RSPH
ROYAL SOCIETY FOR PUBLIC HEALTH
VISION, VOICE AND PRACTICE

Tackling health inequalities: the case for investment in the wider public health workforce

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Foreword

As our nation ages and our healthcare system creaks, healthcare and social policy experts along with economists and philosophers have come to the same conclusion; that prevention is better than cure. If we are to make our healthcare system more efficient and effective we need to engage people with their health and consider different approaches to preventing ill health.

In 2011, UK public spending on healthcare was £119.9 billion.[1] The top three areas of NHS spending in England were on mental health (£12.2 billion), circulatory problems (£7.9 billion) and cancers and tumours (£5.9 billion).[2] Many of these costs are avoidable, with ASH estimating that the annual cost to the NHS in England of smoking-related diseases is around £2.7 billion.[3] People are living longer but often facing several years of painful and debilitating long term conditions which are costly for the individual, families and society.

Many illnesses are a direct result of the conditions people live in and the choices they make. But the sad fact is that the least healthy in society are also those facing greatest poverty and deprivation: the cards are stacked against them. Social justice can only be present in a society where all individuals have the same opportunities to realise their potential for good health and therefore much work needs to be done to tackle health inequalities.

This report looks at an area that we believe has been underutilised in addressing health inequalities and also improving national wellbeing. In this report we look at the evidence for engaging the 'wider workforce' and particularly the role of health trainers and champions in supporting behaviour change within their own communities, providing peer-to-peer support from a position of understanding and common ground. The investment in them is, in light of the economic cost of treating illness, money well spent. The creation of healthy settings also has a key role to play in making healthy choices easier and there is much potential in including public health training across a range of professions to improving the public's health.

With the responsibility of improving the public's health rightly with local authorities, there is a new opportunity to involve many more organisations and citizens in health improvement. Not only will investment in the wider public health workforce help protect the future of the NHS but also move us closer to the prize of social justice for all.

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Executive summary

Over the past century, the United Kingdom has seen major advancements that impact on the public's health. Improvements in medical treatments, health services and living conditions have resulted in significant and measurable increases in average life expectancy.[1,2] But at the same time, we know that serious health inequalities persist. In 2010, the Marmot Review revealed that individuals living in the most deprived areas of England could expect to live on average seven years less than those living in the least deprived areas.[3] This figure increases to seventeen years when considering disability-free life expectancy.[3] These inequalities have major consequences not only for the economy but our shared sense of social justice - without effective action this gap is set to widen even further. The Equality Trust estimates that in the last twenty years alone, health inequality between localities has risen by 40% for men and 73% for women.[4]

Tackling the causes is a challenge for everyone and we recognise there is no one single solution. At the Royal Society for Public Health (RSPH), our focus is on developing the skills and knowledge of the 'wider public health workforce' as a way of reducing health inequality and avoidable illness. This workforce includes any organisation or individual who is not a professionally qualified public health specialist, but has the ability or opportunity to improve the public's health. This includes a huge number and variety of people, from health trainers and health champions to town planners and police officers. We believe that

engaging this workforce will enable a far greater number of people to gain access to vital health support and advice, including those from 'hard-to-reach' groups, who have disproportionately poor health outcomes.

This report assesses the progress made so far and evaluates the social and economic impact of five key aspects of the wider public health workforce; health trainers, health champions, the Making Every Contact Count (MECC) initiative, the role of non-health professionals and the creation of 'healthy settings'.

We look at the case for further investment and demonstrate how health inequalities and avoidable illness could be addressed. This is driven by evidence of how the wider workforce can encourage positive behaviour change throughout the population, build community resilience and empower individuals to lead healthier lives.

This report is intended as a call to action for local authorities and others to engage with their local wider workforce to evaluate and deliver improved health outcomes.

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Introduction

Major advancements in public health mean that people are living longer, healthier lives than ever before. This is clearly demonstrated by the rise in average life expectancy. In 1913, average life expectancy was 53 years old;[2] by 2013, this figure had risen to 81 years.[1] This statistic, however, belies the serious health inequalities that continue to feature across the UK. According to research by the Equality Trust, over the last 20 years the gap in life expectancy between different localities has increased by 41% for men and 73% for women.[4] The Marmot Review states that people living in the poorest areas can now expect to live on average seven years less than those living in the wealthiest areas. This figure rises to seventeen years when considering disability-free life expectancy.[3]

Health inequality is a considerable drain on the welfare system and the economy, as well as being severely detrimental to social justice. The avoidable illnesses caused by these inequalities cost approximately £31 billion each year in productivity losses, £20 billion in lost taxes and welfare costs and £5.5 billion in costs to the NHS.[5] The wider public health workforce could be instrumental in reducing this burden. Investing in health improvement initiatives through this untapped resource has the potential to encourage healthier lifestyles across the population, preventing unnecessary illness and reducing the strain on an already overstretched NHS. Throughout the report, we consider the evidence surrounding such investment, whether it is truly able to deliver the desired social outcomes and whether it is a

financially viable option. The report is divided into six sections. The first section provides a definition of the 'wider public health workforce'. This is followed by five sections, each considering a different aspect of the wider workforce; firstly, health trainers, secondly, health champions, thirdly, the initiative known as Making Every Contact Count (MECC), fourthly, the role of non-health professionals and finally, the creation of 'healthy settings'.

Defining the 'wider public health workforce'

Despite being a term in frequent usage, there are relatively few attempts to clearly define the 'wider public health workforce'. Of the definitions that do exist, there is limited consensus on the boundaries of the workforce. Some suggest a very restrictive definition, which excludes anyone working in a voluntary capacity,[6] whilst others, such as Sim et al[7] suggest a much broader definition, which includes some individuals working outside of the health sector, such as head teachers and soil scientists, as well as medical professionals, such as psychiatric nurses and district nurses.

What is certain is the wider public health workforce is very broad, potentially encompassing a large number and variety of people. However, the core aspect and defining feature of this workforce is its non-professional nature. It consists of any organisation or individual, who is not a professionally qualified public health specialist, but has the ability or opportunity to positively impact public health. This positive impact could be through the work or research of professionals not directly employed in a public health capacity, such as soil scientists or architects or it could be as simple as individuals, such as librarians or receptionists, taking the opportunity to have a 'healthy chat'. This report identifies five aspects of the wider workforce, but is by no means an exhaustive list.

Fig.1 – Defining the wider public health workforce

With effective training, people can be given the skills to motivate and support others in leading healthier lifestyles. If we are to address the major public health issues, such as rising levels of obesity, it is essential that we move more quickly towards public health being a community-wide, shared responsibility.

"Meeting the complex future challenges to public health will require the engagement of many people, from specialists and practitioners to a wider workforce comprising individuals making discrete contributions in their everyday work, often without realising the health impact they could have".[8]

Engaging the wider workforce will enable a far greater number of people to gain access to vital health support and advice. This is the motivation behind programmes, such as health champions and Making Every Contact Count (MECC), which are already helping individuals to adopt healthier lifestyles.

The health trainer service

The first aspect of the wider workforce to be considered is the health trainer service. Introduced by the Department of Health in 2004, the central aim of the programme is to reach out to marginalised groups, who often experience the poorest health outcomes. The service operates by recruiting trainers from within those communities to provide 'support from next door' rather than 'advice from on high'.[9] Through the RSPH Level 2 Award in Understanding Health Improvement and the City & Guilds Level 3 Certificate for Health Trainers, health trainers are provided with the necessary knowledge and skills to support their clients achieve and sustain positive behaviour change.[10] This represents a move away from a paternalistic approach towards an approach based on concordance, in which the client is an active partner, empowered to make their own healthy lifestyle changes.[11] The health trainers typically work with their clients over the course of six sessions, during which they jointly agree a set of behavioural goals in a personal health plan (PHP).

