

***School of Health and Related Research  
The University of Sheffield***

August 2004  
ISBN: 1 84387 079 7

# CONTENTS

<b>Executive Summary</b> .....	<b>i</b>
<b>1. Introduction</b> .....	<b>1</b>
1.1. What is Complementary and Alternative Medicine (CAM)? .....	1
1.2. Background .....	1
1.3. Research approach.....	2
1.4. NDC approach.....	2
<b>2. Objectives of NDC CAM projects</b> .....	<b>3</b>
<b>3. Process issues</b> .....	<b>5</b>
3.1. Consultation .....	5
3.2. Resident involvement.....	7
3.3. Partnerships .....	8
3.4. Funding.....	9
3.5. Assimilation and dissemination.....	10
3.6. Mainstreaming.....	11
3.7. Monitoring and evaluation .....	12
<b>4. Emerging benefits</b> .....	<b>13</b>
4.1. Local subsidised provision .....	13
4.2. Needs of service providers, primary care and the community .....	14
4.3. Co-ordination .....	14
4.4. Development of appropriate services .....	14
<b>5. Emerging issues</b> .....	<b>15</b>
5.1. Staffing and accommodation .....	15
5.2. Working across NDC themes.....	16
5.3. Community and GP relationships .....	16
5.4. Availability of appropriate data.....	16
5.5. Funding.....	17
<b>6. Conclusions</b> .....	<b>18</b>
<b>References</b> .....	<b>19</b>
<b>Appendices</b> .....	<b>20</b>

# Executive Summary

## Background

- complementary and Alternative Medicine (CAM) refers to a diverse group of health-related therapies and disciplines which are not considered to be a part of mainstream medical care. Other terms used to describe them include:
  - natural medicine
  - non-conventional medicine
  - holistic medicine
- CAM offers a range of therapies, which may be used to prevent illness, relieve symptoms of illness, and restore health. CAM may be provided alongside conventional medicine; for example acupuncture is now provided in some GP surgeries
- complementary therapies are often expensive and can usually only be accessed privately. An hour-long session can cost between £20-£40. This combined with problems accessing services, which are often provided in relatively affluent areas in beauty salons, gymnasiums or private practice, means that poorer sections of the community are unlikely to access these services
- although there are as yet no government guidelines as to the use and regulation of CAM, organisations such as the Prince of Wales Foundation for Integrated Health are encouraging the complementary healthcare professions to develop and maintain statutory or voluntary systems of self-regulation

## Demand for CAM

- public interest in CAM has increased in recent years: a 1989 survey indicated that 74% of the public surveyed were in favour of CAM being made widely available within the NHS
- estimated lifetime use of six named therapies (acupuncture, osteopathy, chiropractic, herbal medicine, hypnotherapy, homeopathy) is approximately one in four adults (one in three if reflexology and aromatherapy are included). In any year it is estimated that 11% of the adult population visited a complementary therapist for one of these six named therapies
- unmet need for complementary therapies was not a major issue during community consultations, but CAM did feature in several NDC plans and was identified as a health theme project area common to a number of NDCs

## NDC Approaches to CAM

- the aim of the NDC CAM projects is generally to tackle this inequality in access by providing affordable CAM within, or in association with, the health care services available to NDC residents
- the local NDC projects have taken a number of different approaches to include CAM in their health programmes. The approaches differ in their:
  - aims: addressing issues around
    - chronic physical illness
    - aids to improve mental health
  - provision:
    - large-scale provision of CAM is being achieved through the provision of subsidised services available to the whole population
    - taster sessions or smaller initiatives have been incorporated into health awareness days and into other larger projects such as drug use prevention projects

- the case study neighbourhoods visited were Bristol, Salford and Sheffield. Information from Newcastle NDC is also included as it has an innovative project that is highlighted as an example of good practice in a case study report on renewal.net

### **Emerging findings - process issues**

- generally consultations with local residents and with primary care, represented both by Primary Care Trusts, who are responsible for commissioning services, and individual general practitioners, who provide primary care within the NDC areas, have been key to successful development of these projects
- the scale of projects providing complementary therapies varies widely and this is reflected in the scale of funding associated with these projects. As well as NDC funding, many projects have also obtained funding from other sources such as Salford's funding from the Foundation for Integrated Health. Some projects, such as Bristol's, are part funded by user fees
- different approaches have been taken on the issue of whether to charge for complementary therapies. There is a divergence of policies, which may reflect differences in local circumstances, with a nominal charge considered to represent a deterrent in some areas and for some populations, but not in other areas
- projects with strong co-ordination and partnership working will be those best prepared for continuing after NDC funding is no longer available. They also tend to be the projects with the most positive community feedback and involvement

### **Emerging findings - barriers and facilitating factors**

- all projects are being evaluated, through monitoring of process e.g. number of sessions run, and evaluation of user satisfaction. It could be argued that since there is often a lack of conventional evidence of the effectiveness of the therapies being offered, for example from clinical trials, local evaluations are particularly crucial to identify both the benefits and any potential side-effects of the interventions offered
- one of the key benefits of these projects is making CAM available within deprived neighbourhoods, improving access by removing the barriers of both cost and geographical distance. Increasing the use of these therapies and subsidising cost contributes greatly to reducing inequality in access to these forms of health care
- these projects have also started to identify needs for training and supervision of alternative practitioners and identified needs in primary care, which they may be able to address, as well as identifying the demand for these services within the community
- the ability to build on initiatives pre-dating the NDC and work with effective partners have been factors in the successful development of CAM projects
- provision of complementary therapy is a field in which partnerships with the local health services have started to show early successes in terms of delivery of interventions for which there is significant local demand. Partnership working with the NHS is likely to be a key factor in determining the sustainability of projects and in encouraging appropriate circumstances for mainstreaming
- the main issue hampering the development of CAM projects has been the relatively low priority given initially to health-related projects in NDC areas
- where staff have held posts with responsibility for more than one NDC theme, for example in Sheffield where the lead officer for health is also the joint crime lead, this appears to have slowed progress overall in the health theme as other themes have been given greater priority. However this has also proven advantageous in facilitating joint working and led, in Sheffield, to the incorporation of the CAM project into the drugs prevention work

