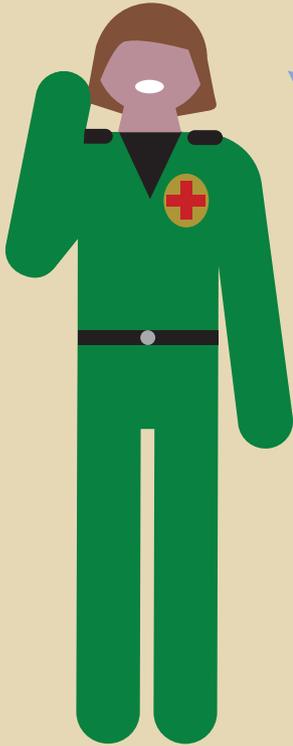




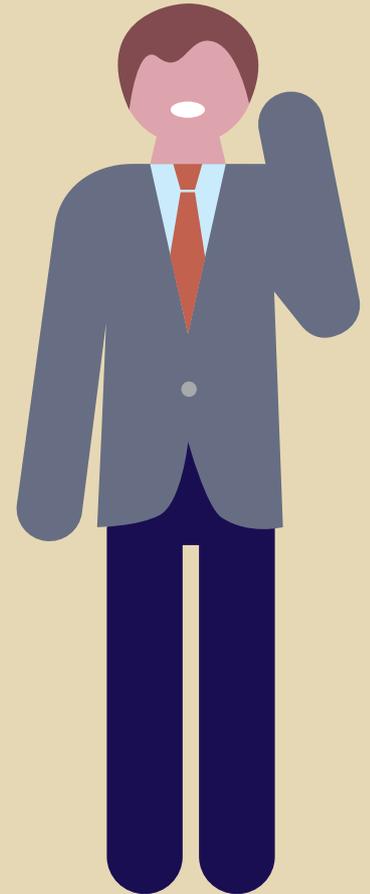
Public Health
England

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ROYAL SOCIETY FOR PUBLIC HEALTH
VISION, VOICE AND PRACTICE



Healthy
Conversations



and the
Allied Health
Professionals
#AHPhealthyconvos



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Foreword from Duncan Selbie and Shirley Cramer

The UK's 172,686 Allied Health Professionals (AHPs) are central to the health and care workforce. The 12 different professional groups making up AHPs have trusted relationships with patients and clients at every point in their lives, within a wide range of settings as well as working closely with other health and care professionals.

With over 4 million client contacts every week, AHPs are an important network through which we can support behaviour change and ultimately improve the public's health. Whether it is signposting people to smoking cessation services or offering brief lifestyle advice on healthy eating, AHPs are undoubtedly an unsung and instrumental part of the wider public health workforce.

There are many examples across all the professions where AHPs are already supporting the public's health. One of the most effective ways that AHPs can do this is through having healthy conversations with their patients or clients. Building on the success of the Making Every Contact Count initiative pioneered by the NHS, this report looks at the extent to which AHPs can and do engage in healthy conversations. Such conversations are critical in supporting people on their journey to change their behaviours and ultimately enable them to lead healthier lives.

While talk is said to be cheap, healthy conversations really do matter because by any measure poor public health is costing us dearly. With the adoption of healthier lifestyles 1 in 4 deaths is avoidable, and the cost of avoidable illness is estimated to be around £60bn.



A handwritten signature in black ink that reads "Duncan Selbie".

Duncan Selbie Chief Executive
Public Health England



A handwritten signature in black ink that reads "Shirley Cramer".

Shirley Cramer Chief Executive
Royal Society for Public Health

Executive Summary

The 12 Allied Health Professions (AHPs) have signed up to a collective ambition to be recognised as an integral part of the public health workforce. This workforce of 172,686 makes up 6% of the total NHS staff and therefore has the potential to make a significant contribution to the national prevention agenda outlined in the NHS Five-Year Forward View and Public Health England's Evidence into Action.

Healthy conversations or making every contact count (MECC) encourages those working within the health sector and beyond to use every opportunity and interaction with patients and visitors to promote healthy lifestyle choices and signpost to relevant healthcare services.

In order to better understand the extent to which AHPs engage in healthy conversations, the Royal Society for Public Health and Public Health England have undertaken a joint project with the support of each of the AHP professional bodies. The project included a survey completed by over 2000 AHPs to determine the extent to which AHPs already undertake healthy conversations with their clients and patients. This survey fieldwork also included a series of focus groups and one-to-one interviews to better understand some of the barriers and solutions to embedding healthy conversations within an AHP's routine interactions with their patients and clients. A public opinion poll with a response rate of 2000 people explored the public's readiness to have a healthy conversation with AHPs.

We found

- **Almost 9 in 10 (87.6%) survey participants agree that their role should include an element of preventing ill health;**
- **Over three quarters (76.0%) agree that their role does provide opportunities for healthy conversations;**
- **Over four fifths of participants (81.8%) said that health improvement or preventing ill health was already incorporated into their daily practice;**
- **Almost one third (31%) would feel comfortable discussing areas of health that do not relate to the condition their client is receiving care for, although for a significant proportion (35%) this would very much depend on the topic;**
- **Almost 9 in 10 (86%) members of the public who responded to the survey would trust such advice if it came from AHPs.**

Whilst there is an overall willingness to engage in healthy conversations; AHPs identified several challenges to doing this in practice including their confidence to initiate a conversation, particularly if it is about an issue not directly connected to the reason they are seeing a client; pressures on time; the need to gauge the appropriate time within the clinical relationship to initiate a conversation; and the lack of easily accessible information about local services and community assets to support signposting.

A number of different solutions were proposed by AHPs to build their confidence in undertaking healthy conversations – these included training and improvements to signposting (including the ability to directly refer patients to services).

