Bringing the
health improvement
workforce together

Contents

Foreword

The communities in which we live are part of the foundations for our wider health and wellbeing. The settings in which we live, work and play have the potential to support healthy and happy lives – encouraging social interaction, access to community groups and cultural resources, and where necessary, providing clear links to health services.

Equally, these settings can be characterised by health pitfalls; from a high street full of fast food shops to a lack of green space, some areas face multiple challenges to promoting health.

All communities are different, facing their own unique mix of health issues – issues in which local authorities have an unparalleled understanding.

The movement of public health to local authorities was a landmark moment, providing an unprecedented opportunity for taking a truly local approach to improving health and wellbeing.

Since then, we have seen many examples of innovation at the local level; our first report with the DCRS team highlighted this specifically within the health trainer service.

Developed in 2005 as a resource *from* communities, *for* communities, the service has greatly adapted and diversified, with many health trainer services moving away from the 'original' model to meet specific local needs.

It is undeniable that placing responsibility for the public's health with local authorities presented unique opportunities, many of which have been capitalised on; for many areas, however, this has been accompanied by ever-increasing budgetary constraints, with many services therefore, facing uncertain futures and, as demonstrated by our previous reports, the looming pressure of target-setting.

This report, the third in the series, explores these issues in more detail. Taking a broader look at health improvement services more generally, we have found the continued adaptation of these services, with a clear movement towards co-location, often accompanied by re-branding or re-structuring.

The wealth of data collected in the DCRS system however, continues to present a clear picture; these services, in whatever guise they appear, are successful in supporting positive behaviour change, amongst those groups often missed by primary care services.

Public health budgets are likely to take further hits in the coming years, particularly with the end of the ring-fence in 2018; it is therefore, more important than ever that we remember the vital importance of community and community-based assets, shaped to the unique local need for supporting a healthier, happier public.

Shirley Cramer CBE
CEO, Royal Society for
Public Health

'The movement of public health to local authorities was a landmark moment, providing an unprecedented opportunity for taking a truly local approach to improving health and wellbeing.'

Foreword

Over the years the data gathered by the Data Collection and Reporting Service has provided important evidence that helps us be clearer about the impact of health improvement services such as health trainers.

This contribution is particularly important for two reasons - first, the holy grail of public health is clarity about which Interventions actually work to reduce health inequalities and second, at a time of government austerity, cuts to local authority public health budgets mean that local commissioners are having to make tough decisions about what to retain and what to let go.
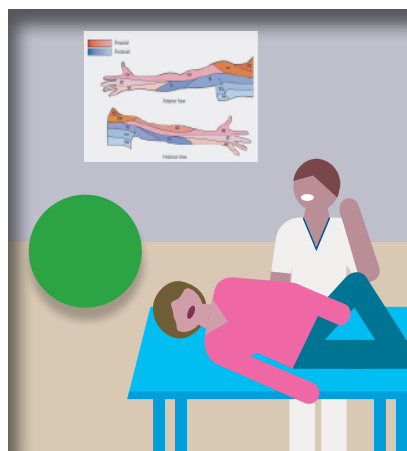
This report is particularly helpful because it uses the DCRS to provide the evidence to explore an important issue:

'What should be the shape of services that aim to support people who experience inequality take control of their own health?'

Its conclusions are clear - we need to take forward a twin-track approach. On the one hand, one of the successes of the health trainer model has been the way in which its skill is now being used to modernise existing specialist condition specific services, such as those concerned with diabetes or weight loss. We should welcome this and support this mainstream change.

On the other, we need to continue to invest in health trainer services that are holistic and neighbourhood based that place a greater emphasis on working alongside people and building longer term relationships, supporting them to focus on their personal priorities for wellbeing.

In very tough times it is tempting to try to identify apparently simple solutions to complex problems, this report provides some of the evidence that we need to ensure thoughtful discussion about how we should design local services to respond to local health challenges.

Professor Mark Gamsu
Leeds Beckett University

'One of the successes of the health trainer model has been the way in which its skill set is now being used to modernise existing specialist condition specific services...'

Executive summary

- Public health is currently unstable; the fiscal realities of budgets have forced local authorities to seek efficiencies in their services. In some cases, this has resulted in the decommissioning of public health services.

- The health improvement workforce and the services which support lifestyle behavioural change have experienced a sizeable change both with a reduction in the number of services being commissioned and also, the ways in which they are commissioned.

- This report confirms both the efficacy and success of health improvement services. Health improvement services under the Data Collection and Reporting Service (DCRS) tend to engage with those deemed most difficult to reach in a way traditional primary care doesn't. Moreover, they achieve sustained behaviour change as well as physical and emotional wellbeing improvements.

