Data Source Descriptions –

CLiK, EQ-5D, WEMWBS, Healthy Foundations

The Current Living in Kirklees (CLiK) Survey 2012

The survey resulted from joint working between NHS Kirklees and Kirklees Council. The purpose of the survey was to provide information about the health and wellbeing of the adult population of Kirklees as well as health and social inequalities. This intelligence is vital for the planning and commissioning of services and programmes of work and for comparison purposes with the previous CLIK surveys in 2001, 2005 and 2008.

The survey was a postal self-completion questionnaire sent in March and April 2012 to a random sample of 55,000 households selected from the Kirklees Land and Property Gazetteer. One postal reminder (with another copy of the questionnaire) followed the first mailing to non-responding households. Ipsos MORI managed the survey mailouts and data entry, and provided a clean dataset, top-line results and preliminary data analysis.

The survey asked about a range of issues. These were chosen because they are known to have significant impact on health and something can be done about them locally. CLiK 2012 content included:

- Aspects of health status including perceptions of physical, mental and emotional health and wellbeing.
- Long-term conditions, illnesses and impairments.
- Self-care issues and support needs.
- Personal behaviours such as smoking, drinking alcohol, eating and being active.
- Health beliefs, attitudes and motivations.
- Being a carer.
- Employment status, type and income.
- Housing suitability.
- Perceptions of support networks, “social connectedness” and local area.
- Household composition, age, sex, ethnicity, sexual orientation, area of residence to identify groups of people.

The survey included instructions that it should be completed by an adult aged 18 or over. Over 12,500 completed questionnaires were received – a response rate of 23%. The results were weighted to be representative of the population of Kirklees.

An executive summary report and technical report for the CLiK 2012 survey are available via the Involve tool on the Kirklees Council website.

EQ-5D

The EQ-5D[1], developed by Euroqol, is a tool to measure health status. It is designed for self-completion by respondents and is ideally suited for use in postal surveys. It is a widely used, recognised and respected measure across the UK, featuring in the Health Survey of England and as an indicator of health status/quality of life in the latest NHS and Public Health Outcomes Frameworks.

The tool exists in a 3-level version (EQ-5D-3L) and a 5-level version (EQ-5D-5L). The 5-level version was used in the CLiK 2012 survey because it is sensitive to a wider range of health states for each of the five domains.

The EQ-5D-5L asks about the severity of problems being experienced today for five dimensions of health. These are mobility, pain/discomfort, anxiety/depression, self-care and usual activities. The responses record five levels of severity (no problems/slight problems/moderate problems/severe problems/extreme problems) for each dimension.

The EQ-5D also includes a Visual Analogue Scale (VAS), similar to a thermometer, which asks respondents to rate their health today on a scale of 0 to 100, where 0 means the worst health they can imagine and 100 means the best health they can imagine.

WEMWBS

The Warwick-Edinburgh Mental Well-being Scale[2] (WEMWBS) is a tool to measure mental wellbeing. It has been validated for use in the UK with those aged 16 years and over. The WEMWBS consists of 14 items (questions) that are all positively worded and relate to the respondent's thoughts and feelings in the previous two weeks. Responses are made on a 5-point scale. The WEMWBS is scored by summing up responses to each item. The minimum scale score is 14 and the maximum is 70.

The 14 items in the WEMWBS cover most attributes of mental wellbeing including both hedonic and eudaimonic perspectives. The hedonic perspective includes the subjective experience of happiness (affect) and life satisfaction. The eudaimonic perspective includes positive psychological functioning, good relationships with others and self-realisation.

References

1. Rabin R, Oemar M, Oppe M, Janssen B., Herdman M. EQ-5D-5L User Guide. Basic Information on how to use the EQ-5D-5L Instrument. Version 1.0. EuroQol Group; April 2011. Available from: http://www.euroqol.org (accessed 07 March 2013).

2. Stewart-Brown S, Janmohamed K. Warwick-Edinburgh Mental Well-being Scale (WEMWBS) User Guide Version 1. University of Warwick; June 2008. Available from: http://www.healthscotland.com/documents/2702.aspx (accessed 07 March 2013).