1. Introduction

About the Allied Health Professionals

- Allied Health Professionals (AHPs) are a group of 12 distinct professions who make up 6 percent of the NHS workforce. AHPs remit is diverse and far-reaching, working in many settings and with a wide range of other professionals. While the majority of AHPs work for the NHS many also work in the voluntary, social care and private sectors. They also work in a variety of settings, including hospitals, outpatient clinics, schools, prisons, people's homes and the wider community.
- In 2013 there were 172,686 registered AHPs. The different professionals and approximate numbers making up AHPs include:
 - **Physiotherapists – 48,863**
 - **Occupational therapists – 33,789**
 - **Radiographers – 29,052**
 - **Paramedics – 19,955**
 - **Speech and language therapists – 13,942**
 - **Chiropodists/podiatrists – 13,060**
 - **Dietitians – 8,340**
 - **Drama, art and music therapists – 3,429**
 - **Orthoptists – 1,312**
 - **Prosthetists and orthotists - 944**

Source: HCPC 2014

- The career progression route for AHPs involves completing a course of study or training at degree level or above. They must also be registered with the Health & Care Professionals Council (HCPC). The HCPC ensures that AHPs meet a standard of training, professional skills, behaviour and health so that they are fit to practise. In addition, each professional group has its own professional body which works to promote the professions good practice and ensure members are meeting their professional and regulatory standards.



Part of the hidden wider public health workforce

- It is estimated that in England around 40,000 people are employed to work in public health but that is less than 0.0008% of the population and it would be a mistake to think that this workforce by itself can tackle the deep rooted public health challenges our nation faces such as the rise in levels of obesity.
- Increasingly there is recognition of the important role that wider health and care professionals can play in tackling these public health challenges. This “wider public health workforce” includes people who champion the public’s health and wellbeing through their day to day contact with the public, but whose primary role is not public health focussed.
- Allied Health Professionals are an integral part of this wider public health workforce. They already contribute to virtually every public health priority and they have a huge potential to do much more. Based on capacity alone AHPs are a significant workforce. In 2013, there were 172,686 registered AHPs and they have tremendous opportunity to support improving the public’s health at scale.
- This report uncovers many examples of where AHPs are already making a difference to the public’s health through leading healthy conversations with their clients and patients.



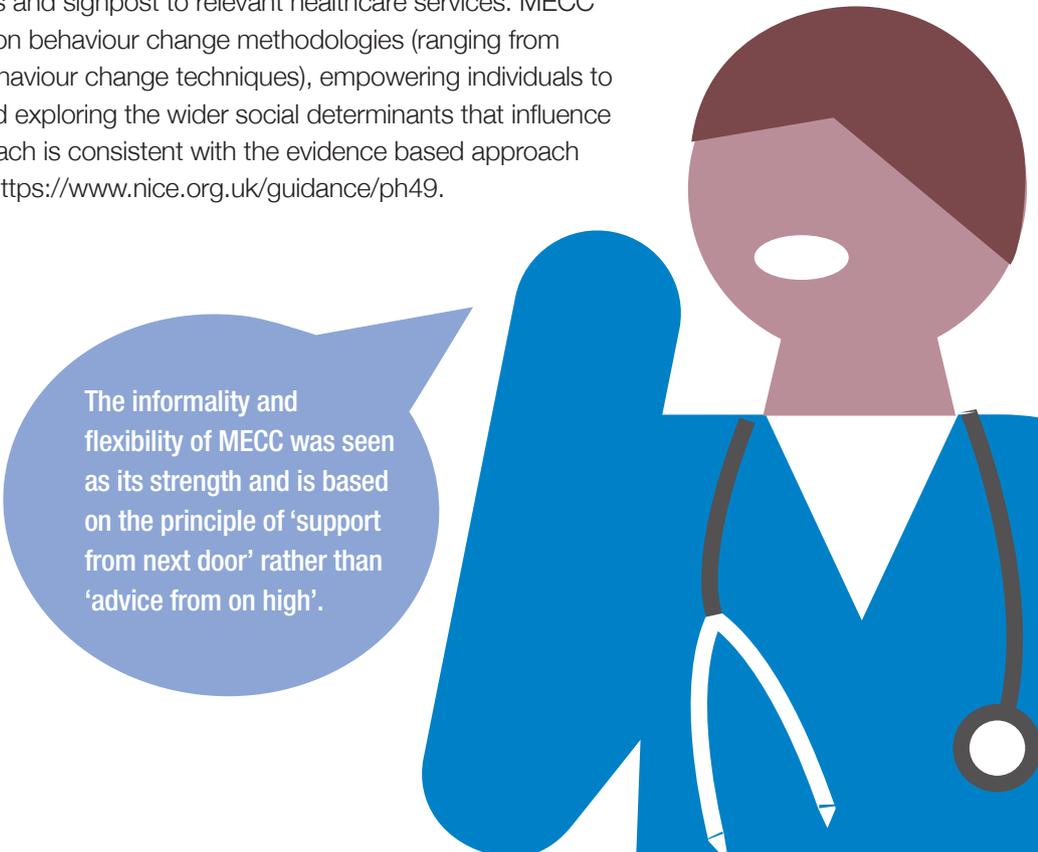
2. What is a healthy conversation?

A healthy conversation takes place opportunistically between at least two people, and involves an individual being encouraged to consider their lifestyle and health with a view to identifying small but important changes. This may involve offering brief advice and signposting to other services. A key way in which the wider workforce can support behaviour change is through initiating these healthy conversations during routine appointments and when delivering routine services. Initially the healthy conversations approach was focussed on healthcare settings, but it is also proving popular outside of healthcare, including within the fire service, police force, local authority services and in leisure centres.