- The workforce however, is in transition. Our research, in the form of an online survey and interviews, has highlighted that this transition takes multiple forms – from restructuring to decommissioning entire services – but many appear to be converging on a model that places integration at its core; often co-locating health improvement services in one site.

- Funding was found to be a key driver in this change. Survey respondents indicated that the transition was in part explained by a desire for a new approach to public health and health improvement; that integrated holistic care is best attained when services are working together. This in turn increases choice and ultimately, exposure to other health improvement services.

- A comparative analysis of traditional health improvement services and non-traditional services (i.e. those that are distinct from a traditional model of health trainer services) found that they engage similar clientele, but that traditional services perform on the whole better across metrics such as self-efficacy, general health and waist measurement.

- The report concludes with a short argument about how this transition is best supported by DCRS – that it is the system's flexibility that enables commissioners to maintain and expand data collection for service evaluation across and within a hub model.

'Public health is currently unstable; the fiscal realities of budgets have forced local authorities to seek efficiencies in their services. In some cases, this has resulted in the decommissioning of public health services.'

The evolution of the health improvement workforce

The Five Year Forward View[1] outlined at length the future role of the NHS in the promotion and protection of the public's health, as well as its role in the prevention of public ill-health. It argued that whilst the NHS still had a distinct role in promoting secondary prevention, the importance and provision of primary prevention services – namely those that promote behaviour change and build community capacity to better the public's health – would now need to be championed by local leadership within local authorities, following the transition of public health services to local authority control in 2013.[2]

This transition was not 'like-for-like' and came with the caveat that local authorities would need to find 7% in-year savings within the public health budget, totalling some £200m.[3] Local authorities and their public health teams have since had to operate in a context where efficiency is crucial to a services sustainability; a challenging prospect where the remit of the budget is so broad covering services including: obesity, smoking, sexual health, physical activity, substance misuse, among others.

An additional real terms reduction in spending budgets of 3.9% per annum until 2020/21[4] has only served to compound this uncertainty. Local authorities, therefore, need to find in the region of £531m in-year savings over the next five years. The promotion of the prevention agenda and the commissioning of health improvement services is seemingly at great risk.

This report, the third in a series of six, explores the drivers and the 'direction of travel' for commissioners, demonstrating in which areas commissioners have adopted a different approach and have either succeeded or potentially underachieved. Finally, it offers some thoughts on how operationally this transition can best be supported and evidenced with the assistance of DCRS.

What is the health improvement workforce?

The 2010 White Paper, Healthy Lives, Healthy People: Our Strategy for Public Health in England,[5] and later, the Healthy Lives, Healthy People: A Public Health Workforce Strategy (2013)[6] outlined the vision for the health improvement workforce. These documents envisaged a workforce that was committed to the population's health by promoting and protecting its health. But also a workforce wholly committed to the prevention agenda - its success hinged on its flexibility and adaptability, embedded with expertise and strong local leadership.

In short, therefore, the workforce is comprised of many different facets of primary healthcare, but all share some professional investment in the public health agenda.

For the parameters of this report, however, the health improvement workforce should be viewed through the lens of the services that offer interventions to support behavioural change, provide information and health advice, improve the health of service users and prevent future ill health, but are ultimately not 'specialist'. Namely services such as health trainer services, smoking cessation services, alcohol and drug screening, weight management services and sexual health services, among others.

Despite being largely diverse in the range of issues presented to the services themselves, they for the most part share a competency core, which places motivational interviewing and providing health promotional information to support behavioural change at the heart of their work. However, the means and the methods of doing so can often be fragmented and the specialism of the individual providing the information may be distinct e.g. a community pharmacist and a lay-health trainer can both provide smoking cessation services.

Methodology

This report adopts a similar approach to the previous two, insofar as it uses a mixed methods approach comprising both qualitative and quantitative methods to make its conclusions.

The quantitative research has used the Data Collection and Reporting Service dataset, in combination with information provided by DCRS; firstly, to assess the general success of all services under the DCRS umbrella, but also to break down by those identified as traditional and non-traditional services. The qualitative research, conducted between March and June 2016, is comprised of two elements, an online survey with 174 respondents and 12 semi-structured interviews with commissioners, service leads and members of the health promotion workforce.

Definitions

'Traditional services' refers to services that follow a model of health improvement, mostly health trainer services, that are holistically focused, have no specialisation, share a common management structure and are often located on one site.

Non-traditional services are those that have augmented in some way, and deviated from the traditional model, either by specialising in weight management, mental health or similar. In many cases, these services are co-located with other services in a community hub.