Often referred to as 'lay health workers', this approach has been utilised in other countries; however, health trainers are a relatively new addition in the UK. According to the 2012 Data Collection and Reporting System (DCRS) report, at the time of publication, there were 2790 people employed as or training to be health trainers.[12] Data from Ofqual indicates that between 2008 and 2013, 3085 people have taken the health trainer qualification offered by City & Guilds.[13]

Overall, the literature indicates that health trainers can achieve a high level of success; evidence shows that clients respond well to the health trainer approach with the majority achieving behaviour change. However, there are some issues, particularly surrounding their ability to integrate with 'hard-to-reach' groups, which are inhibiting their success. Moreover, there are concerns surrounding the quality of the evidence currently available.

Five central themes will be discussed, these are as follows:

- ■ **Behaviour change amongst clients**
- ■ **The benefits for health trainers**
- ■ **The ability of health trainers to integrate with 'hard-to-reach' groups**
- ■ **The response of medical professionals to the health trainer service**
- ■ **The cost-effectiveness of the initiative**

## 5.1 Supporting positive, sustained behaviour change?

When the health trainer initiative was first introduced in the Government white paper, *Choosing Health – Making Healthier Choices Easier*, the initiative was given four key goals, of which one was to 'increase healthy behaviour and uptake of preventative services'.[9] There is growing evidence that health trainers are indeed having a positive impact on healthy behaviour. However, the quality of this evidence has been called into question, particularly in relation to generalisability and missing data.

The success of health trainers is, firstly, demonstrated by the behaviour change statistics. The DCRS, which was commissioned originally as a central data collection point by the Department of Health, shows that the majority of health trainer clients are either successful or partially successful in achieving their PHP.[12] These are agreed between the health trainer and the client at the beginning of the programme and include goals relating to issues such as smoking, alcohol intake, healthy eating, physical activity and emotional or psychological issues. In 2012, of the 70,000 PHPs signed off, 49% were completely successful and 23% were partly successful.[12] In some regions, the PHP success rate is even higher. In a study of eight local projects, White, Woodward and South[14] found that seven projects reported a majority of participants achieving their PHP, with five local projects reporting figures of over 80%. Similarly, in 2012, Kirklees council reported that 93% of participants had reported some level of behaviour change, with 56% being completely successful.[15]

The DCRS data also demonstrates that health trainers consistently achieve impressive results across a range of specific behavioural goals. In 2011/2012, clients on average increased their level of vigorous exercise by 140% and decreased their BMI by 4%.[12] Likewise, in 2013, clients reported on average a 57% increase in intake of fruit and vegetables, a 55% decrease in fatty food intake and in the lowest and second lowest quintiles, a decrease of 43% and 46% respectively in alcohol consumption.[16] Similarly, a longitudinal study conducted by Gardner et al[17] found that over 12 months the mean BMI of health trainer clients decreased from 34.03 to 32.26 and the overweight/obesity prevalence decreased by 3.7%. Given the damaging effect such health behaviours can have on health outcomes, including the increased risk of cancer, heart disease and diabetes, these are significant results. There are also indicators that health trainers may be successful in helping clients to be more effective in managing their health conditions. A study conducted by Harris et al,[18] who examined the success of a pilot study in Sheffield, found that health trainers trained in cognitive behavioural therapy could be very effective in helping clients to self-manage chronic pain. Of the clients participating in this study, 75% reported either fully or partly achieving their goals; 43% of whom maintained this at the follow-up.[18] Additionally, clients who participated in the pilot reported an increase in self-assessed general health, self esteem and wellbeing.[18]

There is also a significant body of qualitative research to support the case for health trainers, which provides a large number of case studies demonstrating the lifestyle changes clients have made. A strong theme is the popularity of the health trainer approach. As will be discussed in greater depth below, the non-professional nature of the trainers and the 'client-led', personal approach is clearly valued.[14]
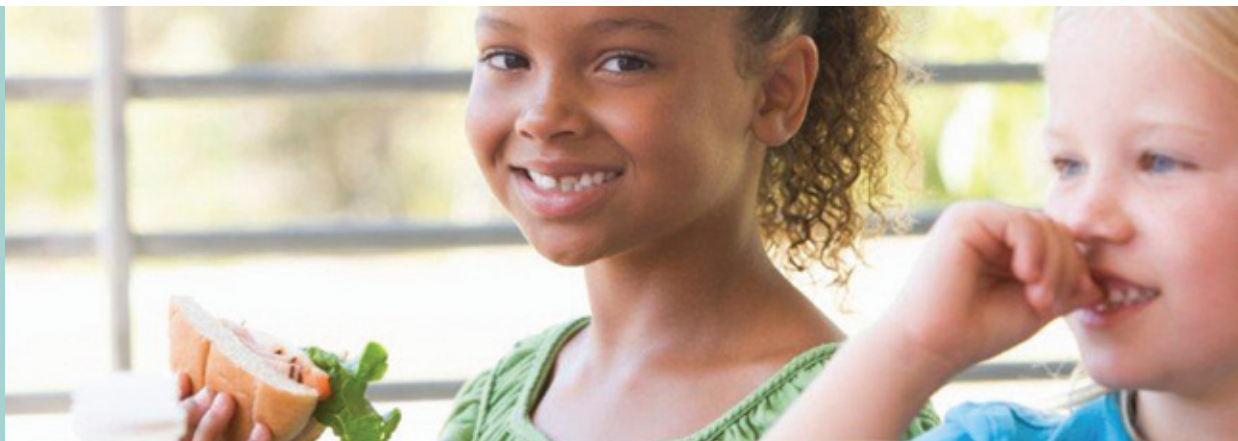
One health trainer client stated:

"because he wasn't medical as such, you relate, if it's a medical person you tend to think they're in charge and with [the health trainer] it didn't seem like that, it just seemed like talking to an acquaintance or a friend even, more on my level".[19]

Moreover, many studies demonstrate that the health trainers are providing a bridge between their clients and primary health care services; in several cases, the trainers have actually accompanied their clients to appointments.[14] This 'bridging' role is reflected in the DCRS data, which indicates that between April and September 2013, 4466 people were signposted to other services and 17,881 people were referred on to specialist services.[16] Health trainers are also able to offer support to clients that GPs may not have the time or skills to provide. One GP praises the health trainer service as it is:

"somewhere to send patients that I don't have the skills to deal with, things like housing benefit, loneliness, all those social problems that, as a GP, I don't want to be prescribing anti-depressants for."[19]

Another theme within the research is that the families and friends of clients are benefitting from the health trainer programme. Ball and Nasr[20] found evidence of a 'ripple effect'. For example, one health trainer stated that:

"what happens, is if you change...the eating habits of one parent, often the other parent will follow suit, and also the children tend to follow suit, so then...it becomes you are reversing the trend of...obesity every day".[20]

Whilst this is all positive, the evidence itself has been subject to criticism. Firstly, many question whether the reported behaviour changes are sustained over the long-term. Trayers and Lawler[21] argue that a health trainer approach is unlikely to achieve long-term success due to its focus on behaviour rather than also considering the need for clear environmental and social change. Many studies do not conduct follow up surveys, so there is limited evidence in this area. However, of the studies that do exist, there are positive findings. The DCRS data from 2012 indicates that 86% sustained their behaviour changes after 3-6 months.[12] The DCRS data from 2013 demonstrates similar success, although unlike previous DCRS reports, this data only refers to the two most deprived quintiles. According to the 2013 data, excluding those who could not be contacted or who were sign-posted elsewhere, 87% in the lowest quintile and 84% in the second lowest quintile maintained their behaviour change.[16] The 2011/2012 data found that this percentage was higher for those who fully achieved their PHP. Of those who were completely successful, 90% sustained change after 3-6 months, compared with 73% for those who were only partly successful.[12] These statistics certainly suggest that the behaviour change is not just maintained over the very short term. However, more research needs to be conducted to corroborate these findings beyond the six month mark.