Healthy conversations between patients and clinicians have several elements to them:

Cue	A hook which enables the patient/client to raise a subject with the AHP, or vice versa
Conversation	The brief intervention
Conclusion	Signposting to follow up / specialist support services

Making Every Contact Count (MECC) is a widely recognised training programme and approach for increasing healthy conversations within health and care services. The MECC premise was based on the need to recognise the huge potential of the wider NHS workforce to support delivery, instead of relying solely on medically trained staff or public health professionals to promote healthier lifestyles. MECC was first introduced as a long-term strategy pioneered by the NHS to ensure that those working within the NHS framework were using every opportunity and interaction with patients and visitors to promote healthy lifestyle choices and signpost to relevant healthcare services. MECC encourages conversations based on behaviour change methodologies (ranging from brief advice, to more advanced behaviour change techniques), empowering individuals to make healthier lifestyle choices and exploring the wider social determinants that influence all of our health. The MECC approach is consistent with the evidence based approach recommended in NICE guidance <https://www.nice.org.uk/guidance/ph49>.



The informality and flexibility of MECC was seen as its strength and is based on the principle of 'support from next door' rather than 'advice from on high'.



In 2010, the Royal Society for Public Health (RSPH) worked with Yorkshire and the Humber Strategic Health Authority on the early pilots of MECC and developed the supporting education programme Understanding Behaviour Change. The RSPH Level 2 Award in Understanding Behaviour Change is an example of a qualification designed in line with the principles of MECC to provide people with the knowledge and confidence to offer brief, opportunistic advice to improve health and wellbeing. This is now a core part of the RSPH Understanding Health Improvement series which has been rolled out in a variety of settings to over 40,000 individuals, including to Allied Health Professionals.

Further MECC programmes have since been introduced such as the one in NHS Midlands and East in 2012/13. This programme resulted in over 100 organisations implementing MECC and over 7000 staff accessing the associated on-line training. While there is limited literature on the MECC initiative, the evidence available suggests that the approach is achieving success. One hospital reported a 70% increased uptake in their stop-smoking service following the introduction of MECC (Nelson et al, 2012). Other data suggests that training just a small number of people can result in a very large number of people receiving health advice. For example, Telford Primary Care Trust trained 16 staff using the MECC e-learning facility. Four hundred and eight people received health advice from the 16 staff, and 170 of those were then referred to other services (RSPH, 2014).

MECC, or having healthy conversations, has been identified by all Allied Health Professional bodies as a public health priority where AHPs can make a real difference.

This commitment by AHPs to initiate and engage in healthy conversations will provide support for the delivery of national outcomes for the prevention agenda outlined in the NHS Five Year Forward View and in Public Health England's Evidence into Action.



3. Methodology – increasing our understanding of how AHPs engage in healthy conversations

In order to better understand the extent to which AHPs engage in healthy conversations with their patients or clients, RSPH and PHE have undertaken a joint project with the support of each of the AHP professional bodies. We wanted to obtain the views of as many AHPs as possible from across the 12 professions as well as getting a perspective from members of the public.

Our methodology was a pragmatic approach rather than a rigorous scientific study to obtain a snap shot of the current situation and AHP perceptions. There were three aspects to this work: a survey of AHPs, focus groups and interviews involving AHPs and a public poll. These are described in more detail below and the specific questions asked are included as an appendix.

Survey

An online survey was promoted to all AHPs between 5 September to 17 November 2014 via social media and AHP professional bodies. The survey aimed to determine the extent to which AHPs already undertake a degree of health promotion with their patients and clients, either through conversations or signposting. It asked about the range of different lifestyle issues as well as what factors may assist these professionals in undertaking healthy conversations with patients. This resulted in 1016 responses from AHPs. The appendix in section 9 gives a summary of the questions asked, along with a breakdown of responses by profession.

Focus groups and one to one interviews

Survey respondents were asked whether they would be happy to participate in focus groups at the end of the survey. Those who agreed were contacted and invited to register for one of four focus groups. The focus groups of between 8-12 participants were held by teleconference to ensure access from AHPs across England. The focus groups were intended to glean more detail on AHP views on the following 4 areas which were highlighted as important in the survey:

- **Is health promotion a core part of an AHP role?**
- **What helps or hinders you to have healthy conversations and how could this be improved?**
- **Signposting**
- **Training needs**

Interviews were also held with representatives from professional bodies to ensure the views of the broad range of professions were captured.

Notes were taken during the focus groups and interviews and key themes extrapolated from these notes. The number of focus groups and interviews was determined by data saturation point plus coverage of all 12 professions.



Public polling

To compliment this work a national online public poll was commissioned from Populus. This was conducted between 4-5 February 2015 and had 2106 respondents (the survey was conducted across the UK and the results have been weighted to the profile of all adults). Respondents were asked about the following and given a range of response options. Full questions are included in the appendix.

To what extent would you trust or not trust the health promotion advice (e.g. on diet, exercise, stopping smoking, sensible drinking) given by different professions?

What would make you any more likely to trust the lifestyle health advice given by someone?

What would your most likely response be to a healthy conversation initiated by an AHP?

What would encourage you to have a conversation about lifestyle health with an Allied Healthcare Professional?

Limitations

While the AHP survey attracted a large number of respondents, these are likely to have been the AHPs most interested in healthy conversations and therefore the results need to be treated with caution. Nevertheless we believe this report gives a useful insight into some of the work needed to mainstream healthy conversations amongst AHPs.



4. Summary of results – AHPs readiness to be part of the wider public health workforce

The 12 AHP Professional Bodies signed up to a collective ambition to be recognised as an integral part of the public health workforce in April 2014. It is clear from this research that AHPs supported this ambition and are keen to engage in lifestyle health promotion activity:

- **Almost 9 in 10 (87.6%) survey participants agree that their role should include an element of preventing ill health;**
- **Over three quarters (76.0%) agree that their role does provide opportunities for healthy conversations;**
- **Over four fifths of participants (81.8%) said that health improvement or preventing ill health was already incorporated into their daily practice examples include falls prevention, promoting physical activity and healthy eating advice;**
- **Almost one third (31%) would feel comfortable discussing areas of health that do not relate to the condition their client is receiving care for, although for a significant proportion (35%) this would very much depend on the topic.**

AHP readiness to provide lifestyle health advice is complemented by a willingness from the general public to receive it from AHPs. Almost 9 in 10 (86%) members of the public who responded to the national poll would trust such advice if it came from AHPs. This compares favourably with other professions including doctors (93%), nurses (91%) and pharmacists (89%). The most important attributes for the public in terms of trusting the lifestyle health advice given was if the professional worked as a healthcare professional for the NHS (81%), have a recognised healthcare qualification (81%) and are a member of a healthcare related professional body (78%); all of which apply to AHPs.