A national success?

The health improvement workforce is central to the success of the prevention agenda outlined in the Five Year Forward View.[1] In providing a broad range of interventions, the workforce has the capacity to not only improve the health of the client user, but also the capacity to reduce health inequalities by supporting the wider population to achieve and maintain behaviour change.

This is especially true in the case of health trainers, who form a large portion of the health improvement workforce currently under the DCRS umbrella. The 2004 White Paper, *Choosing Health: Making Healthier Choices Easier,*[7] outlined the value of lay health trainers in increasing the acceptability of health information to clients who are often described as 'difficult to engage'. The success of health trainers in engendering almost uniform health improvements in their clients has been affirmed by many previous reports produced by, and independently of DCRS. This report adopts a similar approach but used the last 8 months' worth of data to account for some of the changes in health improvement services since the last report, published November 2015.
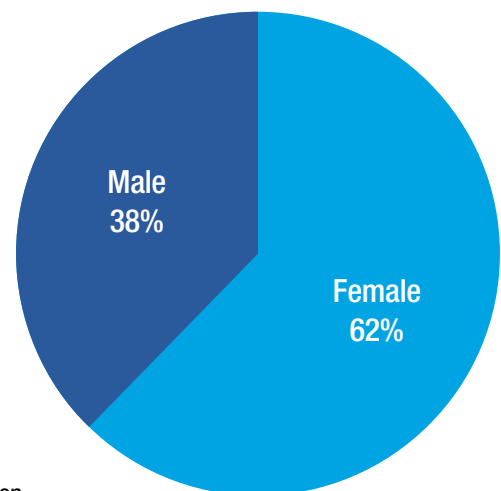
'Health improvement services offer a less formal setting, in which advice feels less judgmental and more conversational increasing the acceptability of the intervention.'

Almost all of those interviewed by RSPH, highlighted that one of their main key performance indicators concerned service throughput, or simply the number of clients entering the service. An analysis of health improvement services showed 81905 clients had come through service between 01/09/2015 to 22/06/2016, which indicates that health improvement services under DCRS are reaching large proportions of their communities, which is the first step to affecting the health of their populations.

Figure 1: Breakdown of service-users by gender

Male 38%

Female 62%

Figure 1 demonstrates that health improvement practitioners are also reaching a significant proportion of men in their services. Men, traditionally, have been described both as most likely to adopt unhealthy or risky health behaviours, most likely to suffer from non-communicable diseases, but paradoxically less likely to be pro-active in doing something about it.[8] This therefore, indicates a real discernible impact upon health inequalities. Even if simply signposting or providing health information to 'nudge' healthy behaviours, health improvement services are able to effectively engage groups that are disproportionately absent from primary health care services. Wang et al found that gender differences are around 68/32 (Female/Male) across the UK, but men are even less likely to present when from deprived backgrounds.[9] Health improvement services offer a less formal setting, in which advice feels less judgemental and more conversational, thus increasing the acceptability of the intervention. The DCRS data indicates that men are more comfortable seeking help in this context, especially where those men are mainly from deprived backgrounds.

In a similar vein, all that were interviewed stressed the importance of targeting those that are most deprived in their communities and said that it formed a key performance indicator.

The most deprived in society are much more likely to achieve poorer health outcomes,[10] engage in activities that harm their health[11] and face greater barriers to improving their health.[12] Figure 2 is therefore, positive viewing for both health improvement practitioners and commissioners alike, as it illustrates the vast numbers of people they see who are from the most deprived socioeconomic groups. The majority (70.6%) of health improvement clients are from the two lowest deprivation quintiles.

Health improvement practitioners are therefore, providing support to clients who are typically more difficult to engage and the least likely to utilise traditional healthcare services – such as general practice. This context provides a vital platform for national success as well as a strong foundation to bring about meaningful behavioural change, individual and public health improvements and provide commissioners with a social return on investment.

The DCRS data indeed demonstrates the considerable success with which services are supporting positive behaviour change amongst clients. As table 1 indicates this success is across a range of physical health and mental wellbeing measures.