The DCRS data has also been subject to criticism. It is not currently compulsory for health trainer schemes to enter data into the DCRS; consequently, the data set is not a complete record of all health trainer programmes.[22] Additionally, those that do enter data are not required to complete all sections, which leads to variation in sample size and may allow some services to avoid inputting less favourable data. Regions, such as the East of England and the East Midlands have previously voiced concerns

that programme managers view data collection as a 'secondary concern'.[23,24] In order to retain users after the introduction of a fee for using the DCRS, the system has had to become more flexible, using a less rigid definition of 'health trainer service' and accepting a far wider range of data rather than set indicators for every service, thus making accurate comparisons of the data more difficult.[25] It is critically important for evaluation purposes that a reliable national picture of health trainers is available and therefore, there is a strong case for much wider use of the DCRS and fidelity across the data.

There are also concerns surrounding the quality of current research more generally. The sampling and data collection methods of some studies have been called into question. Many studies rely on very small samples and in several cases primarily survey health trainers or other stakeholders when evaluating the success of the programmes.[26] The lack of client perspectives in these studies may throw the validity of their conclusions into question. In a study examining two health trainer programmes situated in the North of England and the Midlands, Ball and Nasr[20] state that:

"health trainer clients proved to be an extremely 'hard-to-reach' group"

for research purposes. As a result, only four clients were interviewed. The viewpoint and experiences of the public and in this instance service-users, is a valuable resource for public health evidence and a vital consideration to ensure effective commissioning and evaluation of health improvement initiatives. Additionally, the vast majority of studies rely on self-reporting of behaviour change. This reliance may result in exaggerated statistics. Finally, there are also concerns surrounding the generalisability of the local evaluations. An important aspect of the

health trainer programmes is their responsiveness to local characteristics; consequently, the programmes can vary between areas, which may make comparisons difficult.[27]

Whilst the findings from current research and data demonstrate the excellent potential of the health trainer service, the quality of evidence does require improvement. To accurately assess the health trainer programmes, more research needs to be conducted that assesses actual health outcomes rather than self-reported behaviour change.

A final criticism of the behaviour change evidence relates to the limited success at population level. Whilst health trainers may be successful in supporting behaviour change at an individual level, at a population level the literature indicates that they have had a limited impact. As discussed above, there is criticism of the behavioural approach of health trainers. By not considering the social determinants of health, it is argued that the health trainers will only ever have a limited impact at the population level and therefore, will have reduced capability of addressing health inequalities.[14] There is, however, a significant opportunity for the social determinants of health to be addressed, if health trainer services in England can take full advantage of the transition to the local authority setting.

Overall, it seems that the health trainers are meeting their aim of 'increasing healthy behaviour and uptake of preventative services'. According to the literature, the participants respond well to the health trainer approach and the statistics indicate that clients are making positive and sustained changes to their lifestyles. However, there are recognised weaknesses in the evidence base that need to be addressed and the lack of influence at population level is certainly an issue that requires greater consideration.

5.2 The benefits for health trainers

As stated above, the health trainer project was originally given four key goals to achieve by the Department of Health. The second of these to be considered is the goal to 'provide opportunities for people from disadvantaged backgrounds to gain skills and employment'.[9] This is an area in which there has been mixed success. Positively, the DCRS data from 2013 states that 56% of trainers are from the two most deprived quintiles.[16] This indicates that the service is successfully targeting their recruitment at the most disadvantaged groups. According to the literature, in some areas the health trainer service is also contributing to the rehabilitation of offenders by providing them with employment and training, which they may struggle to find elsewhere.[28] There are also indications that the role inspires the trainers to aim for further qualifications and employment.[29] The connection between unemployment and declining health is firmly established, so in this sense, the health trainer programme is not only tackling health behaviour, it is also seeking to address the wider determinants of health.

There is, however, room for improvement. Firstly, some have questioned whether the method of recruitment is appropriate for targeting the unemployed and disadvantaged. The use of a web-based recruitment strategy and the NHS application process, which requires applicants to demonstrate how they meet various 'competencies', may not be suitable as potential applicants may not have access to a computer or the ability to complete an application form of this style.[22] Another issue raised in the literature is the lack of natural career progression within the role of health trainer and as a result, the high attrition rate within the programmes. According to Rahman and Wills,[30] health trainers initially experience very high rates of job satisfaction, but this eventually turns to frustration. One health trainer states:

"[o]ne thing I struggle with this role is that there is no natural progression. In other roles people will work themselves up, but with the health trainer role there seems to be no clarity of where to go".[30]

The high attrition rate may also negatively affect the cost-effectiveness of these programmes due to the need to more frequently train new staff.

The benefits for health trainers, however, are not limited to their career prospects. Many health trainers report adopting healthier lifestyles as a result of their role. For example, health trainers working with the Leicestershire and Rutland Probation Trust reported that they had become much more conscious of their health and had, therefore, started to eat more fruit and vegetables.[29] Similarly, Rahman and Wills[30] found that the health trainers working in the North East had increased their intake of healthy foods and increased their level of physical activity. There are also mental health benefits, with some health trainers reporting increased confidence and self-esteem. Lorenc and Wills[31] found that the health trainers experienced a sense of achievement from their role and pride in their clients.

As stated above, the majority of health trainers are from the two most disadvantaged groups;[16] therefore, the positive impact the service has on the lifestyles of the trainers themselves, in terms of both the wider determinants and specific health behaviours, may ultimately help to address health inequalities.

5.3 Supporting hard-to-reach groups to lead healthier lives?

Another aim of the health trainer programme is to "target 'hard-to-reach' and disadvantaged groups". An integral part of this is the recruitment of people from within those groups to provide 'support from next door' rather than 'advice from on high'.[9] The DCRS data indicates that health trainers are successfully targeting the more deprived groups in society. According to the DCRS report from 2011/2012, 67% of health trainer clients were from the two most disadvantaged quintiles.[12] With the behaviour change discussed earlier, the service certainly has the potential to impact health inequalities. Visram[32] has suggested that the percentage of clients who are not registered with a GP may also indicate some success in integrating with 'hard-to-reach' groups. At the time of publication in 2010, just 1-2% of the general population were not registered with a GP, compared with 8% of health trainer clients.

However, it is clear that health trainers have struggled to reach some parts of the community, with large variety in levels of community engagement between different areas. One concerning trend is the comparatively small number of men either working as health trainers or receiving the support of a health trainer. According to the DCRS data from 2012 and 2013, men accounted for just one third of all health trainer clients.[12,16] This is a slight increase since 2008, when men accounted for just 27%.[33] It is widely recognised that men are less likely to access primary health services. A report by the National Pharmacy Association found that nine out of ten men do not like to visit the doctor unless they are seriously ill and therefore, are much less likely to access programmes, such as stop smoking services.[34] There are many complex reasons for this; it has been suggested that some men may feel that their health is 'predetermined', they may have difficulty scheduling doctor appointments or they may feel the GP surgery is a 'feminized' environment.[35] According to the Men's Health Forum, who are actively working to address this issue, one in five men die before the age of 65.[36] This seems to be an area that many health trainer services have had difficulty addressing.