- the CAM projects have experienced some staffing problems, but the people involved, largely therapists, are highly motivated and issues such as staff turnover due to short term contracts and dissatisfaction, are not generally identified as key issues in this project area
- the potential problem of accommodation has also been overcome in most cases by the provision of space in GP surgeries for the interim period while healthy living centres or other new community health venues are becoming established

## **Conclusions**

- some CAM projects have been very successful at integrating with primary care and using NHS premises to deliver interventions. Primary care may need to be encouraged to get more involved in these types of partnerships
- CAM interventions can provide short term, measurable benefits in NDC communities. However, as most CAM projects are relatively small scale and changes in quality of life in participants is generally not being formally assessed, even popular and effective projects are unlikely to demonstrate measurable quantitative health change at a population level

# 1. Introduction

## 1.1. What is Complementary and Alternative Medicine (CAM)?

Complementary and Alternative Medicine (CAM) is a title used to refer to a diverse group of health-related therapies and disciplines which are not considered to be a part of mainstream medical care. Other terms sometimes used to describe them include:

- natural medicine
- non-conventional medicine
- holistic medicine

CAM offers a range of therapies which may be used to:

- prevent illness
- relieve symptoms of illness
- restore health

CAM may be provided alongside conventional medicine; for example acupuncture is now provided in some GP surgeries. Other alternative therapies, such as Chinese medicines, may be used by some communities instead of modern western medicine. There is a growing acceptance that CAM has a place in provision of holistic health care and alongside this a concern that they should be subject to the same requirements for evidence of safety and effectiveness as conventional medical treatments. There is increasing organisation and regulation of alternative practitioners, although the extent to which regulation is needed, and the need to develop an evidence-base similar to that of conventional medical care is still a controversial area.

This report focuses on projects providing Complementary and Alternative Medicine (CAM) interventions to NDC residents.

## 1.2. Background

A recent British Medical Association report on acupuncture found that 79% of GPs would like to see acupuncture provided by the NHS. However, currently 90% of CAM in the UK is purchased privately at a cost of around £450 million. Public interest in CAM has increased in recent years: in 1989 a survey indicated that 74% of the public surveyed were in favour of complementary medicine being made widely available within the NHS. A more recent survey provides an estimate for lifetime use of six named therapies (acupuncture, osteopathy, chiropractic, herbal medicine, hypnotherapy, and homeopathy) of more than one in four adults (one in three if reflexology and aromatherapy are included). In any year it is estimated that 11% of the adult population visit a complementary therapist for one of these six named therapies.

An increasing number of primary care practitioners are themselves learning complementary techniques. This gives them a wider range of therapeutic options and this integrated approach to care (orthodox and complementary therapy) fits well within the “whole person” perspective of primary care. An integrated approach emphasises the patient’s own role in health and disease and some believe has the potential to reduce demands on conventional health services (NHS Alliance, 2000).

An inquiry by the House of Lords was mounted in 2000 due to a widespread appreciation that CAM use is increasing not only in the United Kingdom but also across the developed world, and this appeared to raise several important questions of

substantial significance in relation to public health policy. Although there are as yet no government guidelines as to the use and regulation of CAM, the Prince of Wales Foundation for Integrated Health is encouraging the complementary healthcare professions to develop and maintain statutory or voluntary systems of self-regulation. The Foundation aims to "increase the capacity for high quality and appropriate research into complementary medicine and integrated healthcare and to support the complementary healthcare professions in their development of nationally recognised standards of education and training." The Foundation is also involved in increasing access to integrated healthcare, increasing the amount of information about integrated healthcare available to patients, practitioners, press and the public and actively raising additional funds in order to facilitate integrated healthcare in the UK.

CAM is often expensive and can usually only be accessed privately. An hour-long session can cost between £20-£40. This combined with problems accessing services, which are often provided in relatively affluent areas in beauty salons, gymnasiums or private practice means that poorer sections of the community are unlikely to access these services. The aim of the NDC CAM projects is generally to tackle this inequality in access by providing affordable complementary and alternative therapies within, or in association with, the health care services available to NDC residents.

As well as interventions aimed at directly improving physical health, NDCs are becoming increasingly aware of the need to improve the mental health of their populations. CAM is believed to relate to both of these objectives and the NDC projects reflect diversity in the type of therapy offered and the primary impact of improvement in mental or physical health.

### **1.3. Research approach**

Information for this report on CAM projects was collected from four main types of sources. An initial review of the current published literature on CAM was followed by a review of NDC documentation, such as delivery plans and Partnership reports, available from the Partnerships or from the CRESR (Sheffield Hallam University) web pages. This information was supplemented by direct contact with NDC Partnerships (mainly by telephone and email) and a number of case study visits.

Although unmet need for CAM was not necessarily a major issue during community consultations, CAM did feature in several NDC plans and was identified as a health theme project area common to a number of NDCs (see appendix for details). As it was not possible to make contact with all the Partnerships and the information available was often limited and outdated it is important to note that other complementary therapy initiatives may exist or may be under current development that are not identified in this report. Also in some cases CAM appears within other larger projects and therefore may be difficult to identify from the limited information available.

### **1.4. NDC approach**

Local NDC projects have taken a number of different approaches to include CAM in their health programmes:

- different aims
  - some addressing issues around chronic physical illness
  - others focus on using CAM as an aid to improve mental health
- different types of provision:
  - in a few cases relatively large scale provision of CAM is being achieved through the provision of subsidised services available to the whole population

- in many other cases taster sessions or smaller initiatives have been incorporated into health awareness days and into other larger projects such as drug use prevention projects

Subsequent to mapping CAM projects underway in NDC areas, we have selected, visited and studied in depth three NDC Partnerships with CAM projects. This report is largely based on these case studies which were selected to include a variety of approaches and innovative ways of working. They were also selected to reflect projects in varying stages of development. Three neighbourhoods were visited to conduct in depth interviews with health theme leads and other relevant staff from both NDC and, where possible, key partner agencies.

The **case study neighbourhoods are Bristol, Salford and Sheffield. Information from Newcastle NDC is also included** as they have an innovative project that is highlighted as an example of good practice in a case study report on renewal.net. Details of these projects are given in the boxed case study descriptions within this report.