Figure 2: Clients broken down by deprivation quintiles
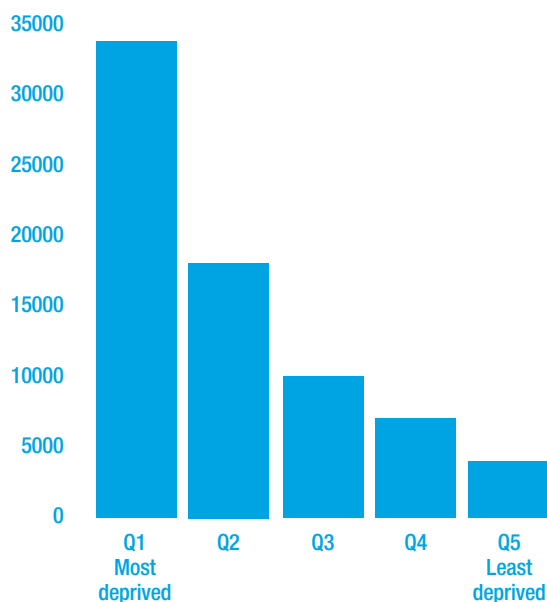
'Not only are they engaging clientele who traditionally do not tend to access healthcare services, they are doing so in an effective way.'

| Measure	Pre-baseline	Post-baseline	Change
Vigorous exercise (40 mins per day)	0.45	1.06	135.56%
Moderate exercise (30 mins per day)	2.45	4.21	71.84%
Fruit and veg consumption (daily)	2.88	4.38	52.08%
Alcohol	5.69	3.58	-37.08%
Smoking (daily)	2.31	1.51	-34.63%
WHO-5	43.81	57.1	30.34%
General health	52.65	65.37	24.16%
Physical health	49.73	61.51	23.69%
SWEMWBS	56.24	67.01	19.15%
WEMWBS	61.29	68.79	12.24%
Self-efficacy	64.49	72.18	11.92%
Waist CM	103.02	98.49	-4.40%
BMI	33.88	32.88	-2.95%

Table 1: Physical and emotional wellbeing scores pre and post intervention.

WEMWBS – The Warwick-Edinburgh Mental Wellbeing Scale is a measure of general population mental wellbeing. The questionnaire has 14-items/questions and covers both the feeling and functional aspects of mental wellbeing.

SWEMWBS – The Short Warwick-Edinburgh Mental Wellbeing Scale is a shortened, 7-item/question, version of WEMWBS. The questionnaire covers more of the functioning aspect of mental wellbeing. The two questionnaires are highly correlated with one another.

WHO-5 – The World Health Organisation 5-item/question is the most widely used measure of subjective wellbeing in the world. It is a simple 5-item questionnaire that can be self-administered and is reasonably non-invasive.

Self-efficacy – The self-perceived ability to achieve certain goals and initiate behaviour change e.g. the inner perception of being able to achieve weight loss.
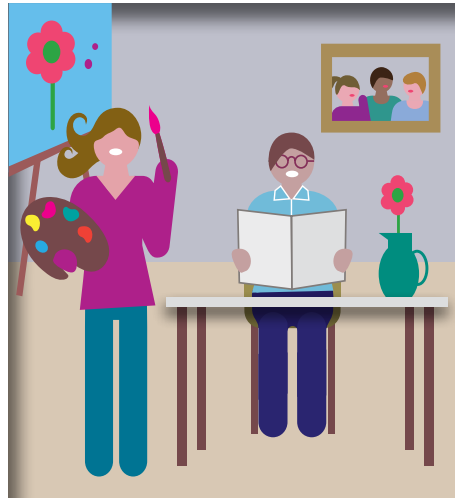
A workforce in transition

Health improvement services, namely that of health trainers, have historically been diverse in both their models of provision and emphasis on specific areas of health improvement. Some have adopted diverging methods of delivering health improvement services, such as over the phone or internet as well as being delivered in different settings – in general practice or in community centres and in some instances, cafés.

In turn, health trainer services have often adopted specialised approaches; for example, some services have greater emphasis on weight management, whilst others may prioritise mental and emotional wellbeing. Often doing so to reflect the local need for these services or to meet key performance indicators outlined by commissioners.

Despite their differences, health trainers can be said to traditionally follow a similar ethos or core competency which sees them employing the same techniques – such as motivational interviewing – and approaching health in a holistic way over multiple sessions. Our survey largely confirmed this, when asked whether they agreed with a series of statements, 93.55% of health trainers agreed or strongly agreed that their *'...role considers health and the public's health as holistic, and treats clients for more than one issue'.* Accompanied with the recognition of the importance of mental health for improving health: 87.5% of respondents agreed or strongly agreed with the statement that *'My role recognises mental wellbeing as a key factor in improving physical wellbeing'.* Prevention of ill-health (87.5%), signposting (82.5%) and building capacity for change (82.5%) were also seen as vital components of their work.

Health trainers have been able to maintain this approach in spite of large portions of services experiencing wholesale changes to either the size or structure of their service. Over two-thirds of survey respondents and almost all interviewees indicated that their health trainer services are in transition. However, this transition is not uniform and different local authorities are adopting different ways in which to achieve this transition.