Jennings et al,[37] who studied a health trainer-led weight loss programme, concluded that in order to reach men for health promotion initiatives, men-only programmes may be more appropriate. There is evidence that increasingly innovative ways to reach men have been adopted with considerable success. The health trainer programme in the North East, for example, has introduced health fishing trips aimed specifically at men.[38] Premier League Health has also used health trainers to target men. Between 2009 and 2012, 16 premier league football clubs, including Manchester City, Liverpool and Tottenham Hotspur, hosted health trainer services at their football grounds. This programme, which accessed over 10,000 men, helped three quarters to make at least one positive lifestyle change.[39] According to Pringle et al,[35] the football and club connection was an effective recruitment method. However, overall, health trainer programmes still need to address the comparatively small number of men accessing the service as this will undoubtedly limit the extent to which the health trainers can reduce health inequalities.

As mentioned above, in order to integrate with communities, health trainer programmes aim to recruit people from within those communities

who have an "understanding of the day-to-day concerns and experience of the people they [are] supporting".[40] When the programmes are successful in doing this, there is very positive feedback from both the trainers and the service-users. Dooris et al[28] studied the use of health trainers by the probation service. They found that the health trainers' experience of the Criminal Justice System was extremely important. This encouraged the offenders to be more trusting and was a source of motivation for them as the health trainers became role models. Likewise, health trainers working for the Leicestershire and Rutland Probation Trust[29] found that there was a noticeable change in the willingness of the offenders to talk openly after they discovered their trainer's offending past.

Contrary to this, other studies found that often the health trainers do not share the social and cultural characteristics of their clients. Cook and Wills[41] argue that the 'person next door' idea is simplistic and unrealistic. Firstly, trainers and clients frequently differ in terms of educational level. The health trainers are often degree educated, whereas their clients, the majority of whom are from deprived communities, are not. The North West trainer programme found that frequently health trainers lived in the deprived areas, but actually differed greatly to their clients in terms of social characteristics, such as educational level.[22] According to the North West evaluation, "the most 'typical' health trainer would be aged around 35, female, white British, living in a deprived area, but educated to college or university standard".[22] A report evaluating the health trainer services across the East of England found that trainers without any formal qualifications were significantly more successful than those educated to degree level. Health trainers without any formal qualifications

helped on average 91% of their clients to completely achieve their behavioural goals, whereas health trainers with a degree helped on average just 66% of their clients.[24] This statistic arguably suggests that the idea behind the health trainer programme is sound, but the literature shows that in some areas the service has moved away from the original design. In Newcastle, for example, a report by NESTA states that the community ties between clients and health trainers has declined due to the expansion of the programme, as trainers were expected to work in a variety of areas across the city rather than just their local area.[38]

Another trend within the literature is the difficulty some health trainers have engaging with people with mental health issues or disabilities. It has been suggested by some programmes, such as in the North West and Derbyshire that this is due to insufficient training. Many health trainer clients have several complex issues that need attention and health trainers may not have the level of knowledge or training required to effectively handle these issues. The health trainer service in Derbyshire found that their health trainers had a disproportionately small number of clients with mental health issues or disabilities, which may be due to difficulties engaging with those groups over such a short period of time.[42] Moreover, the clients they did have were less successful in achieving their behavioural goals. Following the use of semi-structured interviews and focus groups, Ball and Nasr[20] found that many trainers felt their training lacked a counselling and motivational interviewing element. In relation to alcoholism, one participant stated that they:

"have been taught about some of the substances but we haven't been taught how to tackle the problem – it's just a case of well that's what
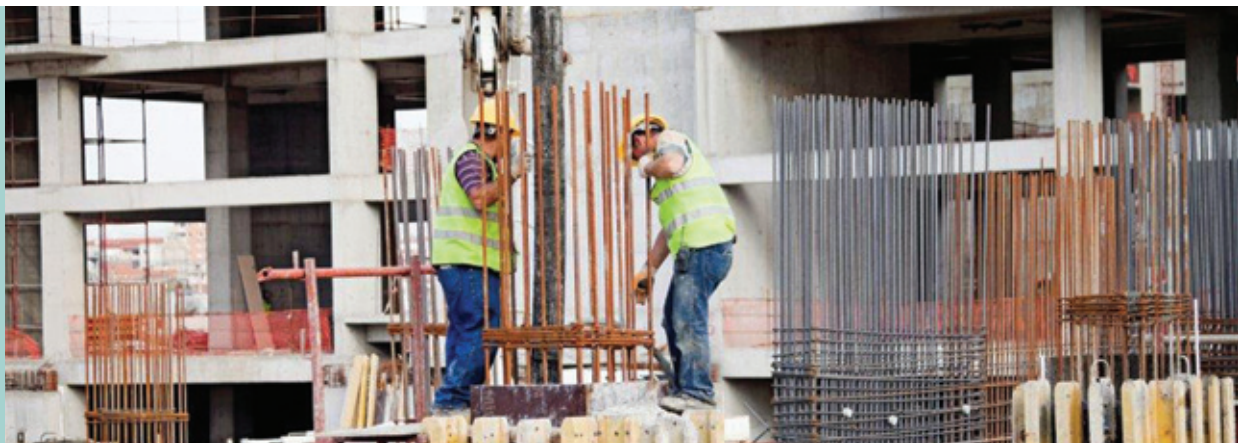
alcoholism is, but we were not shown how to interact with people on that level, or how it affects them, what you need to actually do to help them change. I think counselling skills would come in very handy".[20]

This suggests that the training available may be inadequate for the realities of the health trainer work. Although, there are indications that in some areas further training is being provided. For example, according to the Medway JSNA, health and lifestyle trainers have received motivational interview training.[43] Some areas have also introduced health trainer teams which focus on specific issues, including mental health issues, such as in Bromley by Bow.[44]

Finally, there are also some concerns surrounding the non-professional nature of the health trainer service. The non-health professional aspect of the health trainers is often emphasised as an important feature of the service; however, a proportion of trainers in fact view themselves as semi-professional or aim to become 'professional'. This is a contradiction recognised in several studies. Once health trainers are given training and earn qualifications, the extent to which they are still just 'support from next door' becomes debatable. Cook and Wills[41] found that this could be a source of tension as some health trainers became frustrated with the client's lack of knowledge or apathy towards health issues. They state that:

"The health trainers felt they understood 'the realities' of the communities with which they worked, but their differences, in terms of knowledge and attitudes to health, and professional backgrounds or aspirations must question whether they are truly connected through a shared stake in improving the health of the communities that they live in".[41]

In conclusion, the literature indicates that health trainers may have struggled to integrate with certain groups, which may limit the extent to which health inequalities are being reduced. However, by adopting innovative methods to reach marginalised groups other services have experienced demonstrable success. The literature also indicates that when the programme adheres to the original design, for example when the clients and trainers share similar characteristics, there is a positive response from clients.

5.4 Growing support from medical professionals

The literature indicates that in some areas the health trainer service has been constrained by tensions with medical professionals. The tensions have been the result of three main issues. Firstly, in some cases there has been a lack of understanding of the role of health trainers, which consequently makes medical professionals reluctant to refer patients. A recurrent issue is the confusion surrounding the term 'health trainer'. For example, several studies found that clients thought the role was akin to a personal trainer.[45]

There may also be a belief amongst some medical professionals that health trainers are undermining their authority and are replacing jobs in the medical professions. According to Visram,[32] some medical staff thought health trainers were a "cheap way of ousting staff". Finally, there have been concerns about the quality of the service.[32] A health trainer in a study by Ball and Nasr[20] thought that:

"[p]art of the problem is they feel that we are taking their patients away from them. One answer we get, especially from some of the doctors, is "Well, how do you know he is an alcoholic? How do you know this? Have they been diagnosed by a doctor?".