## 2. Objectives of NDC CAM projects

The objectives of CAM projects are varied and reflect the different ways in which services have developed. Some projects only aim to provide a specific service, others have much broader objectives around promoting the development of CAM services in an area and establishing CAM provision within mainstream NHS services.

### Bristol

CHIPS (Complementary Health in Partnership) provides complementary health services locally, focusing on employing local unemployed therapists and charging low treatment costs currently subsidised by NDC monies. The ambitious aims of this project include not only providing a high quality CAM service, which is accessible and affordable to the whole community and will promote and improve the health of local people, but also to secure long term funding and promote the development of CAM locally.

The specific objectives for the post-pilot stage of the project are to:

- increase delivery of CHIPS services to an average of 50 treatments a week
- research and monitor the viability of the project within the NHS
- introduce additional therapies to the range already available
- develop a long term funding strategy working from within the Wellspring healthy living centre and other locations
- continue to promote the use of complementary therapies through group work and taster events
- continue to improve the service following the Action Research and continued monitoring and feedback from stakeholders

### Salford

The intention is to ensure that services are integrated into the mainstream so they are ready for delivery on completion of new community health buildings.

As part of this process of modelling delivery of integrated services the project aims to:

- provide a range of complementary therapies delivered where possible by local therapists, in response to local demand
- address some key health problems within the locality
- work with mental health need, long term and enduring illness (and any associated carers) as well as with single parents and their children
- provide health programmes designed to encourage community engagement in services while promoting and developing awareness, self-esteem and personal coping skills

The overall purpose is to bring all the different ways of working together to be re-evaluated and redesigned to produce services that are more integrated, accessible and responsive to the community's needs. It is hoped that this process is building, strengthening and sustaining partnerships with the local community, community groups, health workers and the PCT. By providing a range of health programmes the project aims to address some of the issues that affect an individual's sense of well-being. These include developing self-confidence, which in turn can affect their employability, which will have an effect on levels of long-term poverty experienced in the community. By raising health awareness the programme aims to encourage engagement in a range of services, addressing the major issue of engagement across the NDC community. The integration of complementary therapies through this scheme may also play a role in reducing inequalities in access to health services by offering alternatives to existing services that may not be accessed equally by all population groups.

## **Sheffield**

A number of specific plans have been made for the first year of an innovative project working with the Drug Action Team to provide CAM services for drug users and their families. A service manager and a stimulants worker have been appointed to develop and manage a locally based service in Burngreave. They are responsible for recruiting an administrator and two part time therapists, while North Primary Care Trust and Sheffield Drug Action Team provide strategic management, consultancy, and support the manager to establish referral protocols with projects including GP practices. The project was advertised to GP practices, local drugs projects, criminal justice projects and will also accept self-referral. The overall plan operates a daily programme of free complementary therapies, including auricular acupuncture, shiatsu, reflexology and exercise sessions. Auricular acupuncture is also carried out by the stimulant worker, who assesses service users on initial contact and provides brief harm reduction interventions.

Sessions are open to people from the NDC area experiencing problems with substance misuse themselves or within their families. At the same time local complementary therapists have been offered training to increase their skills in working with drug users to enable them to benefit from job opportunities created by the project. Health professionals and voluntary and community groups working with users have been offered training to promote the effective use of complementary therapy in treating stimulant users.

## **Newcastle**

Complementary therapy was identified as a high priority by the Community Action on Health (CAH) team. Particular issues were a demand for a wider range of therapeutic choices by local people and inequity of provision was highlighted, as privately funded complementary therapy was beyond the reach of people on low income. Previously

some progress had been made in increasing the range of provision through local voluntary sector providers - the Riverside Project and the West End Health Resource Centre (Healthy Living Centre). In 1999 the decision was made to approach Newcastle West PCG to determine the feasibility of providing a service within the NHS and a steering group was established, comprising representatives from the PCG, CAH, local GPs and complementary practitioners.

The following key principles were agreed by the group:

- the aim should be to integrate general practice and complementary medicine
- the service would target people on low income who were unable to afford complementary therapy
- a range of therapies would be provided with a focus on those with a strong evidence base
- all therapies would be free at the point of delivery
- the cost-effectiveness of the service would be evaluated

### 3. Process issues

#### 3.1. Consultation

Generally consultations with local residents and with primary care, represented both by Primary Care Trusts, who are responsible for commissioning services, and individual general practitioners, who provide primary care within the NDC areas, have been key to successful development of these projects along with benefits from building on pre-existing initiatives, where they exist.

- **Consultation with residents:** In Salford local consultations for the Salford Health Investment for Tomorrow (SHIFT) redesign of services identified a desire in the community for the provision of more treatment choice including complementary therapies. In the 'Salford Community Plan' the health priority expressed by local people is stated as

*"to improve the health, well being and social care of the people of Salford, reduce inequalities in health and create a modern health service designed around people's needs."*

In designing this project there is the underlying belief that complementary therapies can play a significant role in helping to deliver these requirements by improving health outcomes and changing approaches to social care.

- **Consultation with primary care:** In Bristol the consultation asked GPs what services they would refer to, and what should be available, as well as involving residents from the beginning. A group of local community workers and complementary therapists formed a Steering Group, worked up a funding bid and work plan to develop a project which would provide complementary health services locally - focusing on employing local unemployed therapists and charging low treatment costs which would be largely subsidised by the NDC money. The Steering Group developed a constitution and named themselves CHIPS (Complementary Health In Partnerships)

The object of the Bristol group was to increase the awareness and availability of complementary therapies to the residents of the NDC area. During this time all the

critical project developments were discussed and consulted with local partners - voluntary groups, GP practices, and other health agencies. Issues such as therapy locations, treatment prices, eligibility, equipment needs, staffing needs, job descriptions, therapist responsibilities etc. were discussed and agreed.