Some local authorities are exploring bringing health trainers 'in-house' into local authority control, whilst others may be looking to simply restructure the way in which health trainer services are managed. One local authority health improvement team leader spoke to RSPH and noted that instead of reemploying a health trainer service lead who took voluntary redundancy, they repositioned and brought the service under the line management of the health improvement team.

Others are looking to alternate revenue streams, and looking to utilise the expertise and skill sets of health trainers to provide more specialised and long term services. A growing development within the public health sphere of commissioning is the growing prevalence of strategic partnership agreements – such as Strategic Transformation Plans (STPs) – between local authorities and clinical commissioning groups to commission CCG programmes, such as NHS Health Checks and programmes relating to diabetes management, in services commissioned by local authorities – such as health improvement services.

'We're branching out to meet the need of not just commissioners, but CCGs and clients. We've got health trainers in the vanguard model and are providing NHS Health Checks and Health MOTs.'

However, the direction of travel seems to be towards restructuring health improvement services utilising a community hub model. This approach places health improvement services within one locality – so a health trainer service may be integrated or co-located with other higher and lower tier services such as smoking cessation services, weight management services, general practices and pharmacies. These services then form a health and wellbeing centre or similarly named centre.

'As a health and wellbeing service, we can now offer a fully comprehensive one stop shop support service that clients always said they needed, but not just on lifestyle - in all areas too such as fuel poverty, housing, debt, mental wellbeing and education, skills and training as well as volunteering and physical health issues.'

Health improvement practitioners may themselves be, and are, in health and wellbeing centres under the branding of health trainers, but can also be within them under a completely different title. Our survey highlighted that some health improvement practitioners operate in services under different titles such as health promotion specialists, health promoter, health improvement provider and wellness officer, among others. Which raises the question as to whether this transition had resulted in large scale redesigning of the health trainer service and a shift away from the core competencies of health trainers and their services?

Our interviews and survey has revealed that this isn't the case: in the first instance, many health improvement practitioners come from health trainer backgrounds (27.5%), but also many health improvement practitioners share similar core competencies to that of health trainers, as demonstrated in table 2.

Competency	Health trainers	Other health improvement practitioners
'My role considers health and the public's health as holistic, and treats clients for more than one issue'	93.55%	81.82%
'My role recognises mental wellbeing as a key factor in improving physical wellbeing'	87.5%	88.64%
'My work focuses on building capacity to achieve and maintain results'	82.5%	88.63%
'It is key to prevent other potential ill-health whilst dealing with a client's issues'	87.5%	81.82%
'Signposting to other services is an integral part of the service, especially where clients present multiple issues'	82.5%	88.63%

Table 2: Core competencies comparison

The health improvement workforce is in transition; moving from previous traditional models of provision and management towards a more integrated community hub approach. This is not uniform and local authorities are adopting elements from each or adopting a single model. A move however, that represents a rebranding and a diversification rather than a fundamental redesign. As one commissioner commented: *'we commission the intervention, not the brand'* and this typifies the discussions we had with health improvement teams in local authorities, that public health and health improvement are still hugely important to commissioners and local authorities. However, realities are such that they are seeking new ways to commission the interventions in an efficiency seeking way – often this results in rebranding services and often co-locating.

Drivers of change

'As commissioners look to alternative ways in which to commission and provide health improvement services, it's important to understand why they are doing so.'

As commissioners look at alternative ways to commission and provide health improvement services, it's important to understand why they are doing so. The qualitative research conducted by RSPH highlighted a number of themes and drivers of change, which have prompted commissioners to seek different or alternative ways of providing health improvement services.

Funding

The biggest driver of change is the increasing pressures associated with the funding and financing of services. Public health budgets are at their greatest point of pressure, with local authorities having to seek greater in-year savings than originally expected. Furthermore, as some health improvement services are unprotected, such as health trainers, commissioners are more likely to seek efficiencies in those areas.

Our interviews revealed that commissioners value the work of health trainers, and that they hope the service will be here for the 'long run', but funding and the insecurity of funding means that services are having to restructure and that additional savings only serve to compound the likelihood of further restructure. One service lead commented that *'we're out to tender next year, so we will probably have to restructure again. It looks like the local authority will go for an integrated model'.*

The need to make efficiencies has led to many services being reduced in size, with one health trainer mentioning that their service had been *'dramatically decreased'* in size and that *'staff redundancies had resulted in a smaller team to deliver same service requirements'.* In some cases, the need to save money has led to services being decommissioned – although this is often in combination with other issues such as local need, underperformance and clientele.