However, there is evidence that as the service has become more established that these issues have dissipated. The Leicestershire and Rutland Probation Trust found that over time as trust increased in the service, professional referrals also increased substantially.[29] Additionally, some areas have adopted innovative ways of encouraging greater understanding by the medical professions. For example, a GP surgery in the North East village of Throckley sends its registrars to spend a morning with the trainers to see first-hand exactly what the role entails.[38] In addition, an increasing number of GP surgeries have a health trainer operating within the surgery. The Earl's Court surgery in London is a good example of this. It is now a health and wellbeing centre, offering the usual doctor and dentist appointments, but also wellbeing coaches, peer mentors and other community services, such as events and activities, which are open to the public. To ensure that the surgery continues to meet the needs of the local community, the surgery also employs community researchers.[46] There are also indications that other health professionals are starting to have 'healthy conversations' with patients, particularly those in the dental profession and health visitors. This demonstrates the growing support and utilisation of brief advice and brief intervention techniques for health improvement.

5.5 Does the health trainer service provide value for money?

The final point to be considered in relation to health trainers is the cost-effectiveness of these programmes. At a time of increasing budgetary constraints, it is essential that public health programmes are able to demonstrate value for money. However, within the literature there are relatively few attempts to do this. The North West Public Health Observatory states:

"it is widely acknowledged that there is no simple means of measuring cost-effectiveness of the health trainer service".[22]

The most visible attempt to address this is by Graham Lister[47] for the Department of Health. Overall, Lister[47] concluded that health trainer programmes could demonstrate value for money. In his report, Lister suggests an assessment tool for determining the cost-effectiveness of health trainers, whilst recognising the difficulties surrounding the collection of evidence and argues that his conclusions are not definitive. Lister states that health trainer programmes:

"can achieve high levels of value for money… but [the analysis] also highlighted the variability between services, the problems of data collecting and the difficulty of capturing some aspects of the value of the health trainer service".[47]

A more recent attempt to assess cost-effectiveness is by Pennington et al,[48] who examined studies of lay health-related lifestyle advisors (HRLA) from a range of countries. Pennington et al[48] conclude that 'HRLAs can be cost-effective when they target behaviours associated with significant detriments to health'. This study found that initiatives focussed on smoking cessation demonstrated high value for money, whereas programmes focussed on other areas such as increased uptake of mammography, healthy eating and exercise did not demonstrate value for money.[48]

Whilst health trainer programmes may be relatively inexpensive to set up and run, many of the issues discussed above will impact cost-effectiveness. High staff turnover and consequently, frequently having to train new staff will certainly impact value for money. Attrition rates are a concern for several regions. Moreover, the number of clients will also

have an impact. In some areas, tensions with medical professionals and difficulties integrating with communities may restrict client numbers. Accordingly, there is significant variation in cost-effectiveness across health trainer services. In 2012, a programme based in North Lincolnshire reportedly saved the NHS approximately £83,500, whilst the service in Oxford was abolished due to a perceived lack of value for money.[38] An analysis conducted by the Oxford PCT found that other services offering similar support were significantly more cost-effective. While the stop smoking service in Oxford cost roughly £145 per quitter, the health trainer programme was estimated to cost £9,600 for the same outcome.[49]

in relation to cost-effectiveness, which need to be addressed. An analysis of the Joint Strategic Needs Assessments (JSNA) and Joint Health and Wellbeing Strategies (JHWS) indicates that the health trainer service has limited visibility in these documents (see appendix a); however, as has been shown above, this service is a worthwhile investment for local authorities.

5.6 Conclusion

It is clear from the literature that the health trainer programmes can be very successful in motivating and supporting sustained lifestyle changes amongst clients. These programmes are primarily targeting people from the two most disadvantaged quintiles and therefore, have the potential to address health inequalities. Whilst there are areas of concern, such as their ability to target men, progress has been made. There are, however, certain gaps in the literature, particularly

Health champions

Unlike health trainers, a large section of the wider workforce operates in a voluntary capacity, offering brief advice and brief interventions alongside their other daily activities. Health champions, sometimes referred to as lay health workers, are one such example. Health champions, who can be based in either a workplace or community setting, work within their local area motivating and supporting friends, family, colleagues and neighbours through sign-posting and organised events. As will be demonstrated below, there are projects operating at all stages of the life course. There is no national health champion programme, so projects can be easily adapted to suit particular age groups.

Similar to the health trainer service, the health champion initiative seeks to reduce health inequalities by enabling a far greater number of individuals to access health support and advice. Through effective training, such as the RSPH Level 2 Award in Understanding Health Improvement, health champions aim to empower their local community to make healthy lifestyle changes. Health champions, who are members of the community or workplace, have the advantage of greater familiarity with the people they are seeking to help and far more sustained contact than health trainers, who support clients over a set number of sessions.

Estimating the number of health champions is problematic due to the large variety of settings in which they operate and the lack of a uniform training programme; however, the statistics up to December 2013 for the Level 2 Award in Understanding Health Improvement indicates that 29,413 people have completed this course alone. The evidence currently available demonstrates that health champions are achieving considerable success, with participants from both the community and workplace programmes reporting positive behaviour change.

6.1 Supporting friends, family, neighbours and colleagues to lead healthier lives?

The majority of the research conducted into the success of lay health workers has been conducted outside of the UK. A study conducted in the USA examining a lay-led weight loss programme found that participants supported by a lay health worker lost significantly more weight than those who attempted to lose weight without such support. Similarly, a study of a cardiovascular health awareness programme in Canada found that the communities who took part in a volunteer-led programme had fewer hospital admissions for cardiovascular disease.[50] A study conducted by Aoun et al[51] examining a lay-led 'waist disposal challenge' across 44 Rotary Clubs based in Australia also demonstrates the potential of such programmes to support positive behaviour change. This study found that on average 56.6% of participants, of whom the vast majority were men, lost weight. The average BMI reduction for the clubs was 1.07%.[51]

The literature on UK health champions is less extensive and unlike the health trainer literature and supporting DCRS data, is restricted to regional or programme specific evaluations. The review of the literature does give some indication that the UK health champion programmes, based in both the community and the workplace, are successful in supporting people to lead healthier lives. This section will consider four major community-based projects, the Healthy Living Pharmacy (HLP) initiative and also, workplace health champion projects.

The first project to be considered is the Altogether Better project based in Yorkshire and the Humber, which has approximately 18,000 champions supporting over 105,000 people across the region.[52] The reports evaluating this initiative, which was introduced in 2008, demonstrate the utility of the health champion approach for supporting healthier lifestyles. Within this project, the health champions are very active in organising classes and events, such as walking groups, tai chi sessions and delivering talks on specific conditions, such as diabetes and arthritis. Many of these classes have had a positive impact on client health behaviour. In relation to the Older and Active project, 88% of participants reported feeling healthier after attending the classes. Moreover, 65% of participants reported that they had started additional exercise outside of the class.[50] A fall prevention exercise class aimed at older people also resulted in a 27% fall reduction over 12 months.[50] These statistics demonstrate that volunteer-led programmes can be an effective way of supporting people to lead healthier lifestyles. However, the project did raise concerns surrounding the training available for health champions. To ensure that this behaviour change success is maintained, it was suggested that greater training should be provided as the programme develops.[53]

Another community-based, health champion initiative is the Well London project.[54] It aims to improve the health and wellbeing in the 20 most deprived London boroughs by developing the community's resources and skills to tackle the health issues in their areas. The project adopts a bottom-up approach, engaging with local communities to set priorities, and provides a variety of different initiatives across the different boroughs, such as 'Be Creative, Be Well', 'Youth. com' and 'Buywell'. These initiatives are run by local volunteers, many of whom have completed RSPH training. The health champion project operating on the White City estate in the borough of Hammersmith and Fulham is one particularly strong example of this success. The primary role of the champions, all of whom were recruited from the local area and spoke multiple languages, was to signpost residents to other relevant projects or services. The 40 champions recruited were able to signpost 400 people on to stop-smoking services, to recruit 1200 people to 'fun-filled community events' and organise events, such as cooking classes, exercise classes and community engagement sessions, which were attended by over 1000 people.[55] These statistics demonstrate that the health champions can be very effective at integrating with local communities and mobilising them to take positive health action. Additionally, they can provide a bridge between local people and other services.