Despite broad support among AHPs to provide lifestyle health information there was also an appreciation that this would only be one part of the solution to improving population level health and wellbeing. AHPs recognised that motivations to change lifestyle health require more than just information provision, with other factors such as tackling social isolation, improving support networks, providing access to affordable exercise and healthy food being equally important.

Almost 9 in 10 (86%) members of the public would trust such advice if it came from AHPs.



“As a physiotherapist I see at least one person with type 2 diabetes, 2-3 people who are overweight or obese and 3-4 people with hypertension each day. I feel that we are in an ideal place to be ambassador for healthy lifestyles.”
Physiotherapist

“ We need to promote public health as we see patients regularly and for decent chunks of time. We could make a real difference.”
An Allied Health Professional

5. The barriers to healthy conversations

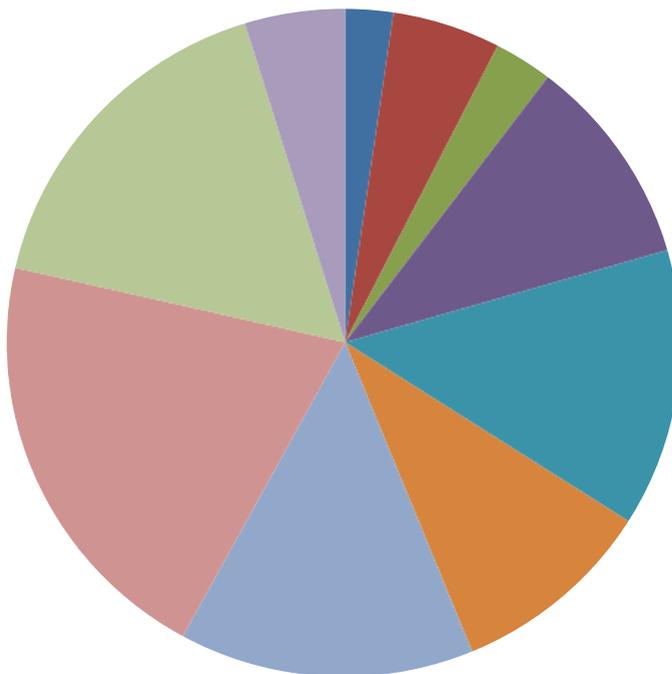
Despite there is an overall willingness to engage in healthy conversations; AHPs identified several challenges to doing this in practice, highlighted in figure 1, these followed four themes:

- CONFIDENCE** how comfortable the AHP feels initiating a conversation, particularly if it is about an issue not directly connected to the reason they are seeing a client
- CONTEXT** the AHPs skill to gauge with the client what lifestyle health conversation is appropriate and possible
- TIME** the ability to incorporate opportunistic healthy conversations into time pressured consultations
- SIGNPOSTING** having up to date, easily accessible information about local services and community assets

Here we explore each of these potential obstacles with some of the suggested solutions.

Figure 1: The barriers AHPs identified to conducting a healthy conversation

- Not feeling that I am the role model for the behaviour (2.3%)
- Embarrassed about raising the subject (5.2%)
- Language barriers (2.8%)
- Difficult to weave into conversation (10.2%)
- Impact on clinical treatment time and intervention (13.5%)
- Starting a conversation on a sensitive topic that cannot be withdrawn (9.8%)
- Inadequate time to support the client (14.1%)
- Inadequate skills or knowledge to support the client (20.6%)
- Inappropriate for the patient/client at that time (16.6%)
- Not regarded as a priority by employer (4.8%)





Confidence

The confidence to conduct a healthy conversation with patients or clients is underpinned by factors including knowledge and understanding of relevant lifestyle health information, being comfortable in the practice of initiating and conducting the healthy conversation and feeling at ease with the topic of discussion. Figure 3 shows the relative confidence different professionals feel about conducting a range of lifestyle conversations.

A concern identified by one fifth of the AHPs who took part in the study, was feeling that they had inadequate knowledge or skills to support the client. This related to both knowledge of lifestyle health promotion and the broader skill of engaging in healthy conversations. Many AHPs in the study expressed concerns that it was difficult to start a conversation unless they felt comfortable about the particular subject being talked about. We asked about a range of lifestyle issues and it was clear that different professions felt more confident talking about lifestyle issues linked to their area of expertise.

Only half of AHPs reported having received any specific training, either at University or in the workplace, on how to conduct healthy conversations and where and how to signpost patients or clients to further support. Some AHPs reported difficulty in being able to find time to undertake the training required due to busy clinics and staff shortages.

AHPs were conscious that not handling lifestyle conversations in the correct manner may potentially damage the relationship with the patient and lead to it becoming an unhealthy conversation in which patients feel dictated to and judged.

AHPs expressed concerns around “being seen to be nagging, offending or patronising patients” and that this in turn could interfere with treatment compliance or the patient’s belief in the AHP as a competent practitioner. The public reinforced this with 43% stating that a non-judgemental approach would be important in encouraging them to have a healthy conversation with an AHP.

AHPs felt less comfortable discussing lifestyle health issues with a client if they did not consider themselves to be a role model for the behaviour. This was particularly true when raising the issue of weight management and physical activity. Whilst being a role model for healthy living was important for 64% of the public, they placed greater importance on whether an AHP had successfully dealt with a similar issue (78%).

