London Health Commission – Response from RSPH 29/01/2014

Healthy lives and reducing inequalities

- *How can we empower individuals and use community assets to enable them to improve their own health?*
- *How can we better empower and support individuals and communities to put them in control of their own health care?*

The Royal Society for Public Health strongly advocates for the role of the 'wider public health workforce' in supporting communities to improve their health and wellbeing through empowerment and mobilising community assets. The core aspect of this workforce is its non-professional nature. This workforce 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. In particular, Health Trainers and Health Champions need to be used more widely and provided with greater support and training. These individuals are most effective when they are part of the communities that they work with, and can help improve health in communities with the greatest health needs. This approach represents a move away from the idea that public health is solely the domain of the medical professions and instead make it a community-wide responsibility. In addition, this approach views the client as an active rather than passive partner, who is empowered to make healthy lifestyle changes (Martindale, 2013: 160).

Synopsis of the evidence

The success of health trainers is, firstly, demonstrated by the behaviour change statistics. The Data Collection and Reporting System (DCRS) data 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% (DCRS Support Team, 2012: 17). 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 (Shircore, 2013: 13,16). Similarly, a longitudinal study conducted by Gardner et al (2012: 1178) 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%.

Health trainers based in community settings, such as pharmacies, are yielding similarly positive results. The Healthy Living Pharmacy (HLP) initiative, which enables greater exposure of the health trainer programme to the public, has been a very popular programme, as demonstrated by a 98% patient satisfaction rate (Royal Society for Public Health, 2013). 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 (National Pharmacy Association). With 84% of adults visiting a pharmacy at least once a year, 78% for health related issues, there is clearly excellent potential for the HLPs to impact unhealthy behaviour (Evans, 2013: 6).

There is also a significant body of qualitative research, 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. The non-professional nature of the trainers and the 'client led', personal approach is clearly valued (White, Woodward and South, 2013: 217). 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 (White, Woodward and South, 2013: 217). 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 (Shircore, 2013: 14). Another theme within the research is that the families and friends of clients are also benefitting from the health trainer programmes. Ball and Nasr (2011: 28) 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' (Ball and Nasr, 2011: 28).

There is also opportunity for social determinants to be addressed alongside behaviour if health trainer service in England can take full advantage of the landmark transition last year to the local authority setting.

In terms of success, a number of studies highlight that the health trainers, of which the majority are from the two most disadvantaged quintiles, frequently move on to other employment or further study as a result of the experience and skills they gained in the health trainer role. In this sense, the health trainer programme is not only tackling health behaviour, but is also seeking to address the wider determinants of health.

In addition, 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 (Institute for Criminal Policy Research, 2011: 26). Similarly, Rahman and Wills (2013: 210) 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.

As stated above, the majority of health trainers are from disadvantaged groups. According to the DCRS data from 2013, 56% of health trainers are from two most deprived quintiles (Shircore, 2013: 21). Therefore, the positive impact the service has on the lifestyles on the trainers themselves, may ultimately help to address health inequalities.

Unlike health trainers, a large section of the wider workforce operate in a voluntary capacity, offering brief advice and brief interventions alongside their other daily activities. Health champions 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.

One community based initiative, which has utilised health champions, is the Well London project. This project 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. This project, which adopts a bottom-up approach, engaging with local communities to set priorities, 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 (Well London). 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 these champions, all of whom were recruited from the local area and spoke multiple languages, was to signpost local 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 (Sheridan and BenOmar, 2011: 6). 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 are effective in providing a bridge between the local people and other services.

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 significant impact on health later in life, so initiatives directed at this age group are hugely important. 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 (Royal Society for Public Health, 2011: 1). Additionally, as members of their peer group, Youth Health Champions may be more effective at disseminating health information to young people than adults.

Research conducted by Volunteer 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 (Casiday et al, 2008: 3). A review of the literature demonstrates that these findings were replicated in several of the health champions programmes.

The first benefit is in relation to increased career prospects and increased skills and knowledge which can help address the social determinants of health. 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 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' (Turner and McNeish, 2013: 18).

The research also demonstrates the vast 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 (Woodall et al, 2012: 11). 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 greater condition management (Woodall

et al, 2012: 11). 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'. 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' (NHS Confederation, 2012: 2)

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

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 (NHS Confederation, 2012: 1). This demonstrates considerable value for money. 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 (White and Woodward, 2013:24).

Overall, the literature indicates that the wider workforce has huge potential to improve health outcomes, and specifically, to target groups where health inequalities are most pronounced. It is clear that a paternalistic, top-down approach to health improvement only widens health inequalities and it is essential that peer-to-peer approaches are adopted and expanded to ensure that everyone in society has the same opportunities to health advice and care. Initiatives specifically targeted at disadvantaged groups, such as Well London, have been successful in engaging local communities and supporting them to achieve behaviour change.

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