- **Consultation with local groups and other initiatives:** Sheffield community consultations for the development of the 10-year delivery plan identified high levels of substance misuse as a major cause of ill-health locally. The 10-year plan identified the need

*“in partnership with the Sheffield Drugs Action Team and local service providers, (to) develop and implement plans to reduce levels of, and harm resulting from, substance misuse”*

Research studies conducted by the Black Drugs Service, Drug Action Team and Rockingham Drug Project identified stimulants such as crack cocaine and khat as the predominant drugs used by drug users in Burngreave. This project was developed in consultation with citywide and local drugs projects and the Sheffield Drug Action Team. Those consulted included Sheffield Black Drugs Service, who have undertaken extensive research and training with Burngreave's black communities and Women on the Edge, a local project for African-Caribbean and Asian women whose partners are drug users.

Consultation in Sheffield with drug projects and other community projects and members revealed concerns that users would not access a project based in primary care because of having to acknowledge drug use and have this recorded on patient records. Community members were also adamant that centralised projects, which had been funded to deliver services in Burngreave, had failed. A project designed for Burngreave and delivered in Burngreave, with an identifiable physical base, was therefore requested by the local community.

The Newcastle West PCT has always had a commitment to public involvement and, for the last six years, together with the Health Action Zone, has funded a community health project, Community Action on Health (CAH). CAH employs a full time community worker and works with over 100 local groups to identify health needs. It also runs an annual Community Health Conference, which agrees priorities for further development and it was through this work that complementary therapy was identified as a high priority.

### **Bristol (Barton Hill)**

The NDC area comprises four neighbourhoods within the two Bristol wards of Lawrence Hill and Easton and an estimated 6,100 population. Both wards are ranked amongst the 10% of wards most deprived in England. Worklessness stands at 17%, 28% of households are in receipt of income support, and residents are relatively more likely to die at an earlier age. The area is currently in a state of transition with 12% (2001) of the community comprising members of black and minority ethnic groups, compared with 4% in 1991. Overall the area is becoming more culturally mixed, and residents are becoming more vulnerable to social exclusion and less attached to living in the area.

- 23% have a limiting long-term illness
- quality of, and access to health facilities are rated more highly than the NDC average: access to doctors is seen as easy by 83%
- the standardised illness and disability ratio was 155.59 (2001)
- the standardised mortality ratio was 154.05 (1997-2000)
- the estimated proportion of the population suffering from depression, anxiety or psychoses was 24.5% (2001)

#### **Interventions**

CHIPS (Complementary Health in Partnership)

Following two successive eight-month pilots, the project is now match funded for three years.

- CAM sessions take place at local GP surgeries and patients pay nominal fee of £5 (£3 concessions) and can receive up to eight sessions in total, unless extra access is granted. The therapists are paid £20 and provided with premises. The target groups for the CHIPS project are the unemployed, elderly, disabled, those receiving income support or other benefits and anyone suffering from health problems who is dissatisfied with traditional treatments. CHIPS accepts referrals from GP's, health workers, the CAAAD (Community Action Around Alcohol and Drugs) project as well as self-referrals from the NDC area.
- Group sessions and taster events are run in partnership with other projects, e.g. working with: baby massage, auricular acupuncture for older people, work with women's groups and Somalian groups, etc

### **3.2. Resident involvement**

Resident involvement in CAM projects varies from being involved in initial consultations only through to forming steering groups and training of local CAM practitioners.

In Bristol residents have formed a steering group, CHIPS (Complementary Health in Partnerships), of therapists, other community workers, and interested people. During the consultation process they asked local GPs what services they would refer to, and what should be available. Residents were involved from the earliest possible stage in identifying demand for this service. Barton Hill Settlement initially provided a selection of introductory courses to Reiki, Indian Head Massage and Aromatherapy. Also to address the training needs of local people, who wanted to become therapists, CHIPS agreed to offer adult Further Education and Training Certificates to CHIPS therapists. Due to funding limitations they are now not able to offer this; however staff do advise interested people where to go for information and possible funding e.g. Employment Links and the Barton Hill Settlement. A library of reference books and college prospectuses is also being compiled.

In Salford the project is managed by Big Life Services but the intention is to hand over its management to CHAP (Community Health Action Partnership) when appropriate. This will be done through the creation of a steering group, which will include local representatives, to guide and oversee the project.

In Sheffield, ideas arising from consultations were fed into the development of the project e.g. community members expressed a wish to see services delivered in an identifiable physical location in the area as opposed to project funded sessions delivered in primary care settings, which might be outside the NDC area.

### **3.3. Partnerships**

The CAM projects are particularly good at engaging key local partnership agencies such as Primary Care Trusts and local GPs, as well as national bodies such as the Prince of Wales Foundation for Integrated Medicine. Local health services are involved in these projects in a number of different ways:

- PCTs are providing some funding
- general practices make accommodation available
- as well as partnership and practical support, there are examples of leadership from PCTs and health professionals, e.g. a Director of Public Health (Bristol North PCT) provides leadership for the CAM project, which helps to raise project credibility and profile with other health professionals

Partnership working is identified as a "significant characteristic" of Complementary Health in Partnership (CHIPS) in Bristol as there is close liaison with GPs and the local Community Action Around Alcohol and Drugs (CAAAD) project. Each general practice is represented on the steering group and, along with other health professionals, contributes to developing local services. The NDC has effective joint working initiatives, including referring across services, and is developing regional and national links with related organisations.

The CHIPS partners are:

- Corbett House Surgery, Corbett House Clinic, Lawrence Hill Health Centre: GP's and health workers based at these locations refer to the project, the project also uses room space at each of these locations to deliver therapies
- CAAAD (Community Action Around Alcohol and Drugs) - refer to the project and provide room space etc
- New Deal Shop: provides front line referrals to interested residents and use of space to deliver therapies
- Health development worker (NDC)
- Prince of Wales Foundation for Integrated Medicine (PWDIM): CHIPS won an award to be part of their Integrated Healthcare Collaborative, sharing best practice
- Healthy Bristol: provided a lot of help with PWDIM award bid, also provided good initial bridge with local GPs and help with GP education
- University of Bristol: several members of the Research Group
- Mid Devon Primary Care Trust: members of the Research Group
- Barton Hill Settlement: CHIPS works with several community projects based here delivering group work and taster events

In Salford the main partner for health projects is the Big Life Company who have a strong track record in developing and delivering health projects in community settings and is involved with capacity building in the area. In addition, the Prince of Wales's Foundation for Integrated Health have provided funding (£10K) to support a series of seminars providing 'expert' advice and guidance on the processes required to achieve integration. Salford PCT have also give support to the delivery of complementary therapies within the new Local Improvement Finance Trust (LIFT) building and are willing to look at the possibility of the integration of services as part of Salford Health Investment for Tomorrow (SHIFT) redesign work.