There was also an assumption that other professionals may already be having the lifestyle health conversation with the client and concern at not knowing what has already been said. However some AHPs felt that multiple professionals saying the same thing would have a positive, cumulative effect on the client by reinforcing the message which in turn might support people to change their behaviour.

Figure 2: AHP percentage confidence levels to conduct healthy conversations, by topic



Time

AHPs reported time pressures as a barrier for engaging in healthy conversations, either because it impacted on treatment time or not having enough time to support the patient once a lifestyle health topic was raised. Consultation times with patients were seen as tight and 43.2% of AHPs reported that their total contact time with patients was less than 2 hours.

While there was broad support for healthy conversations, AHPs wanted to ensure that this should not detract from the core business of an AHP or increase the burden on AHPs through extra workload and therefore ensure they were opportunistic, client led and supported both AHP and patient outcomes.



“I hope all AHPs will find their own way in which to pro-actively support this important area of work.”

Meta Killick, Music Therapist

Having a healthy conversation was seen by some as an extra layer to be inserted into a patient consultation and it was difficult in a short consultation to find the time. Diagnostic radiographers reported that they have very short timescales in which patient interaction occurs which may well limit the opportunities. For example, breast screening appointments are only 6 minutes long and every second is utilised. Paramedics may also have a very short time frame with each patient, often an unscheduled emergency contact, so there may not be the time or opportunity. Paramedics and diagnostic radiographers were also unlikely to have multiple contacts with the same patient. By contrast other AHPs may see their clients over several sessions and this enables them to build up a therapeutic relationship over time.

Context

AHPs voiced concern that healthy conversations must not become tick-box exercises and that the approach must be patient or client led as much as possible. AHPs felt that they needed to judge the appropriate topic at the right time and were sensitive to not alienate their patients.

As part of a patient-led approach, conversation topics should be relevant to the individual, related to patient care and needs-led. The importance of relevance to AHPs was mirrored by similar findings when the public were asked what would encourage them to have a healthy conversation with an AHP. The most important consideration was if the conversation was related to a condition the patient was already talking to the AHP about, as almost half the public (45%) believed this is key.

For example, radiographers treating people with cancer may talk about healthy eating with clients to help them cope with their current treatment and to reduce future cancer risk whereas a prosthetist fitting footwear or a spinal brace may find the leap to a conversation about sexual health or substance misuse more difficult.

Judging the right moment when to have a healthy conversation was important. AHPs cited some situations as inappropriate, for example if a patient has just received a cancer diagnosis, whilst undertaking procedures requiring detailed concentration or when a patient was in considerable pain. Equally when the AHP was asking the client to take on a lot of information already, adding extra lifestyle advice wasn't always viewed as the best time.

It is perhaps reassuring to learn that, when the public were asked how they might respond should an AHP raise a lifestyle health conversation with them; a significant proportion would react favourably. More than one third (35%) of the public said that they would welcome a healthy conversation, that by doing so it would make them feel that the AHP cared about their health and wellbeing (36%) or that it would prompt them to consider taking action (35%). Nevertheless it is clear that given the complex and individual needs of each patient, AHPs' ability to make a judgement call as to when and how to raise a particular subject in conversation was fundamental.

“I think that knowing where to signpost people is very important. I have to find a lot of this out on behalf of a patient.”

An Allied Health Professional

Signposting

Referring patients and clients on to more specialist advice and services is a critical part of the healthy conversation and AHPs taking part in the research already signpost to a range of different services including falls prevention, walking groups, weight management groups, smoking cessation and wellbeing services. Figure 3 outlines the relative knowledge by profession about where to signpost for key public health priorities and figure 4 shows the correlation between AHPs confidence speaking about a topic and knowing where to signpost for further support. In general AHPs reported being more confident discussing a topic if they know where to signpost for further support; equally they may actively seek out support services for those topics they feel most confident discussing.

Some AHPs, such as those in specialist centres or ambulance services, cover a wide geographical area spanning several local authorities and clinical commissioning groups. This makes it difficult to keep up to date with locally relevant healthy lifestyle services which will vary from area to area.

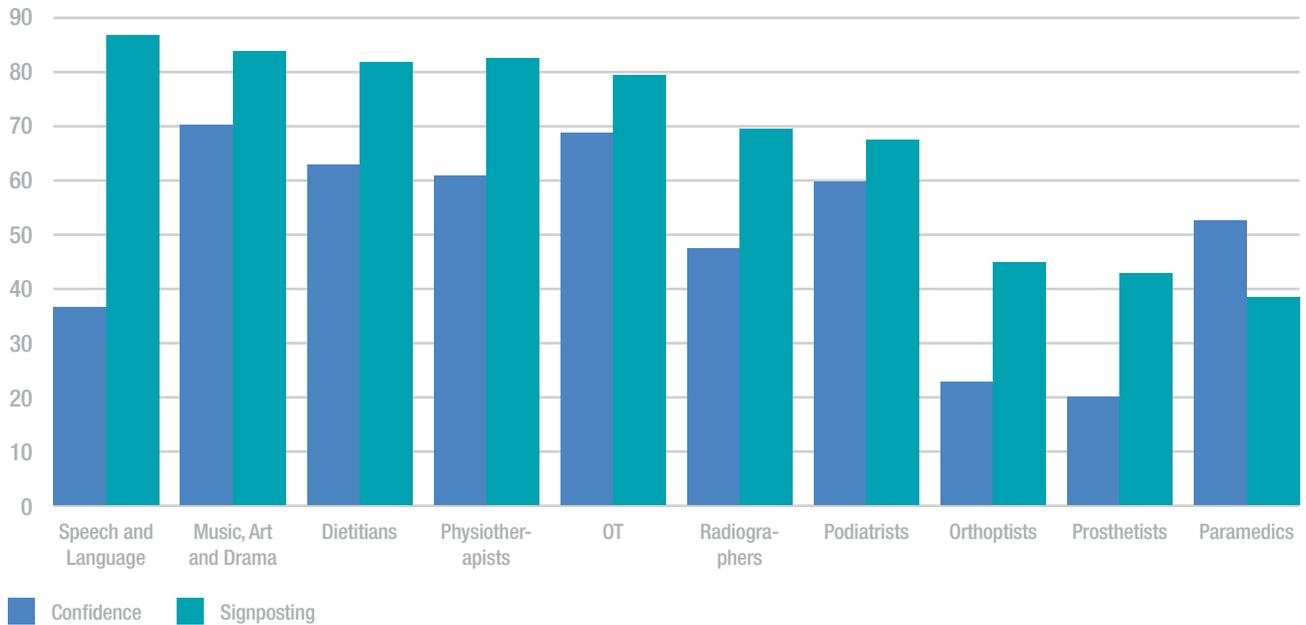
The ability to keep up-to-date with an ever changing environment and the latest lifestyle health advice was reported by participants as a challenge. While AHPs generally keep up to date with core messages around smoking, alcohol and physical activity they highlighted a need to have systematic ways of keeping abreast of relevant wider public health messages and services.