Healthy Foundations

Healthy Foundations (HF) is a segmentation model originally developed for the Department of Health to provide insights for social marketing to improve the effectiveness of healthy policy, campaigns and interventions[1].

HF meets the following criteria of a good segmentation model[2]:

- It defines a small number of groups so that all members of a particular group are as similar to each other as possible and as different as possible from the other groups.
- It builds on current knowledge.
- It provides a language for understanding people.
- It adds value when developing and targeting interventions.
- It is not too complicated.
- It is accessible.

What sets the HF model apart from other segmentation tools is that it is built on the three core dimensions of motivations, environment (social circumstances) and life stage. It is therefore consistent with the rainbow model of health and wellbeing. The HF model identifies five distinct motivation segments which differentiate people based on health attitudes and beliefs. The segments can be summarised as follows:

Unconfident Fatalists (UF) *have the lowest sense of control and self-esteem of all segments; have low resilience; are fatalistic; and have very low motivation levels to look after their health.*

Live for Todays (LFT) *generally have medium motivation levels and self-esteem; have short term fatalistic views; lack of concern for their future health and wellbeing; low resilience; and most resistant to change.*

Hedonistic Immortals (HI) *generally motivated by enjoyment and risk; show a lack of concern for their health and wellbeing; have high self-esteem and a positive outlook; can show resilience but need support.*

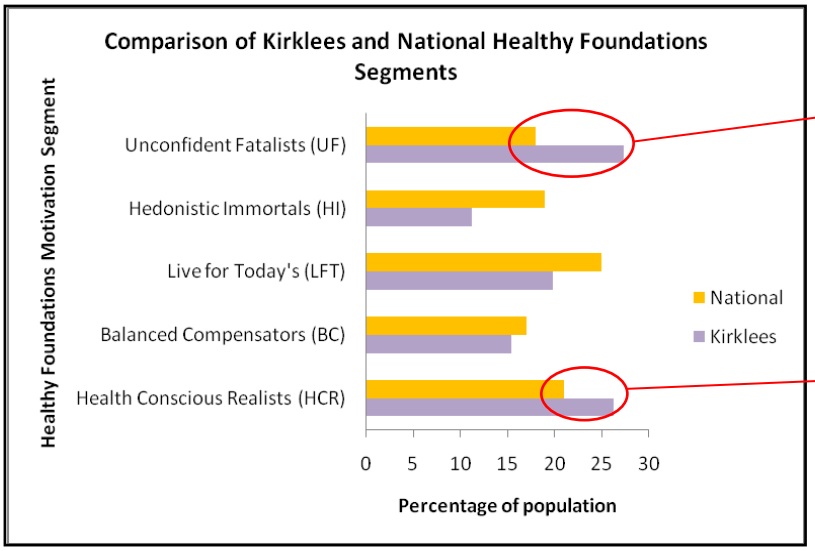
Balanced Compensators (BC) *generally have high levels of motivation to look after their health; have high self-esteem and sense of control; are high risk-taking (but will compensate for health risks); and are resilient.*

Health-conscious Realists (HCR) *are generally self-motivated; are comfortable with control and choice; see health as a priority; have high self-esteem and low levels of risk-taking; and are strongly resilient.*

Results from CLiK 2012[3] have provided us with a HF "profile" of the Kirklees adult population. Figure 1 illustrates how Kirklees compares with the national HF profile and

Figure 2 summarises some of the characteristics of each HF motivation segment in Kirklees. Further information (including pen portraits) about the segments can be found in the HF Quantitative Report[2].

Figure 1



The results from CLiK 2012 show clear patterns of association between health and wellbeing issues and HF segments. The findings for some key health and wellbeing indicators are summarised in Figures 3a to 3c. Similar findings were found in both the national HF development study and the Health Survey of England (HSE)[1] 2011.

The HF motivation segments are not intended to be used as labels for individuals or communities but provide us with a useful model for understanding people's health attitudes and beliefs and the impacts of social determinants. The qualitative component of the national HF study[4] has provided insight into the social and psychological dynamics of the five segments. The intervention approaches developed from this clearly describe the range of intervention, engagement and communication approaches that are needed for people in these distinct segments. Targeting people in this way is likely to be more effective than a blanket approach or one that targets people on the basis of demographic differences or geographic location.