In Newcastle the three year pilot is jointly funded by Newcastle Westgate New Deal for Communities (NDFC) and Newcastle PCT. Funding also covers transport and the production of patient information leaflets, whilst practices provide space free of charge, and the time of the Project Manager is funded by the PCT. A steering group, which meets every other month, manages and directs the pilot project and tackles any issues brought to the group as they arise. The group also assesses the appropriateness of providing treatments to individual cases arising from requests by GPs from the surrounding area. In addition the meetings provide a forum for clinical supervision and education as the practitioners can discuss cases with the GP providing clinical support.

In Sheffield the main partners are:

- Women on the edge (family support) who provide out reach work
- North Sheffield PCT who provide Strategic Management and Consultancy and help the liaison with local GPs
- Drugs Action Team - providing Strategic Management and Consultancy

### 3.4. Funding

The scale of projects providing complementary therapies varies widely and this is reflected in the **scale of funding** associated with these projects. As well as NDC funding from around £60K to £230K, many projects have also obtained funding from other sources such as Salford's funding from the Foundation for Integrated Health. Some projects such as Bristol's are part funded by user fees. The intention is that NDC funding in Bristol will eventually reduce from providing 100% of the project costs to providing only 40%. Plans to identify alternative or additional sources of funding include looking for research funding and combining a number of large and small grants from different sources. Bristol have also been supported through rent-in-kind, where locations have donated rooms freely where therapies can take place. In Sheffield the complementary therapy project is funded as a part of a £1.5 million drugs project.

**Projects have taken different approaches to the issue of user fees** and there are both economic and cultural reasons why user fees may be more or less acceptable in different areas. Local decisions are generally based on local views rather than any empirical evidence of the impact of user fees on specific local populations; as such evidence is difficult for projects to identify. Some project managers believe that charging for CAM services ensures that users value them, whilst others are more concerned that charges will reduce access for those population groups who would benefit most from such services. Involvement of the local community in project development should help to ensure that any proposed user fees are set at levels that are seen as fair and do not prevent a new service being accessible to members of the local community.

### **Salford (Charlestown and Lower Kersal)**

Charlestown and Lower Kersal NDC lies within the inner city of Salford. The New Deal area includes distinct communities and pockets of housing as well as an industrial area, the student village of Salford University, and large areas of green land. The area is typical of Salford's many tight-knit and relatively stable communities and the majority of people have lived there over ten years. The NDC has a small black and minority ethnic population of 6%. The NDC area is included in wards, which are ranked 201<sup>st</sup> and 542<sup>nd</sup> most deprived (10% most deprived) wards using the Index of Multiple Deprivation.

- 31% report having a limiting long-term illness
- 85% of users are satisfied with the local hospital
- the standardised illness and disability ratio was 207.66 (2001)
- the standardised mortality ratio was 171.53 (91997-2000)
- the estimated proportion of the population suffering from depression, anxiety or psychoses was 23.7% (2001)

#### **Intervention**

- The project started as a £1000 "Real Time Community Change" project, the idea coming from interested individuals within the community and also driven by an existing HAZ project. Therapists are brought in from other agencies to do work on complementary therapies.

The main focus of the project is to design and deliver integrated pathways of health care, including bringing complementary health treatments into mainstream service provision. A key aspect to the project is the involvement and support of the PCT. The Foundation for Integrated Health is supporting the process with its information, networks, collective experience and strategic guidance. The intention is that services are integrated into the mainstream ready for delivery at the new community health buildings managed by CHAP (Community Health Action Partnership).

The main beneficiaries of the project within the NDC area are:

- people with mental health problems, especially those who are seen to have mild to moderate problems, i.e. people with anxiety, depression, or experiencing some other kind of stress related disorder (this may include refugees living in the locality)
- people with chronic or enduring health problems, and their carers
- single parent families and their children

### **3.5. Assimilation and dissemination**

A number of **approaches** are being taken **to assimilate** and **disseminate** the emerging findings from the various projects being carried out by the various NDCs, including production of archives and publications.

In Bristol CHIPS has developed a referral database to record the number of local residents accessing the scheme, recorded personal details, therapies accessed, referral route, number of treatments and number of non-attendances. This is designed to facilitate subsequent evaluation of the project and can be used in future planning for continuation of the service. CHIPS is also undertaking some Action Research of the project, involving interviews with key stakeholders, the learning from which will help optimise the service.

Bristol CHIPS are also beginning to create a 'Best Practice Complementary Health Research' library containing information on similar UK projects and successes. CHIPS won an award to become one of five projects in the Prince of Wales Foundation of Integrated Medicine's Integrated Healthcare Collaborative. Amongst other things this has involved being provided with funding to take part in a series of conferences, with the objective of helping to develop and disseminate learning as well as some funding towards individual project development. The Lords report recommended developing key centres of excellence for research into CAM. Bristol University is one of these centres, and is involved with the CHIPS research group in the development of a clinical based research model to evaluate the use of Integrated Health Clinics in General Practice, based on the CHIPS model. It will look at the following questions:

- what is the effect on patients' health status?
- what are the health care costs and savings?
- what are the problems and benefits perceived by patients and healthcare providers?
- what are the essential elements within the particular service offered which are related to success or failure of this model of healthcare provision?

It is hoped that this, and similar research, will help convince the PCT and other funding bodies of the benefits of financing ongoing complementary therapy services.

In Newcastle, GPs are kept informed of the progress of the pilot through a newsletter, which includes examples of typical cases referred to practitioners, of those that respond best, and details of waiting list times.

### **3.6. Mainstreaming**

Selected key agencies for mainstreaming CAM projects vary, depending on the population who have been targeted, but they will include large agencies such as PCTs through to local drug action teams.

It is hoped that eventually funding for the whole Sheffield drugs project, including the CAM, will be provided by the Government's Drugs Action Team (DAT) pooled treatment budget. This will ensure that substance misuse services within Burngreave, including the innovative use of complementary therapies, become a key component of services city-wide.