Figure 3: AHP percentage knowledge of where to signpost by topic



Forming good links with Local Authority Public Health teams was said to be an important way for many to keep up to date with lifestyle health advice and services in localities. Voluntary and community groups were also reported by participants to provide a good source of information, and many of these organisations had an incentive in providing this information to AHPs so that their patients/clients could be referred on.

Figure 4: Percentage correlation between confidence in speaking about a topic and knowing where to signpost



ADDRESSING DAMAGE CAUSED BY ALCOHOL

Paramedics attend a range of patients who may have underlying alcohol misuse issues. Paramedics from Yorkshire Ambulance Service referred 300 patients in 2014 into alcohol services through their Alcohol Referral Pathway. One male patient in Sheffield who was going through a difficult period in his life turned to alcohol. This resulted in three ambulance call outs, on the final occasion, he responded positively to a paramedic asking if he would like to be referred to an alcohol service to gain support. This proved to be the start of his journey to recovery. He was contacted by the Sheffield Care Trust Substance Misuse Service and offered counselling, a support group, medication and signposted to other support services for housing and financial advice.

Liz Harris MCPara, College of Paramedics & Clinical Development Manager, Yorkshire Ambulance Service





Holistic versus clinical

AHPs often reported talking about lifestyle health in the context of a particular health condition for which they are seeing patients. This may in part explain the variation in confidence and frequency of healthy conversations taking place, and also knowledge for where to signpost patients.

AHPs in general reported being most comfortable talking about and signposting to services for physical activity, healthy eating, smoking cessation and obesity. Those they reported being less likely to engage in healthy discussions on are perhaps viewed as more specialised areas such as domestic violence, substance misuse and sexual health.

Our research found that the professionals who reported feeling more confident at conducting healthy conversations, and also undertook them on the broadest range of topics; appeared to be those who are more practiced at taking a holistic view of an individual's health. This group of participants included music, art, and drama therapists, occupational therapists (OTs), and physiotherapists. The ability to converse on a broader range of subjects with confidence may in part be explained by the therapists' core role in often dealing with sensitive health, mental health and personal issues.

OTs undertake dual training which includes both mental and physical health. Music, art and drama therapists are also skilled in supporting people who are emotionally fragile or potentially volatile, and are trained in how to de-escalate situations. This may enable these professionals in particular to have confidence in undertaking healthy conversations on a broad range of topics with their clients or patients.

For other professions, appointments may often focus more on particular clinical outcomes, and therefore healthy conversations may be more limited towards those lifestyle areas that impact directly on the condition being treated.

Table 1 outlines the healthy conversations that each profession reported to be most comfortable undertaking. It also illustrates some examples of where the healthy lifestyle conversations are directly relevant to the consultations being undertaken as part of the treatment or therapy. Many individual practitioners did, however, report feeling confident in undertaking conversations across much broader aspects of public health.

Table 1: Examples of types of healthy conversations undertaken by AHPs with patients/clients

Allied Health Professional	Examples of patient conditions or scenarios which may be affected by lifestyle behaviours	Most comfortable having a healthy conversation about
Radiographer: Therapeutic	Cancer patients – routine discussions about mitigating side-effects of treatment	
Diagnostic	Pre-natal screening (smoking cessation and weight management), orthopaedics (weight management)	Smoking cessation, healthy eating, stress
Orthoptists	Age-related Macular Degeneration/glaucoma (physical activity), hyperthyroidism (smoking cessation), intracranial hypertension (obesity)	Smoking cessation, healthy eating
Paramedics	Alcohol induced injuries, falls	Alcohol
Physiotherapists	Joint issues exacerbated by excess weight (obesity/healthy eating), back pain exacerbated by lack of physical activity, a range of respiratory conditions including COP, and pain, linked to smoking	Physical activity
Occupational Therapists	Work with people who have experienced injury, illness, disability or a major life change to enable them to carry out occupations (activities) that they need or want to do.	Healthy eating, mental health, stress physical activity
Podiatrists	Musco-skeletal pain, such as Plantar fasciitis exacerbated by excess weight (physical activity), peripheral arterial disease (smoking), large proportion of patients 65+ (dementia)	Physical activity, smoking cessation
Speech and language therapists	Approximately 60% of work is with children, (broad range of lifestyle issues); eating, drinking, swallowing issues; mental health and communication	Physical activity, healthy eating, mental health
Music, art and dramatherapists	Holistic approach – look at lifestyle health in the round with no topic off limits	Most topics
Dietitians	Particular focus on topics related to weight management – healthy eating, obesity, alcohol, physical activity	Healthy eating, obesity, physical activity
Prosthetists/ orthotists	Fitting prostheses or orthoses to maintain/ develop mobility	Physical activity, obesity

6. Supporting AHPs to have healthy conversations

Overcoming barriers

A number of different solutions were proposed by AHPs to build their confidence in undertaking healthy conversations – these included training (22.2%) and improvements to signposting (including the ability to directly refer patients to services) (17.8%). Figure 5 illustrates what would enable AHPs to undertake healthy conversations with their patients or clients. Table 2 below summarises the suggested solutions to the barriers reported by AHPs for undertaking healthy conversations.