Behaviour change interventions alone will not reduce health inequalities. The HF model is useful because it helps us to understand how motivations and behaviours are shaped by our environment and life stage, and why we need approaches that are both "top-down" and "bottom up" to tackle inequalities.

The national HF study explored the relationship between environment/ circumstances (deprivation level measured by IMD) and health attitudes/beliefs (motivation level) and identified four distinct quadrants. These represent the different ways people respond to their environment; namely **fighters**, **thrivers**, **survivors** and **disengaged**. There are some important practical implications from this. For example, asset-based community

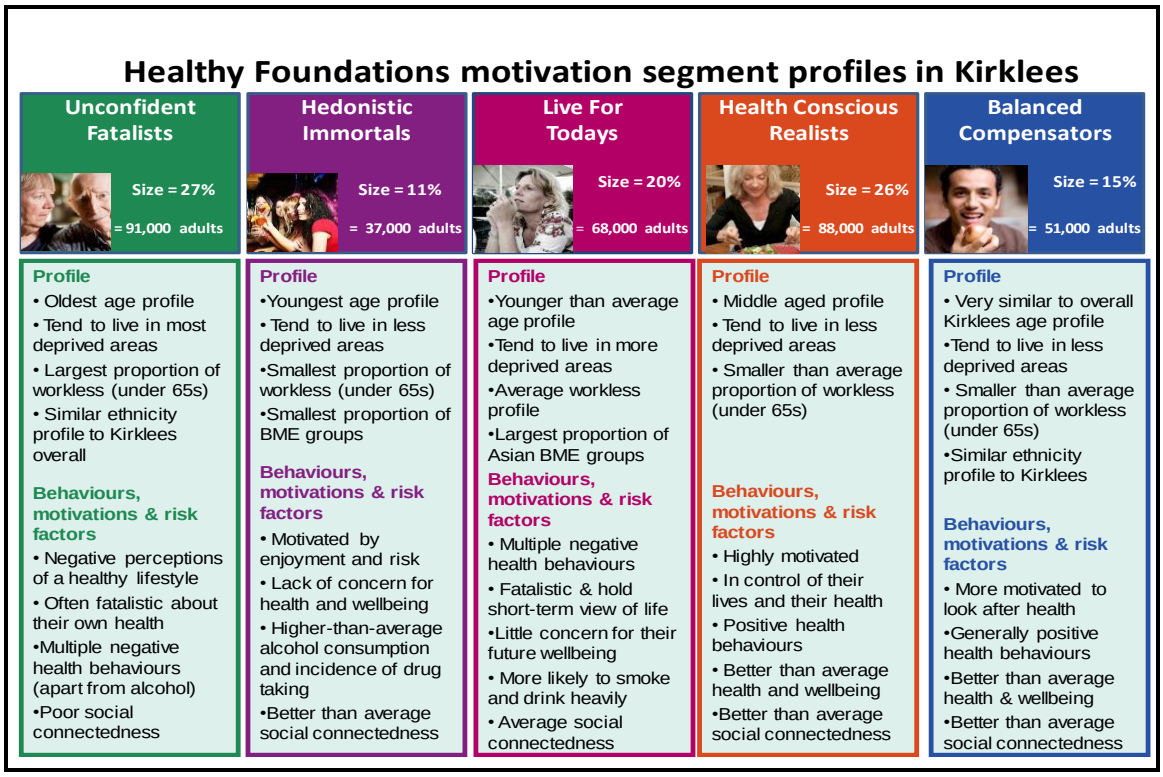
development (ABCD) projects could work with **fighters** (Health-conscious Realists and Balanced Compensators living in poor areas but with higher levels of motivation to look after their health) to motivate and support **survivors** (Hedonistic Immortals, Live for Todays and Unconfident Fatalists living in poor areas and with low levels of motivation in looking after their health). This approach could also be coupled with a revised approach to "Every Contact Counts" in which a series of one-off interventions are replaced by a longer term relationship (it has been suggested that the policy would be better titled "Every Relationship Counts")[6].