The strive for efficiencies has led to greater uncertainty for health improvement services with the recognition that services will either be moved or drastically cut back. But the research conducted by RSPH also indicates an opportunity for health improvement services to use this situation to create better services and achieve more together than they currently are

Delivering integrated, specialised and holistic care

Some health improvement leads and local authority public health teams highlighted to RSPH that the transition can be seen 'positively'. By converging on a model which places integration at the core of the wider health improvement service, it improves the client's outcomes. The ability to create a single locality for health improvement has allowed for greater connected care and increased the health improvement workforce to more effectively signpost to one another.

Many health trainers indeed stated that they felt that their work was more connected and enabled greater cross-service care. One health trainer stated that working in a wellbeing centre '*enables closer working and cooperation with other service providers'.* Through a process of sharing information and close more tangible signposting pathways, health trainers can offer a better more integrated service but also one that can achieve greater holistic outcomes.

Clients choice

Increasing the connectivity of services inevitably increases both the profile of services within the centre and the choice of services available to clients. As one health trainer commented being part of a health and wellbeing service meant the service itself was *'…viewed as a formal part of the NHS services, and access routes seen as through the overall centre routes'.* It allows for clients to enter the centre and to be directed to specific services or to utilise certain services as they see fit.

Clients may use a health trainer to motivate and sustain behavioural change, whilst being able to use a smoking cessation practitioner, co-located at the same site, to seek specialist advice and tools to solidify behaviour change. Commissioners are therefore increasingly turning to an integrated model of provision to ensure that clients have options open to them to help improve their health and thus have a wider impact on the public's health.

Health improvement practitioner development

Another frustration of health trainers and the wider health improvement workforce is the lack of natural progression.[13,14] Health trainers are initially very satisfied in their roles but become increasingly frustrated by either the lack of professional recognition or personal development, in turn leading to greater attrition rates within the profession.

Commissioners, in some areas, are seemingly responding to this and providing greater career progression and pathways. By moving towards a more integrated model of health improvement services, it allows for the blending of management structures and in turn a mixture of public health tier provision. One health improvement lead highlighted that *'a health trainer may show aptitude for alcohol management, and be able to get additional training in it and progress and upgrade'.* The ability for health improvement practitioners to shadow and train with and under other higher tier providers can be of real benefit to both health trainers themselves and to the wider public health workforce.

Coordinating and prioritising local need

Local authorities are increasingly looking for value for money, whilst in turn attempting to generate the greatest public health impact. This often leads to commissioners looking to augment health improvement services to have specific specialities. In the example of health trainers, many have a weight management emphasis or others a mental or emotional health emphasis.

Putting out to tender before co-locating can in some instances lead commissioners to consider their local need and to coordinate services appropriately, with the result of creating a single locality in which many of the services contribute most significantly to one or two major local public health needs.

'Local authorities are increasingly looking for value for money, whilst in turn attempting to generate the greatest public health impact.'

Different means; same ends?

From the public health perspective, this change and convergence towards a model where health improvement services become increasingly integrated and connected in order to become more efficient, often with less resources – may be seen as somewhat problematic. Raising the question of whether non-traditional services are as efficacious as those that are traditionally a health trainer service.

Measure	Non-traditional	Traditional	Difference
WEMWBS	N/A	10.90%	N/A
WHO-5	20.66%	31.05%	10.39%
Self-efficacy	5.85%	11.92%	6.07%
SWEMWBS	14.10%	19.25%	5.15%
General health	21.10%	25.90%	4.80%
Moderate exercise (30 mins per day)	72.46%	74.06%	1.60%
BMI	-3.48%	-2.49%	0.99%
Physical health	15.04%	15.89%	0.85%
Smoking (daily)	-33.90%	-34.63%	-0.73%
Waist cm	-3.20%	-6.47%	-3.27%
Fruit and veg consumption (daily)	51.99%	47.53%	-4.46%
Alcohol	-30.03%	-41.70%	-11.67%
Vigorous exercise (40 mins per day)	143.18%	121.74%	-21.44%

Table: Outcome comparison traditional vs. non-traditional services (% change)

Our analysis largely dispels with the notion that the two models are all that different from one another. Both traditional and non-traditional models of provision see relatively similar clients – they tend to be female (66%; 60% - Traditional; Non-traditional) and be in the lowest two quintiles of deprivation (75%; 72%).

What becomes somewhat clear when looking at the relative performance of both traditional and non-traditional services is that whilst both are achieving incredibly high levels of behaviour change, traditional services perform almost uniformly better. This success is considerably more holistic and across both physical and emotional health. The areas in which non-traditional services perform best is in physical activity, often with notable difference in emotional wellbeing.