Figure 5: Enablers for AHPs to undertake a healthy conversations

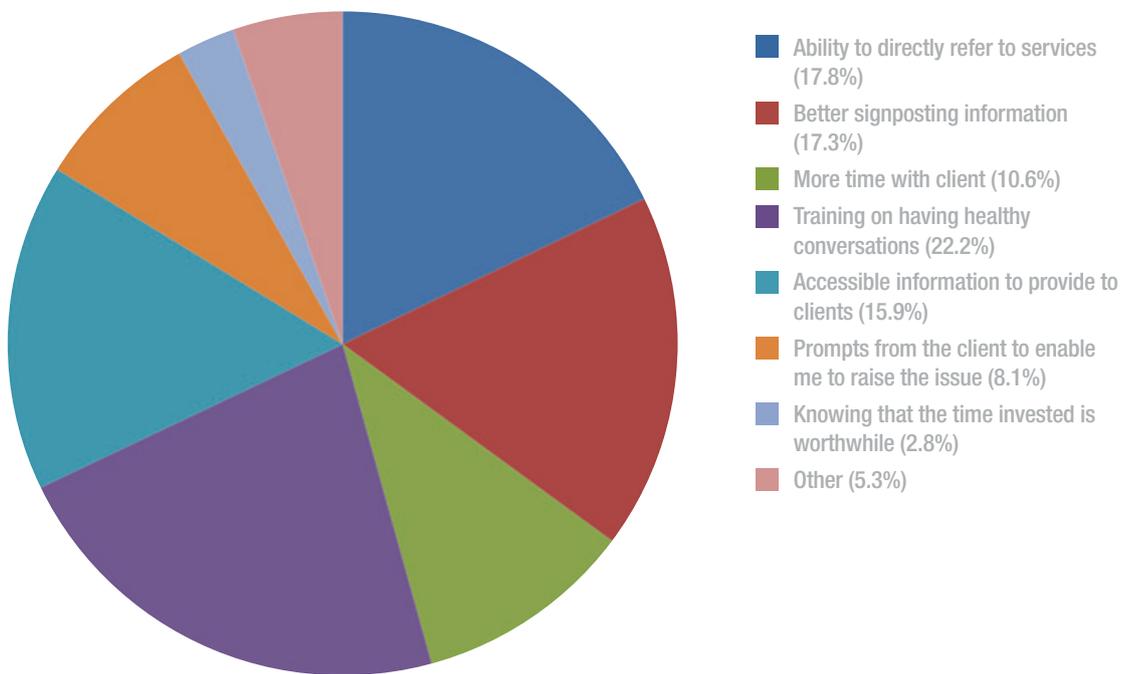


Table 2: Suggested solutions from participants to some of the barriers to undertaking healthy conversations

BARRIERS	SOLUTIONS
Impacting on AHP-patient treatment	Designing healthy conversation as a very brief intervention
Not enough time to support the patient	Better signposting information
AHP knowledge of lifestyle health topics	Public health support through accessible information such as newsletters, and support from professional bodies
AHP knowledge of having a healthy conversation	Training such as RSPH Level 2, MECC
Healthy conversations not detracting from core AHP work	Promote benefits of win-win of lifestyle health improvements on AHP patient outcomes



“More training is important in how to be able to deliver information to patients in a way that they are sufficiently motivated to help themselves to make changes and so we as clinicians can work more collaboratively with our patients.”

Allied Health Professional

Training

Training was identified by participants as a means of equipping AHPs with a better understanding of undertaking a brief intervention or healthy conversation in a non-judgemental, non-clinical, patient-centred and relevant way. Approximately half of AHPs who took part in the study have already received training in lifestyle health advice (17.7% as part of their degree programme, and 34.4% as part of post graduate or workplace training). A further one third of AHPs were keen to receive training and have not yet had the opportunity.

The proportion of AHPs who had training on healthy conversations or MECC was lower, with just over one quarter (28.1%) having received this and almost two thirds (61.5%) who had not, but would like to. The remaining 10% of AHPs in the study did not believe that healthy conversations training was required or relevant to their role.

In order to be registered to practise, AHPs need to complete a course of study or training at degree level or above. Whilst a making every contact count approach is starting to be included in many AHP undergraduate courses, it is not currently a specific requirement of the Health and Care Professions Council (HCPC) or professional bodies.

In addition to including lifestyle public health and healthy conversations within the curriculum of undergraduate courses, AHPs felt that it was important to ensure similar training was also available for the existing AHP workforce, otherwise “when newly qualified AHPs are exposed to the workplace, their public health promotion ethos may be diminished.”

There is a broad range of CPD training available for AHPs, including NHS and Local Authority training, RSPH Level 2 Understanding Health Improvement, Making Every Contact Count and motivational interviewing tools. AHPs referenced the importance of a training needs analysis for staff and a range of accessible delivery formats including e-learning, locally delivered training and inclusion in professional conferences and meetings.

Improvements to signposting

Keeping up to date with local services was a challenge for participants, with the wide range and ever-changing types of organisations AHPs can signpost to. A national database of information or signposting hotline were suggested as one way of bringing all of the signposting information together, although this was also recognised to be a challenge. AHPs said that a good source of information could be Local Authority websites and public health teams but that the quality and reliability of this varied across the country. Accessing the information needed to be quick; given the limited time AHPs are with their patients/clients.

As autonomous practitioners, AHPs reported being keen to utilise services to which they could directly refer or signpost. They were conscious of the need to make the process as streamlined as possible for their clients.