Another major volunteer-led programme, which has yielded similarly positive results is the Age UK initiative, Fit as a Fiddle (now extended as 'Fit for the Future'). This programme offered older people volunteer-led events and projects all over the UK, addressing topics such as healthy eating and physical activity. Following this programme, the percentage of participants eating five portions of fruit or vegetables per day increased from 37% to 45%, further increasing to 47% three months later.[56] Fit as a Fiddle also achieved a high level of success in relation to physical activity. Between the start of the programme and three months after it ended, the average amount of time participants spent walking increased by 33%. The time participants spent doing strength and endurance exercise also increased by 71%.[56] Additionally, the programme had a significant impact on mental wellbeing, particularly in relation to social isolation;

"If Fit as a Fiddle does pack up I think we will all go back into our little shells".[56]

The Fit as a Fiddle project did however, experience some of the same difficulties as the health trainer service in accessing 'hard-to-reach' groups. Demonstrating once again the difficulties of targeting men, overall they accounted for just 26% of participants. Initiatives that were specifically targeted at men had more success. The National Cascade Projects reported that men accounted for 45% of their participants and some projects in the North West (eg. 'Men in Sheds') reported that they accounted for 35%.[56] Project coordinators found that:

"activities provided for men needed to be specifically designed to ensure participation".[56]

The health champion projects are not limited to adults and older people. In 2006, NHS North East Essex introduced 'youth health champions'. Taking a life-course perspective, the early health experiences of children and young people can have a significant impact on health later in life, so initiatives directed at this age group are critically important. Whilst there is not currently an evaluation of this programme available, a seminar hosted by RSPH in 2011 did yield positive findings. It was felt by participants that giving young people such a responsibility enables them to develop vital skills such as organisational and communication skills and provides them with a sense of empowerment, thus boosting their confidence.[57] Additionally, some felt that youth health champions may be more effective at disseminating health information to young people. The Assistant Head Teacher at Manningtree High School stated that:

"I have found that the youth health champions programme has been one of the most effective vehicles I have come across in delivering the health aspects of our PSHE programme. Peer-led sessions on health have been a huge success, students feel that they can connect with their youth health champions and that the message is much clearer and engaging".[57]

In support of this work and as part of a national roll out, the RSPH has developed a Level 2 Certificate for Youth Health Champions, specifically for young people and adults working with youth.

Health champions based in other community settings, such as pharmacies, are also yielding positive results. The Healthy Living Pharmacies (HLP) initiative, which enables greater exposure

of health champions to the public, has been a very popular programme, as demonstrated by a 98% patient satisfaction rate.[58] The pharmacies offer services relating to smoking, weight loss and condition management.[58] Within the first year of the HLP initiative, the participating pharmacies reported a 140% increase in people participating in the stop-smoking programme and of the patients suffering from respiratory problems, 70% were showing improvements in the management of their condition.[59] Moreover, 23% of those taking part in the weight loss programme in Portsmouth lost at least 5% of their body weight.[60] One study also estimated that during the first year, those entering a Healthy Living Pharmacy were twice as likely to set a successful 'quit date' for smoking.[59] This success has been replicated elsewhere as the HLP initiative has expanded. Examining the HLPs in Birmingham, Dudley, Buckinghamshire, Milton Keynes, South Staffordshire and Lambeth, all areas reported an increase in the number of people setting 'quit dates' and all, except Lambeth reported an increase in the number of people successfully quitting smoking.[61] With 84% of adults visiting a pharmacy at least once a year, 78% for health related issues, there is clear potential for the HLPs to impact unhealthy behaviour.[61]

The success of community-based initiatives is mirrored in the workplace-based health champion projects. With 60% of the working populations' waking hours spent in work, the workplace is an opportune place for health improvement action. Moreover, according to a report by the Joseph Rowntree Foundation, for the first time the majority of people living in poverty are actually in employment; therefore, workplace-based initiatives could be an effective means of reducing health inequalities.[62] Early evidence suggests that organisations who adopt workplace health champions experience decreased levels of sickness absence. A workplace programme introduced by the NHS, which took place over a five year period, found that the monthly sickness absence within the Primary Care Trusts involved reduced from 4.9% to 2.6%. This is significantly below the average absence rate for that year of 4.24%.[63] Similarly, with regard to a study conducted by PricewaterhouseCoopers, 45 of 55 workplaces who introduced workplace wellness programmes reported on average a 30-40% reduction in days lost due to sickness absence.[64]

Overall, the literature demonstrates that health champion and volunteer-led programmes in both the workplace and the community can achieve considerable success in encouraging participants to adopt healthier lifestyles. However, greater research needs to be conducted in order to assess the impact of health champions, particularly over the long-term.

6.2 Improving the health and wellbeing of health champions

Research conducted by Volunteering England found that people who work in a voluntary capacity experience a range of benefits to their physical and mental health and wellbeing, including increased self-rated health status, a reduction in frequency of hospitalisation, increased self-esteem and increased quality of life.[65] A review of the literature demonstrates that these findings were replicated in several of the health champion programmes.

The first benefit is in relation to increased career prospects and increased skills and knowledge. The Altogether Better programme for example, provides participants with a range of qualifications, such as RSPH Level 1 and 2 Awards, first aid training and other vocational training. Many champions have subsequently gone on to gain additional qualifications and employment elsewhere. One health champion stated that:

"this project not only increased my knowledge and communication skills, but also helped me in getting a job".[66]

The connection between health and unemployment is well documented, so this is a very positive finding for the health champion programmes.

The research also demonstrates improvements in the champions understanding of health issues. A report analysing the Altogether Better programme aimed at older people found that 83% of champions reported having a high level of knowledge, compared to a mere 22% at the beginning of the programme.[50] As a result of this increased knowledge, the literature shows that many participants reported making their own lifestyle changes, such as eating more fruit and vegetables or increasing their level of exercise. Additionally, many report significant improvements in physical health, such as reduced BMI, lower blood pressure, weight loss and improved condition management.[50] One participant stated that:

"people in the street cannot believe it is me as I have lost five stone and have gained so much confidence".[66]

Similar to the health trainer service, there is also evidence of a 'ripple effect', as demonstrated by the following quote:

"being a health champion has really helped me and my family. We are more outgoing and we do more activities together. We are healthier, fitter and happier".[67]

The qualitative research into the Altogether Better programme also demonstrates the wide range of mental health benefits the champions receive from their role. The New Economics Foundation proposes the 'five ways to wellbeing', which if followed, could significantly improve our mental health and wellbeing. The 'five ways' include 'connect', 'be active', 'take notice', 'keep learning' and 'give'.[68] Recently, a sixth 'way' has been introduced, which is 'grow your world'.[69] The health champion role encourages participants to incorporate all these actions into their daily lives, for example, by integrating with the local community, organising exercise classes, completing qualifications and training and volunteering to help others. A recurring theme in the literature is the increased confidence and reduced social isolation champions experience. One health champion stated that:

"being a health champion really helped me turn my life around. It has built my confidence. I feel valued and trusted by the staff at the project. I also have a real direction in my life".[66]

Another health champion from the same programme stated that:

"I have always been very health conscious, but believe the project has brought some happiness into my life".[66]

These findings demonstrate that the champions themselves experience real benefits from participation in the programmes relating to physical and mental health, and also career prospects.