In Bristol, through the Prince of Wales's Foundation of Integrated Medicine, the NDC are also researching other examples of CAM projects that are starting to deliver integrated services with the co-operation of the PCTs:

*"We are using the learning from these (other projects) to help us adequately prepare for integrated approaches, as well as guiding us through the many pitfalls that exist in this process...the ideal would be PCT funding but is a long way down the line"* (CHIPS co-ordinator, Bristol)

Before the Newcastle NDC CAM pilot was implemented, local policy was not to fund provision of complementary therapies. The positive results from the evaluation of the project resulted in a recommendation from both the PCT Professional Executive Committee and NDC Board to pursue the feasibility of developing complementary therapies for the treatment of pain management and mental health issues, as potential options for increasing capacity and patient choice. This development will take time and the agreement does not, as yet, assure future funding. To maintain the current project and retain the expertise of the practitioners, the PCT is funding the pilot for a further year.

### 3.7. Monitoring and evaluation

All projects are being evaluated, by monitoring progress against process targets, e.g. number of sessions run, user satisfaction, and health benefits. It could be argued that since there is often a lack of conventional evidence, for example from clinical trials, of the effectiveness of the therapies being offered, that local evaluations are particularly crucial to identify both the benefits and any potential side-effects of the interventions offered.

- **Process measures**

Process measures can be collected to assess service delivery and use, but they will be of more benefit in assessing service achievements if they can be compared against previously set targets. Salford provides an example of monitoring progress through the collection of process data, whilst Bristol has gone one step further and are comparing actual achievement against proposed achievement.

During two and a half years of the Salford pilot, GPs referred over 650 patients to the service. Forty-one GPs accessed the project, including at least one from each practice in the area. Throughout the pilot the following process measures were monitored as well as client satisfaction with the service:

- number of attendances
- ethnicity of attendees
- non-attendance rates 'DNAs'
- number of sessions attended
- use of conventional drugs

Bristol NDC has set process targets, based on pragmatic consideration of space and staff availability and finance. Their target is the provision of 100 treatments per quarter.

- **Satisfaction with the service**

In Salford all local people accessing treatments or attending health programmes are being asked to complete service satisfaction and evaluation forms.

*"Evaluation is of major concern to all those within the complementary therapies field as we try to gain recognition for our work and demonstrate the benefits which we feel can be made available for all" (Salford)*

Nearly all (96%) patients were satisfied with their treatment, with 62% of these being extremely satisfied. There were 42 positive comments and only eight negative ones from the satisfaction surveys and these largely related to the short-term nature of the relief obtained and a perceived need for more frequent treatments. The project has a steering group who are overseeing the monitoring and evaluation and whose role is also to identify the best approach "to be adopted by the PCT in the long-term."

Positive feedback has also been obtained from satisfaction surveys in Bristol. Results are available from an evaluation of the CAM project by CHIPS. A survey of clients and health workers indicated high rates of satisfaction with the service, from referral through to treatment. Full details of the survey results are given in Appendix 2. Evaluation of individual treatments was based on completion of a

monitoring form on first and last treatment plus a community regeneration based questionnaire, although for further evaluation, the NDC are looking at using a tool more appropriately designed for evaluating alternative therapies.

- **Change in health status**

To evaluate progress, Salford is using a baseline health assessment of participants, which includes the MYMOP questionnaire, a widely used nationally validated assessment tool. Individual outcomes are being mapped against overall targets. Alongside their evaluation of impact on outcomes in different health conditions, they are also monitoring the uptake of services by different age groups and ethnic groups.

Findings to date show that six months after the first treatment 58% of patients reported improvement, 37% remained the same and 5% got worse. From the patient satisfaction surveys, 83% of patients reported that they required no further treatment from their GP during treatment and for six months after. Over two thirds (69%) of GPs supported the continued provision of complementary therapies within the PCT.

- **Other issues**

Further evaluation of CAM services in any of the NDC areas might demonstrate potential savings if the service can be shown to have successfully.

- reduced health service use (fewer admissions/ referrals or fewer GP contacts) or
- increased worker productivity (including fewer days lost at work or fewer benefits claimed)

However, such an evaluation would require a more robust research design using a comparison group not accessing the project therapies, but this is still a consideration for the future.

Whilst some NDCs have been evaluating their CAM interventions from commencement of provision, other NDCs are still planning the evaluation programme. In Sheffield a mid term evaluation is planned for 2004/05 to look at ongoing service delivery, including additional therapies being offered through employing additional therapists and through providing placements for trainees. The evaluation will also review the experience of users, families and other agencies. The evaluation report and future strategy will be produced in 2005/06 and will feed into service development.

## **4. Emerging benefits**

Many of these CAM projects are in their relatively early stages and the health benefits and other outcomes will become clearer as they develop. However, some key messages are already emerging from the more established projects, which are discussed below.

### **4.1. Local subsidised provision**

Some of the key benefits of these projects for making CAM available within deprived neighbourhoods include improving access by removing the barriers of both cost and geographical distance. Increasing the use of these therapies and subsidising cost contributes greatly to reducing inequality in access to these forms of health care.

*"By integrating services and therefore changing the way services are delivered the project will make a difference through its contribution to increasing the take-up of services, as well as increasing patient choice and satisfaction, all improvements that are part of the city wide agenda for health, as well as the local NDC agenda. The project will also make a difference through a contribution to health improvements in the locality." (Salford)*

#### **4.2. Needs of service providers, primary care and the community**

These projects have started to identify needs for training and supervision of alternative practitioners. They have also identified needs in primary care, which such projects may be able to address, as well as identifying the demand for these services within the community.

*"The pilot has allowed us to start to think critically about clinical governance issues. Especially regarding the requirement for clinical supervision for the practitioners and the level of responsibility that the GP maintains if delegating to a practitioner that has no statutory regulated body. The pilot is to give us a measure of the level of demand both from healthcare professionals and the public." (Newcastle)*

#### **4.3. Co-ordination**

Projects with strong co-ordination and partnership working will be those best prepared for continuing after NDC funds are no longer available. They also tend to be the projects with the most positive community feedback and involvement. Some projects are exhibiting sound groundwork preparation.