The national HF model shows that a person's age and life stage (e.g. being in a settled relationship, having children, retiring) can influence health attitudes, beliefs and outlooks. It is possible for a person to move from one motivation segment to another over their life course. The CLiK 2012 results enable us to divide the adult population of Kirklees into a number of life stages comparable with the national HF model (see Figure 4)

To conclude, the HF model (i) helps us to understand the relationship between health motivations (and behaviours), life stage and wider social determinants; (ii) gives us a meaningful way to communicate with providers, commissioners and Joint Health and Wellbeing Boards about how to improve population health outcomes; and (iii) contributes to the evidence base for multiple and holistic approaches to tackling health inequalities including building community resilience through asset-based community development approaches.

Further information about Healthy Foundations and the preliminary findings from CLiK 2012 can be found here or from the phi@kirklees.gov.uk.

Figure 2: Overview of Healthy Foundations motivation segments profile of Kirklees and some key characteristics



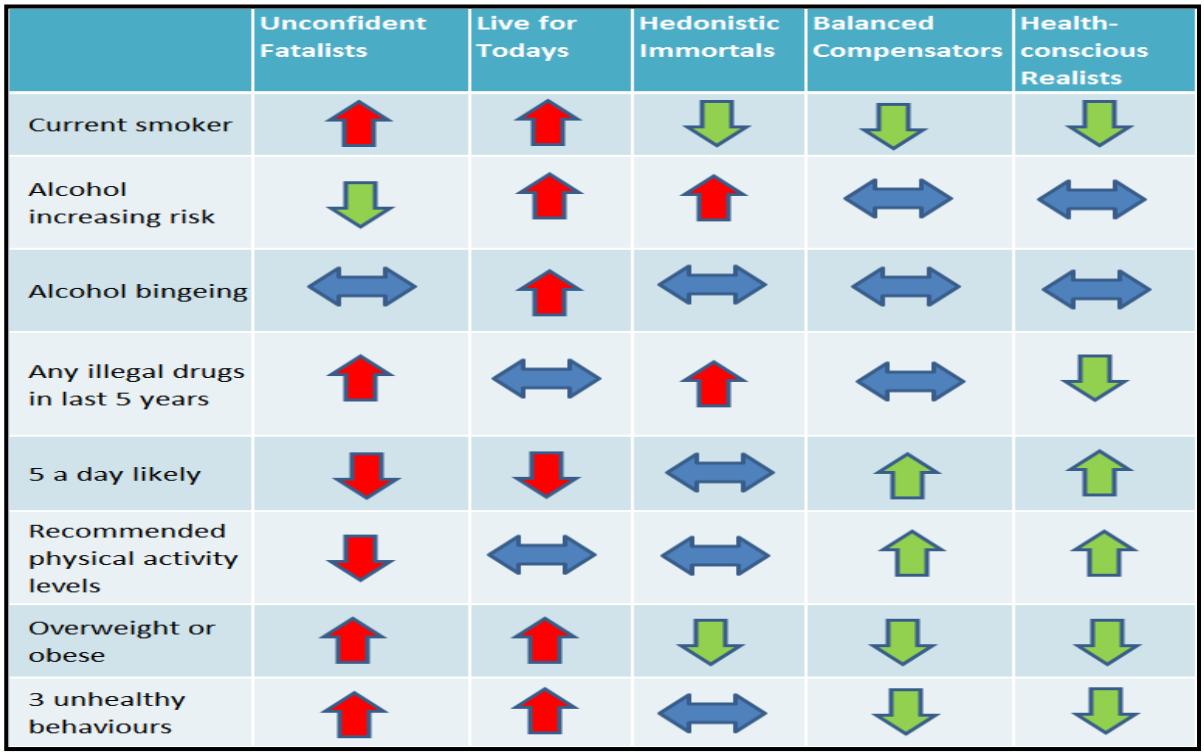
Source: CLiK 2012

Figure 3a: Comparison of "social connectedness" indicators across HF motivation segments