6.3 Do health champion programmes provide value for money?

The final aspect to be considered in relation to health champions is cost-effectiveness. Similar to the literature on health trainers, there are few attempts to demonstrate the value for money of the programmes. One attempt, however, is by the York Health Economics Consortium, which found that for every £1 invested in the Altogether Better project, there is a return of up to £112.42.[67] This demonstrates considerable value for money. Similarly, using the VIVA measurement, Volunteering England suggests that for every £1 invested in volunteers, the NHS receives between £3.38 and £10.46 back. The VIVA measurement takes into consideration the potential monetary value of the number of hours given by volunteers, which is then divided by the cost of training and supervising the volunteers.[70]

Workplace-based programmes also showed evidence of cost-effectiveness. According to research conducted by Pricewaterhouse Coopers,[71] in 2013 sickness absence cost UK businesses £28.8 billion, a significant proportion of which is due to avoidable illnesses. As discussed above, the evidence suggests that the health champion initiatives can be very successful in reducing an organisations level of sickness absence. One business who took part in the workplace-based Altogether Project claimed to have saved around £30,000 over six months due to reduced sickness absence.[66] The 2008 study conducted by PricewaterhouseCoopers examining the introduction of workplace wellness programmes found that 14 of the 55 case studies specifically reported savings. For example, a car manufacturer reported savings of £11 million over a 13 year period due to a 1% reduction in absenteeism.[64]

6.4 Conclusion

Whilst greater research does need to be conducted, the existing literature indicates that the health champion initiatives could be instrumental in helping people to adopt healthier lifestyles. Initiatives targeted at disadvantaged groups, such as Well London, have been successful in engaging local communities and supporting them to achieve behaviour change. There is also some evidence that the health champion projects provide value for money.

Making every contact count

A similar approach to the health champion initiative is the approach known as Making Every Contact Count (MECC) based on the Prevention and Lifestyle Behaviour Change: Competence Framework, which was first introduced by NHS Yorkshire and the Humber. Initially, this approach sought to provide NHS staff, from hospital porters to receptionists, with the skills to offer brief health advice to colleagues and members of the public as outlined in the framework. However, this approach has proven to be very popular, spreading widely with organisations from private health clubs to fire and rescue services having adopted the approach.[72] Whilst there is currently limited literature on this initiative, the literature that is available suggests that MECC is already achieving success.

The popularity of this initiative, it is argued, is due to the relative simplicity with which it can be introduced. It is both low cost and easily incorporated into the work of staff. One participant stated that:

"It's not about adding a great deal to what you do. It's about asking in a different way".[73]

Similarly, another stakeholder stated that:

"it is low investment – the training is free and it's not going to add to your workload, potentially in fact it can make the job easier if you are signposting people onto other services".[73]

The training for this approach is also well received;

"the training is perfect – it's simple, it's easy and it's short".[73]

The literature demonstrates that even training just a small number of people in MECC can result in a large number of people receiving health advice. For example, the Telford Primary Care Trust found that by training 16 staff members using the MECC e-learning facility, 480 people received opportunistic advice, 170 of whom were then referred to other services.[74]

Whilst this is a relatively new initiative, the literature indicates that MECC could be instrumental in supporting people to lead healthier lives. According to a 2012 report, one hospital had a 70% increased uptake for their stop-smoking service following the introduction of MECC.[72] NHS Hertfordshire experienced similar success; between September 2010 and October 2011, there was 440% increase in the number of referrals to the smoking cessation service.[74] There are also benefits for the people trained to use MECC, with an estimated 65% making positive lifestyle changes as a result of their training.[75] The non-professional nature of this initiative is viewed as an important feature. A study conducted by Nelson et al[73] found indications that people were more willing to listen to receptionists or hospital porters, for example, as these people were more on the 'same level'.

However, similar to the health trainer and health champion programmes, this initiative has experienced some difficulty, including some tensions with medical professionals. A respondent in the study conducted by Nelson et al[73] stated that they were:

"not surprised by the resistance from the medical profession. There are numerous initiatives whereby primary care is not the early up takers".

A further issue identified was initial reluctance from some members of staff, who felt they were being given additional work or that they did not have the right to comment on the lifestyle choices of others.[73]

Overall, the literature suggests that many staff trained to use MECC have now partially integrated 'healthy chats' into their work. In an evaluation conducted 18 months after the introduction of MECC, NHS Stockport found that 43% of their staff were having 'healthy conversations' with at least 50% of their clients.[76]

Whilst more research needs to be conducted, evidence so far indicates that MECC is a popular initiative due to the ease with which it can be incorporated into the day-to-day activities of employees and adapted to a variety of different working environments. The literature also indicates that MECC can be successful in encouraging people to make healthy changes, such as attending a stop-smoking service.

8

Role of the non-public health professions in health improvement

The wider public health workforce also includes professionals who work outside of the public health sector. Health outcomes are the result of myriad factors. Some factors cannot be altered, for example, a person's family history of disease. However, many factors which negatively affect health outcomes, such as access to housing, quality of food, local environment or level of education i.e. the wider determinants of health, can be improved. Professionals working within these sectors can be considered members of the wider public health workforce as, through effective planning and policy, they have the opportunity to significantly improve the public's health. This is the motivation behind the Health Impact Assessment (HIA), which is a tool for assessing the possible health consequences of policies and projects created in the non-health sectors.[77]

Incorporating health improvement awareness training into the training for other professions, such as architecture, is an effective way of improving public health by making such issues an instinctual consideration for people working in those areas. In relation to roles such as town planners, Botchwey et al,[78] recognising the link between public health and the built environment, stress the importance of developing interdisciplinary courses, which at the time of their research only a small number of US universities offered. A study conducted by Pilkington[79] in the UK demonstrates the potential benefits of this approach. In their study, public health training was added to an architecture course at the University of the West of England. Using questionnaires both before and after the training, this study found that the architecture students felt that they had a greater understanding of the importance of public health and were considerably more likely to incorporate this into their future work.[79]

Whilst much of the literature to date focuses on professionals working on the built environment, this approach is relevant for many other professions, such as those working in teaching. A study conducted by Shepherd et al,[80] which reviewed literature from all over the world, found that public health training for teachers resulted in improved knowledge on health topics and greater confidence to teach and act on health issues with their students. Additionally, there have been calls for the police to have greater training in public health, particularly in relation to mental health.[81]

Whilst these professions are not directly employed to influence public health, their actions can have a significant impact on health outcomes and there is a strong case for incorporating a public health aspect into their initial and 'continuing professional development' training. The transition last year of public health responsibility back to local government provides the ideal environment for such an approach to be adopted within the local authority setting.