The extent to which this is a result of specialisation and prioritisation is unclear; many non-traditional services have adopted a hub model of delivery and as such, may see specific client's present to their service, or are a specialised service which specifically offer weight management services or smoking cessation services. But what is clear, is that both traditional and non-traditional services can support far reaching behaviour change, across many metrics, for those that are typically seen as more 'difficult to engage'.

How can DCRS support this transition?

With increasing financial constraints and a changing commissioning environment, many services are facing an uncertain future. The Data Collection and Reporting Service has responded to this challenge by enabling users to have the greatest flexibility possible, thus recognising the increasing variety in service models.

This report has argued that the direction of travel appears to be towards that of a community hub model, where health trainers are integrated with other health improvement practitioners to offer a one-stop shop for health improvement.

We therefore, have a situation in which a growing number of services encompass a number of distinct services, each with their own system of data collection. DCRS enables cross-service collection and reporting, with tailoring for each of the services – so integration offers an opportunity to unify data collection as well as provision to give a more coherent picture of a services performance.

The greatest strength of DCRS is arguably its ability to tailor itself to the service's need. From the traditional operational model to multi-service provision, DCRS can support most, if not all, services under health improvement.

'This report has argued that the direction of travel appears to be towards that of a community hub model, where health trainers are integrated with other health improvement practitioners to offer a one-stop shop for health improvement.'
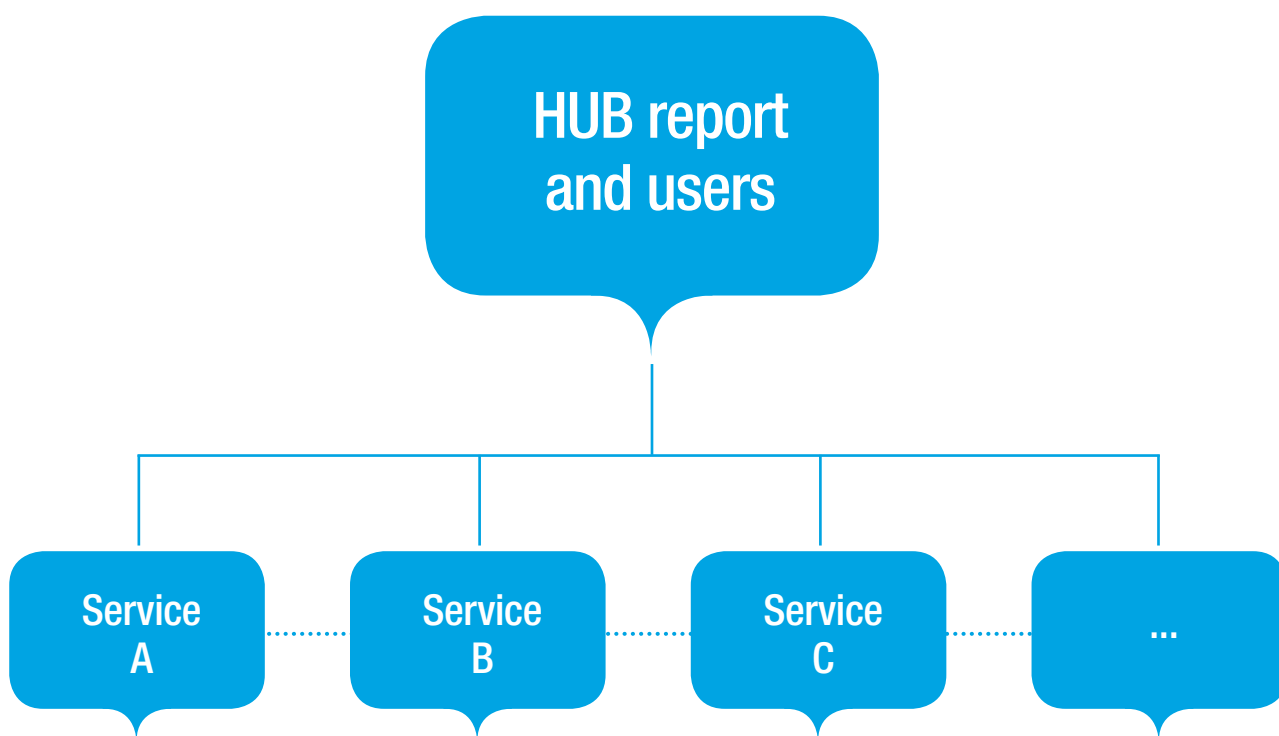

Figure 3. Diagram showing how DCRS can support multiple services under one location or management structure.