	Unconfident Fatalists	Live for Todays	Hedonistic Immortals	Balanced Compensators	Health-conscious Realists
Someone to count on for comfort	↓	↔	↑	↑	↑
Someone to rely on in a crisis	↓	↔	↑	↑	↑
Feel lonely/ isolated most/all of time	↑	↔	↓	↔	↓
Agree that, in local area, people treat each other with respect and consideration	↓	↔	↔	↑	↑
Agree that local area is a place where people trust each other	↓	↔	↔	↑	↑
Agree that local area is a place where people of different ages get on well	↓	↔	↑	↑	↑
Agree that local area is a place where people of different ethnic backgrounds get on well	↓	↔	↑	↑	↑

Source: CLiK 2012

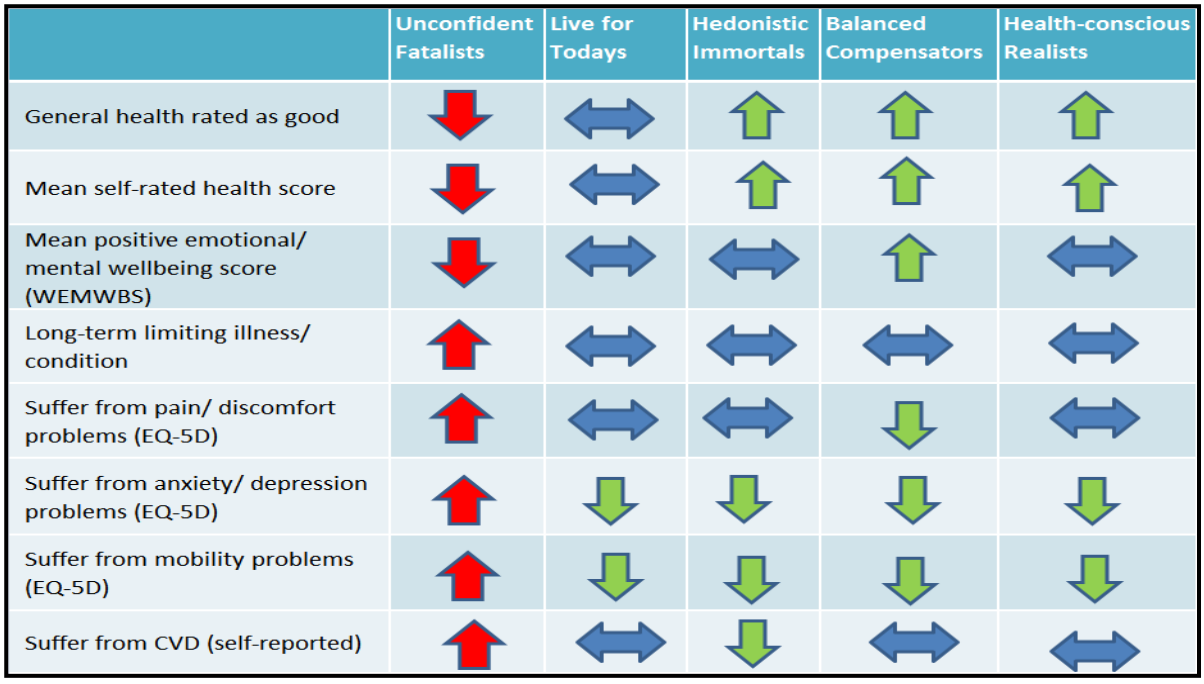
Figure 3b: Comparison of health behaviours across HF motivation segments



	Unconfident Fatalists	Live for Todays	Hedonistic Immortals	Balanced Compensators	Health-conscious Realists
Current smoker	↑	↑	↓	↓	↓
Alcohol increasing risk	↓	↑	↑	↔	↔
Alcohol bingeing	↔	↑	↔	↔	↔
Any illegal drugs in last 5 years	↑	↔	↑	↔	↓
5 a day likely	↓	↓	↔	↑	↑
Recommended physical activity levels	↓	↔	↔	↑	↑
Overweight or obese	↑	↑	↓	↓	↓
3 unhealthy behaviours	↑	↑	↔	↓	↓