The creation of 'healthy settings'

'Healthy settings' is an approach rooted in the Ottowa Charter of 1986, which takes a 'whole-system' approach to health promotion.[82] A setting can be defined as '[t]he place or social context in which people engage in daily activities in which environmental, organizational and personal factors interact to affect health and wellbeing'.[83] Creating a 'healthy setting' is about taking a multidisciplinary approach to reduce the health risk factors across, for example, a workplace, a community, a school or university.[82]

Several of the projects discussed in this report are examples of such an approach, such as the Well London initiative. Projects utilising health champions, contribute to the creation of 'healthy communities' and take an assets-based approach to community development by engaging local people. This in time produces communities with stronger 'social relationships, social support, social networks and social capital'[84] with a greater capacity to tackle health issues. This section will consider in particular 'healthy universities' and 'healthy schools'.

Universities are ideally placed to influence the health of their students. With most universities providing their students with accommodation, places to eat and purchase food and places to socialise, they have a captive audience for health promotion initiatives. Consequently, universities and the related workforce can be considered a part of the wider public health workforce, with clear potential to influence the physical activity, alcohol consumption and diets of their students.

With many students living away from home for the first time, the university setting is arguably a critical stage for the development of healthy lifestyles. The University of the West of England (UWE) is a good example of a university adopting such an approach. UWE, a member of the UK National Healthy Universities Network, has introduced university smokefree clinics with student practitioners, weekly cooking demonstrations, the availability of reasonably priced fruit and vegetables, a self-help anxiety app developed by UWE and a range of 'feel good events'. Additionally, by September 2014 the university aims to have made their campuses 'smokefree spaces'.[85] A study conducted by Dooris and Doherty[86] into the potential introduction of a healthy universities national programme found that there was clear enthusiasm for such an approach, with 96% of the respondents stating that they would be interested in either knowing more or participating in the programme. Dooris and Doherty[87] state that:

"[d]espite the lack of leadership to date, there was a strong sense that it is the right time for a formal commitment to be made to extend the healthy settings approach beyond its application in schools...and put higher education 'on the map".

To date, much of the 'healthy settings' activity has been focussed on 'healthy schools'. This is one area of the wider workforce that is frequently discussed in the JSNA and JHWS documents (see appendix a). A report published in 2011 evaluating the national healthy school programme

presents a positive picture of the programme. With regard to the healthy eating aspect, many schools introduced innovative ideas, such as introducing 'family groups' seating, introducing metal cutlery instead of plastic cutlery to make lunch feel more important and also, the introduction of cooking classes, health eating classes and gardening clubs.[88] According to this report, the schools gave positive feedback on this initiative, with 77% reporting that the programme had 'fair' or 'a lot' of impact on the schools healthy eating activity.[88] Some schools reported that the initiatives resulted in the school improving the quality of the food more generally in the school and in some cases, changed the attitude of parents to healthy eating.[88] Additionally, they found that 87% reported some impact on their schools' provision of PSHE

and 72% reported that they had some impact on physical activity provision.[88] However, the report also found some factors that constrained the success of the initiative, including staff engagement and limited contact with students.[88] In the South West, following the success of the national healthy schools programme, the 'healthy school plus' was developed for the most deprived schools that had already achieved 'healthy school' status. The evaluation of this project found that 96% of schools reported improvements in behaviour or knowledge.[89] These findings suggest that a 'healthy settings' approach in a school environment has great potential to improve knowledge and behaviour around health.

Conclusion

The wider public health workforce encompasses a huge number and variety of people, from those employed specifically in a public health capacity, such as health trainers and health champions to those working, for example, as receptionists or librarians with the opportunity to have 'healthy conversations'. This report has considered five key aspects of this workforce; health trainers, health champions, Making Every Contact Count, non-health professionals and 'healthy settings'. Whilst there is variation in the extent and quality of the evidence currently available, overall the literature demonstrates the excellent potential of the wider workforce to improve healthy behaviour and reduce inequalities.

The evidence surrounding health trainers, health champions and MECC demonstrates that these interventions are achieving considerable success in supporting behaviour change. The trainers, champions and clients report a wide range of benefits that extend beyond simple improvements to physical health. They report improved mental wellbeing, increased social interaction, higher levels of community cohesion and improved career prospects. It is clear from qualitative evidence that the non-professional, client-led, personal approach is popular amongst target audiences.

The evidence also, however, highlights some difficulties inhibiting the success of the initiatives. The ability of the workforce to integrate with 'hard-to-reach' groups is one area of concern, although there is evidence that adopting innovative methods may help to overcome some barriers to engagement. Greater research is also needed, particularly into the extent to which behaviour change is sustained and the cost-effectiveness of the programmes, in order to strengthen the evidence base.

There is considerable potential for other aspects of the wider workforce as well. The movement of public health responsibility back to local government provides an opportunity for developing an integrated, cross-departmental approach to tackle health concerns. Professionals working in areas such as housing, education and planning have the potential to significantly impact health outcomes and therefore, should be provided with additional public health training to enable them to recognise the impact of their work. This is an area which currently has limited evidence, but certainly merits greater consideration.

The final aspect of the wider workforce considered by this report was 'healthy settings'. This section considered the work of 'schools' and 'universities', which are both ideally placed to influence the health of their staff and students. Again, whilst the evidence is patchy, there is clear potential for such an approach to improve health outcomes.

Without a sea change in our approach to health improvement, our health services will be unable to cope with the growing tide of lifestyle-related poor health. The difference in life expectancy between rich and poor will grow ever larger and our economy will pay the price. Changing this pattern can only take place by harnessing our communities' assets. The RSPH, therefore, calls for greater investment in the wider public health workforce. Along with this, there must be greater evaluation of this workforce, in particular through the DCRS, allowing us to gain a greater understanding of what initiatives are achieving success and where investment should be focussed.

To conclude, this report has demonstrated the importance of investing in the wider workforce in all its forms, and that, with effective training and management, the workforce has considerable potential to significantly reduce avoidable illness and ultimately, health inequalities.

Appendix a –
The visibility of the wider public health workforce in JSNAs and JHWSs

Since 2007, the NHS and upper-tier local authorities have been required to complete a Joint Strategic Needs Assessment (JSNA). The purpose of the JSNA is to assess the health and wellbeing needs of a particular local area to guide commissioning and to inform the Joint Health and Wellbeing Strategy documents (JHWS).[90] The JHWS outlines the strategy of a local authority to meet the priorities and concerns identified in the JSNA.[91] These documents provide an insight into the public health priorities of local areas. Following an analysis of the JSNAs and JHWSs for each local authority, it seems that there is mixed visibility of the wider workforce in these documents.

A positive finding is that a large proportion of JSNAs discuss the use of brief interventions and the need to utilise or develop community assets, such as peer educators, volunteers and social enterprises. However, only a small minority of either the JSNAs or JHWSs discuss the use of specific initiatives, such as health trainers, health champions or MECC. Less than a third of JSNAs refer to the health trainer service; this figure decreases to just over 10% for JHWSs. Similarly, less than 20% mention the use of health champions, decreasing to just over 10% for JHWS. With regard to MECC, less than 20% of JSNAs referred to this initiative and just over 10% for JHWS. When these initiatives are discussed this is often only in relation to specific health behaviours or particular groups, such as offenders or travelling populations. The figure is slightly higher for the use of healthy settings, primarily the healthy schools programme, with over 40% of JSNAs referring to either healthy schools or healthy workforces, although this similarly decreases to 15% for JHWSs.

Of those that discuss the use of brief advice and brief interventions, this is frequently solely in relation to primary care staff, such as GPs, midwives and people working in A&E rather than recognising the wide variety of people that could carry out these interventions. The JSNAs and JHWSs are key strategic documents guiding commissioning in local authorities; it is, therefore, vital that the wider public health workforce has greater visibility within these documents.

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