Conclusion

This report has highlighted that the current commissioning landscape is becoming increasingly uncertain in its direction. The increasing pressures placed on local authorities to seek in-year savings or cuts has forced strategic thinking about the future of health improvement services. This in turn has lead in many areas to decommissioning of services, notably that of health trainers, and in many other areas, commissioners have sought to restructure the way in which health improvement services are managed and the ways in which services are provided.

There has been a move towards a more integrated model, which places diverse health improvement services within a single locality. This was seen as preferential in order to increase choice, to minimise costs and to prioritise local need. It is seen as a way to deliver care that is holistic and client-centric – increasing the pathways between services and ultimately offer greater opportunity for significant and sustained behaviour change.

An analysis of health improvement services that were seen to have moved away from traditional models of provision (i.e. non-traditional) were found to be seeing very similar clientele; most were deprived and female – but performed on the whole slightly less well than traditional models. When viewed in isolation, non-traditional services perform slightly less well in emotional wellbeing metrics and seem to offer less holistic care. But this is in part explained by the diverse models comprised within non-traditional services such as such as those with particular specialisms.

Finally, this report has argued that DCRS is ideally placed to take forward the data collection and analysis of health trainers and wider health improvement services, offering the flexibility and inclusivity needed to encompass a wide range of health improvement services under distinct models of provision and organisation

References

1.   NHS England. Five Year Forward View. Available online at: https://www.england.nhs.uk/wp-content/ uploads/2014/10/5yfv-web.pdf (2014, last accessed 21st October 2016)

2.   Department of Health. Local government's new public health functions. Available online at: https://www. gov.uk/government/uploads/system/uploads/attachment_data/file/212962/Public-health-intelligence-local- government-functions.pdf (2012, last accessed 21st October 2016)

3.   Department of Health. Public health ring-fenced grant 2016/17 and 2017/18. Available online at: https:// www.gov.uk/government/uploads/system/uploads/attachment_data/file/499614/PH_allocations_and_ conditions_2016-17_A.pdf (2016, last accessed 21st October 2016)

4.   Department of Health. Department of Health's settlement at the Spending Review 2015. Available online at: https://www.gov.uk/government/news/department-of-healths-settlement-at-the-spending-review-2015 (2015, last accessed 21st October 2016)

5.   Department of Health. Healthy Lives, Healthy People – our strategy for public health in England. Available online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216096/dh_127424. pdf (2010, last accessed 21st October)

6.   Department of Health. Healthy Lives, Healthy People: a public health workforce strategy. Available online at: https://www.gov.uk/government/publications/healthy-lives-healthy-people-a-public-workforce-strategy (2013, last accessed 21st October 2016)

7.   Department of Health. Choosing Health: Making Healthier Choices Easier. Available online at: http:// webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/ PublicationsPolicyAndGuidance/DH_4094550 (2004, last accessed 21st October 2016)

8.   Pringle A, Zwolinsky S, McKenna J, Robertson S, Daly-Smith A, White A. Health improvement for men and hard-to-engage-men delivered in English Premier League football clubs. *Health Education Research.* 2014; 29: 503 – 520

9.   Wang Y, Hunt K, Nazareth I, Freemantle N, Petersen I. Do men consult less than women? An analysis of routinely collected UK general practice data. *BMJ Open.* 2013; 3

10. Office for National Statistics. Detailed analysis of health deprivation divide using the 2011 census. Available online at: http://webarchive.nationalarchives.gov.uk/20160105160709/http://www.ons.gov.uk/ons/ dcp171776_352724.pdf (2014, last accessed 21st October 2016)

11. Pampel F C, Krueger P M, Denney J T. Socioeconomic disparities in health behaviors. *Annual Review of Sociology.* 2010; 36: 349 – 370

12. Withall J, Jago R, Fox K R. Why some do but most don't. Barriers and enablers to engaging low-income groups in physical activity programmes: a mixed methods study. *BMC Public Health.* 2011; 11

13. Royal Society for Public Health. Tackling Health Inequalities: the case for investment in the wider public health workforce. Available online at: https://www.rsph.org.uk/filemanager/root/site_assets/about_us/reports_ and_publications/lowres_-_tackling_health_inequalities_-_the_case_for_investment_in_the_wider_public_ health_workforce.pdf (2014, last accessed 21st October 2016)

14. Rahman E, Wills J. The career journeys of health trainers in two health trainer services in England. *Perspectives in Public Health.* 2013

The Royal Society for Public Health is an independent, multi-disciplinary organisation, dedicated to the promotion and protection of collective human health and wellbeing.

Royal Society for Public Health

Tel: 020 7265 7300

Email: info@rsph.org.uk

Website: www.rsph.org.uk