Source: CLiK 2012

Figure 3c: Comparison of health status indicators across HF motivation segments



	Unconfident Fatalists	Live for Todays	Hedonistic Immortals	Balanced Compensators	Health-conscious Realists
General health rated as good	↓	↔	↑	↑	↑
Mean self-rated health score	↓	↔	↑	↑	↑
Mean positive emotional/ mental wellbeing score (WEMWBS)	↓	↔	↔	↑	↔
Long-term limiting illness/ condition	↑	↔	↔	↔	↔
Suffer from pain/ discomfort problems (EQ-5D)	↑	↔	↔	↓	↔
Suffer from anxiety/ depression problems (EQ-5D)	↑	↓	↓	↓	↓
Suffer from mobility problems (EQ-5D)	↑	↓	↓	↓	↓
Suffer from CVD (self-reported)	↑	↔	↓	↔	↔

Source: CLiK 2012

Figure 4: Equivalent life stages identified from the CLiK 2012 survey and the national HF study

CLiK lifestages		Equivalent national HF lifestage	
Lifestage A = Freedom years under 25 i.e. aged under 25 yrs, living alone and no children	2%	11%	**Freedom years under 25** i.e. under 25 yrs, never lived with a partner and never had any children
Lifestage B = Freedom years over 25 i.e. aged over 25 yrs, lives alone and no caring responsibilities	5%	6%	**Freedom years over 25** i.e. over 25 yrs, never lived with a partner and never had any children
Lifestage C = Younger settlers i.e. aged under 45, living with another adult, no children in household and no caring responsibilities	8%	9%	**Younger settlers** i.e. aged under 45 yrs, living with partner, no children in household and and no caring responsibilities
Lifestage D = Older settlers i.e. aged 45-64, living with another adult, no children in household and no caring responsibilities	7%	9%	**Older settlers** i.e. aged 45 yrs and over, living with partner, no children in household and and no caring responsibilities
Lifestage E = Younger jugglers i.e. aged under 45 yrs who are parents or have caring responsibilities	32%	25%	**Younger jugglers** i.e. aged under 45 yrs, either have children in the household or significant caring responsibilities re-code re carers
Lifestage F = Older jugglers i.e. aged 45 yrs and over who are parents or have caring responsibilities	17%	16%	**Older jugglers** i.e. aged 45 yrs and over, either have children in the household or significant caring responsibilities re-code re carers
Lifestage G = Alone mid-life i.e. aged 45-64 yrs and living alone	9%	9%	**Alone again** i.e. previously lived with a partner or had children but don't curently have a partner in the household
Lifestage H = Pensioner with partner/ other adult i.e. aged 65 yrs and living with at least one other pensioner	8%	9%	**Active retirement with partner** i.e. retired with partner
Lifestage I = Pensioner alone i.e. aged 65 yrs and living alone	8%	5%	**Active retirement without partner** i.e. retired without partner
Lifestage J = Pensioner with other adults i.e. aged 65 yrs and living with younger adults	4%		
Lifestage unclassified i.e. not matching criteria for lifestages A to J	2%	2%	**Lifestage unclassified** i.e. could not be classified

Source: CLiK 2012[2] and national Healthy Foundations Research report No. 1[3]

References

1. Health Survey of England (HSE) 2011: Volume 1. Chapter 8: Healthy Foundations Segmentation. The Health and Social Care Information Centre; 2012.
2. The Healthy Foundations Lifestages Segmentation. Research Report No. 1: Creating the Segmentation Using a Quantitative Survey of the General Population of England. Department of Health; 2011.
3. Current Living in Kirklees (CLiK) Survey, NHS Kirklees and Kirklees Council; 2012.
4. The Healthy Foundations Lifestage Segmentation. Research Report No. 2: The Qualitative Analysis of the Motivation Segments. Department of Health; 2011.
5. Dahlgren and Whitehead, Social Model of Health. 1991
6. Gamsu M. Tackling Health Inequalities at a Local Level – Lessons from the King's Fund. Health Equalities Issue 2: November 2012, BHA; 2012.

Date this section was last reviewed

23/07/2013 (PL)