In Bristol the first year was taken up in planning by the multi agency steering group to ensure thorough preparation before treatments began, pre-empting problems in their early stages. Liaison and involvement of GPs and health workers ensured consideration of national and local developments in primary care and built on pre-existing development and acceptance of CAM. Their plans are to mainstream and maintain the services after NDC funding ceases. This is a community issue, although also driven by health professionals in the area, so the community are likely to feel ownership and support the project.

In Newcastle they are building relationships between CAM practitioners of different disciplines and between CAM practitioners and GPs, and increasing health professionals' awareness and knowledge of CAM.

#### **4.4. Development of appropriate services**

The NDC projects allow the provision of services that the community feel are appropriate to the area and have not been imposed upon them. For example, the Salford projects target three categories of significant poor health where social factors are also involved. These are mental health, long term and enduring illness (together with any associated carers) and single parent families. Through the delivery of therapies, courses, activities, groups and classes, it is possible to make a difference to the way individuals are living their lives, which is expected to have a positive impact on health outcomes.

## 5. Emerging issues

### 5.1. Staffing and accommodation

One of the most common barriers to success identified in the NDC health projects so far has been that of staffing and accommodation. Although the CAM projects have experienced some staffing problems, the people involved (largely therapists) are highly motivated and issues such as staff turnover due to short-term contracts and dissatisfaction are not generally identified as key issues in this project area. The potential problem of accommodation has also been overcome, in most cases by the provision of space in GP surgeries, for an interim period while healthy living centres or other new community health venues are established.

#### **Sheffield (Burngreave)**

The Burngreave NDC area is in north east Sheffield, one mile from the city centre and adjacent to the Lower Don Valley. The Index of Multiple Deprivation score is 71.51, which puts it in the most deprived 10 per cent of wards in England. The area is ethnically diverse with a large and mixed ethnic minority population, mostly African Caribbean and Pakistani. There are significant Somali and Yemeni communities and there has recently been a large influx of asylum seekers. The 2002 Household Survey indicated that 12 per cent of NDC respondents had applied for refugee status and 52 per cent are from black and minority ethnic communities.

- users are consistently more satisfied with health facilities, 78% find access to doctors easy
- the standardised illness and disability ratio was 188.16 (2001)
- the standardised mortality ratio was 140.05 (1997-2000)
- the estimated proportion of the population suffering from depression, anxiety or psychoses was 24.0% (2001)

#### **Interventions**

1. complementary therapies are part of a 1.5 million-pound drugs project to provide education, support and therapies for users, their families and communities
  - a. the project provides complementary therapies primarily for crack cocaine and Khat users and their carers as part of their rehabilitation
  - b. the project provides training for local complementary therapists to improve their knowledge and skills around working with drug use issues
  - c. the project promotes the use of complementary therapies with drug users and their families, to statutory, voluntary, community health, and social care providers
2. Turning Point
  - a. this is a similar complementary therapies service at the Rockingham Drug Project in Sheffield city centre. NDC funding has allowed NDC residents better access to the service. This service has been in operation since 1997 and has expanded to include a comprehensive programme encompassing a range of free complementary therapies offered on a daily basis. The therapies include auricular acupuncture, shiatsu, Indian head massage, tai chi, relaxation and reflexology. This service is staffed by 6 workers and provides on average 468 client sessions per year. The service has been successful in supporting people in tackling their substance misuse problems,

particularly stimulant users. NDC funding has allowed NDC residents better access to this service

- b. the service operates a training service, which is staffed by experienced drug workers and has been in operation for two years. Training on a range of substance misuse issues is offered to professionals in South Yorkshire and within Turning Point nationally and is successful in providing high quality training to enable workers to improve their skills in working with drug users. Last year 45 professionals were trained

## 5.2. Working across NDC themes

Where staff have held posts with responsibility for more than one NDC theme, for example in Sheffield, where the lead officer for health is also the joint crime lead, this appears to have slowed progress overall in the health theme as the other theme has been given greater priority (crime is certainly seen as the more urgent priority in the Burngreave area). However this has also been advantageous in facilitating joint working as this has resulted, in Sheffield, in the incorporation of the CAM project into the drugs prevention work.

## 5.3. Community and GP relationships

The NDC boundary does not necessarily delineate a specific community or geographical area and projects and populations may need to straddle such boundaries. In Bristol, the NDC team have built up a relationship with a GP practice which was located outside the NDC area but which serves 45% of the NDC population, as well as one that is located within the NDC area.

*"Now the NDC GPs are...more interested - especially in osteopathy and chiropractic with a couple now on the Research Group and some attending the Steering Group meetings." (NDC Worker)*

## 5.4. Availability of appropriate data

A lack of good public health data can hinder progress. In most NDCs, because they are specifically designated to encompass areas of deprivation, their boundaries are not necessarily coterminous with either ward or enumeration district boundaries, which are the most commonly, used grouping mechanisms for routinely collected health data. Salford had problems linking health data to their NDC population.

*"The data we have access to is not post coded and we don't have the recent census data" (NDC worker, Salford)*

Similarly, the evidence-base for some therapies, especially CAMs is limited and that which is available is not necessarily robust. During development of guidelines for implementation of CAM practices in NDC areas, problems were identified with introducing orthodox research methodologies and further difficulties with finding good practice examples to cite:

*"...not many examples of integrated healthcare projects so we have to make a lot of it up as we go along, e.g. booking policies, therapists contracts" (CHIPS Co-ordinator, Bristol)*

## 5.5. Funding

Local arrangements for how projects are funded can result in restrictions to their development or additional time required to address administration issues. Staff in Bristol highlighted problems with funding NDC projects through the healthy living centre, where individual projects are not allowed to make a profit.

*"In three years we will have built up a 100 day reserve. But we are not allowed to fund health projects from that. The money has to go back into the main pot for the NDC and then to be applied for again."* (NDC worker, Bristol)

### **Newcastle (Westgate)**

Newcastle NDC (formally WestGate NDC) is situated in a predominantly residential belt to the west of Newcastle City centre. The NDC area covers approximately 4000 homes of various types and tenures in the Arthur's Hill, Cruddas Park, Elswick and Rye Hill areas. The topography (north to south slope) of the area as well as the transport infrastructure has been problematic for regeneration attempts in the past. Multiple communities of interest and identity co-exist in the area. The Index of Multiple Deprivation score for the NDC area is 64.47, which puts it in the most deprived 10% of wards in England.

- users tend to be less satisfied with doctors (80%) and access to doctors (66%) but they are more satisfied with local hospitals (86%)
- the standardised illness and disability ratio was 208.10 (2001)
- the standardised mortality ratio was 193.30 (1997-2000)
- the estimated proportion of the population suffering from depression, anxiety or psychoses was 23.6% (2001)

### **Interventions**

1. chosen therapists based in GP surgeries throughout the Newcastle West Locality provide complementary therapies. Access is via the patient's own GP, who maintains overall clinical responsibility for the patient's care. Any GP within the locality can refer/ delegate patients to any of the therapies. Transport is provided if patients have difficulty in travelling to any of the practitioners
2. the conditions chosen are those where the patient's needs were being poorly met by conventional treatments, such as chronic, painful and stress related conditions. Particular examples include asthma, migraine, back and neck pain, eczema, hayfever, anxiety and insomnia
3. a resource pack was produced which includes details on the method of referral, appointment systems, criteria for referral, time allocation to patients, and number and frequency of treatments for each therapy. Also in the pack is a copy of the GPC guidance on referral/delegation of patients to complementary practitioners, the personal details of the practitioners, (including contact numbers, background information on their training), and the forms used for evaluation
4. patient information leaflets have been produced for each of the therapies. These give brief background information about the therapy, what they should expect during a visit and what the usual course of treatment entails. The leaflets are kept within practices and are used by GPs during consultations with patients prior to referring / delegating care to the CAM practitioner. The leaflets were distributed to community settings promoting the pilot
5. discharge letters are completed which provide a summary of treatment and feedback on outcomes. If treatment for an individual is required for a period of

- more than six to eight sessions the GP is contacted by the CAM practitioner to discuss the progress so far and the appropriateness of continuation of therapy
6. the complementary therapies pilot clearly demonstrated that the complementary therapies provided are well tolerated, popular treatments, of which there is evidence of health improvement, and a cost offset for conventional care

## 6. Conclusions

Although CAM therapies may not have been initially identified very widely as key priorities for NDC communities, the demand for CAM services and the uptake of services, where they have been made available at no cost or low cost, suggests that the projects discussed in this report are meeting a need in NDC communities.

However the overall impact of these projects will be difficult to measure and it is likely that they are not being accessed equally across an NDC community. It will be useful to review these projects when they are better established to understand who is using the services and the extent to which the NDC projects have encouraged the integration and mainstreaming of CAM into community health services.

## References

House of Lords Select Committee on Science and Technology (2000) (6th Report): Complementary and Alternative Medicine  
<http://www.parliament.the-stationery-office.co.uk/pa/ld199900/ldselect/ldsctech/123/12301.htm>

Foundation for Integrated Medicine (2000) *Integrated Health Care: A Guide to Good Practice*.  
[http://www.fihealth.org.uk/fs\\_publications.html](http://www.fihealth.org.uk/fs_publications.html)

### **Key issues for NDCs in developing CAM-related projects**

- generally consultations with local residents and with primary care (represented both by Primary Care Trusts who are responsible of commissioning services and individual general practitioners who provide primary care within the NDC areas) have been key to successful development of these projects
- the CAM projects are particularly good at engaging key local partnership agencies such as PCTs as well as national bodies such as the Prince of Wales Foundation for Integrated Medicine
- the key agencies targets for the mainstreaming of CAM projects vary depending on the population who have been targeted. They vary from large agencies such as the PCT or health authority to local drug action teams
- as there is a lack of conventional evidence of the effectiveness of the therapies being offered (for example from clinical trials) the local evaluations is particularly crucial to identify both the benefits and any potential side-effects of the interventions offered
- projects with strong co-ordination and partnership working will be those best prepared for continuing after NDC funding is no longer available. They also tend to be the projects with the most positive community feedback and involvement
- when establishing CAM projects the potential problem of accommodation must be considered. This may be provision of space in GP surgeries for the interim period while healthy living centres or other new community health venues are becoming established
- a key to successful projects, whatever the topic, is local NDC staff with strong knowledge of the local area and the specific needs of the local community
- any health project does not deal with an isolated issue - Ensure cross cutting work in association with other NDC themes wherever possible

## Appendices

### Appendix 1 - Partnerships with CAM projects

<b>NDCs</b>	<b>Details and therapy provided (where known)</b>
Bradford	Aromatherapy project
Brighton East	Aural acupuncture Children's outreach
Bristol	Acupuncture, Acupressure, Aromatherapy, Chiropractic Indian Head Massage, Massage, Nutrition Advice Osteopathy, Reflexology, Shiatsu
Hartlepool	Initial taster sessions in various therapies
Hull	Support not pills
Newcastle	Homeopathy, Osteopathy, Acupuncture Aromatherapy/ Therapeutic Massage Shiatsu, Chiropractic (Six posts, one for each of the six complementary therapies, each provide a weekly four hour session (24 therapy sessions/wk)
Newham Westham Plaistow Rochdale	Directory of alternative therapies available in the area
Sheffield	Therapies provided for drugs users and their carers
Salford	(Large complementary therapies project for inclusion in new Healthy Living Centre)
South Kilburn	Healthy body and mind. Four sessional workers employed

## **Appendix 2 - Results of NDC evaluations of CAM projects**

### **Bristol Satisfaction Survey**

GP/Health workers survey:

- 100% confident referring to CHIPS
- 100% feel CHIPS is a useful service
- 100% feel it has had a positive impact on their patients
- 45% patients are very receptive to referral (45% fairly)
- 36% often refer patients (64% sometimes)

Clients survey:

- 49% received complementary therapies before CHIPS
- 62% felt referral to CHIPS was very good
- 89% felt the treatment they received was very beneficial
- 95% saw a direct improvement to their health
- 100% would like to see CHIPS become permanent
- 100% would use complementary therapies again
- 41% would pay £10; another 41% would pay £5