Building AHP knowledge and understanding

In order to build knowledge and understanding AHPs who took part in the study suggested support was required at a professional, organisational and departmental level.

Some professional bodies provided members with regular updates on policy issues, NICE guidance and regular communications. Participants mentioned a role for professional bodies to recognise the importance of the public health agenda, and that there may be a role for further guidance from professional bodies in the area of undertaking healthy conversations.

Within organisations and departments, some AHPs reported taking a proactive leadership role to encourage more healthy conversations with clients or patients. Examples included internal competitions to encourage team members to have healthy conversations or sharing the workload of engaging with local services between team members. Staff were also encouraged to keep up to date with latest research by using social media such as Twitter or Facebook, and accessing e-Newsletters.

Dietitians in Birmingham have partnered with local authority leisure services to offer people working to lose weight access to fun and relevant opportunities for physical activity. By matching the activities to the lifestyle of the individual be it walking, dancing, swimming or gardening the dietitians are able to support people to make sustainable lifestyle changes. This process works because Birmingham City Council has a web site outlining facilities available in each part of the City, many of which are free of charge, which makes signposting easier.

Making Every Second Count

More time with patients was flagged by 10.6% as making healthy conversations easier. In order to make the most of the time AHPs have with patients there have been pilots of approaches testing the provision of information as soon as a patient enters a setting by utilising posters and flyers in the waiting room or in maintaining contact with patients via social media channels.



Physiotherapists in Pennine Acute Trust agreed embedding healthy conversations into their role was important. The whole team supported this initiative and they decided to focus on physical activity initially given that this is an issue they are already comfortable with. Each member of the team took on a different role to spread the workload. Clinic rooms were equipped with easy access resources and posters encouraging clients to ask about their lifestyle. The department partnered with local exercise groups including the 'I will if you will' campaign so that they could understand the offer of each service and see which would be suitable for their clients. They developed their skills in brief interventions and now regularly signpost to local groups. Many of the physiotherapists have joined the groups too.



'We are developing a breast screening hub which will include breast practitioners/mammographers talking with women about their fears around mammography for breast screening using social media tools. There will also be the opportunity for service users to talk to other service users, as well as access a wide range of relevant information about breast screening and breast health. The work is in the development stage at the moment but we have a Facebook page where initial discussions are taking place (as a kind of test bed). We are also developing a theoretical understanding of how staff engage with patients on-line, what the perceived barriers are and what training might be needed.'

Dr Leslie Robinson, Senior Lecturer, Directorate of Radiography, University of Salford



Finding the opportunity to engage

Prompts for patients / clients to initiate conversations are being used by some AHPs, for example posters stating 'you can ask me about stopping smoking / losing weight' in the waiting rooms. These help the client to make the choice whether they want to initiate a healthy conversation.

Some AHPs link healthy conversations into the dialogue they are having with clients about their condition, while others raise healthy lifestyles at the end of an appointment with an opener such as '*we are talking to everyone about alcohol at the moment, would you mind if we have a very brief chat about alcohol before you leave?*'. Others reported using a more general opener such as '*are there any other aspects of your health and wellbeing you would like to talk about today?*'



Birmingham Community Healthcare NHS Trust, Podiatry Service has integrated the discussion around smoking and alcohol into a new patient assessment. They send out an alcohol screening questionnaire prior to the appointment and then review it during the first contact. Smoking and alcohol status is recorded as part of their electronic records and data is audited on a monthly basis allowing the department and trust to review their performance.

Speech and language therapists may identify children with glue ear who are experiencing language delay as a result of poor hearing. Children who live in a house where people smoke have a higher risk of developing glue ear and therefore speech and language therapists discuss the link between the condition and smoking with parents and encourage them not to smoke around their child. Parents are signposted to smoking cessation support services.

A natural conversation with a prosthetist or orthotist and their client is the extent to which they will be able to increase mobility as a result of their prosthesis or orthoses. The professional will be able to take these opportunities to highlight where appropriate the added benefits of physical activity and increase the individuals confidence in what they can achieve

Orthoptists see people with intracranial hypertension caused by obesity which can cause fat deposits around the eyes leading to sudden loss of vision. This provides a perfect opportunity for the orthoptist to have a conversation about healthy eating or weight management.





Evidencing success

Despite many case studies demonstrating the value of healthy conversations, evaluation of this area of work is fairly limited. In our survey of AHPs almost three quarters (70.3%) said they either never or rarely evaluated health promotion activities.

Of those who do evaluate, the most common means of doing so included:

Audit (26.4%), routinely collected data (23.7%), surveys (16.9%), case studies (21.9%) and measuring changes in referral or uptake rates.

One of the challenges for the work of AHPs is that it is often hidden due to a lack of data and information (Quality Watch report). Demonstrating the value of healthy conversations was seen as an important factor in spreading best practice. Knowing that the time invested is worthwhile was flagged by a small proportion (2.8%) of AHPs as a factor which would encourage them to conduct a healthy conversation.

There is a need to better understand the impact and outcomes of healthy conversations by AHPs. This will support the inclusion of making every contact count into AHP service specifications and may encourage AHPs to engage in healthy conversations.



7. Conclusion



AHPs are already engaged in undertaking healthy conversations, although there is clearly an opportunity to spread this practice more widely across these 12 professions to support the delivery of national outcomes for the prevention agenda outlined in the NHS Five Year Forward View and in Public Health England's Evidence into Action.

Embedding healthy conversations into the work of the whole AHP workforce will require a systematic approach with a focus on clarity of expectations of AHPs through commissioning agreements, provision of training, support from employers and easy access to local information to support signposting.

Multiple agencies and organisations have a role to play in supporting AHPs to further develop their contribution to the prevention agenda including the AHP federation, AHP professional bodies, employers, Public Health England, NHS England, Local Authorities, Health Education England, Higher Education Institutions and the Health and Care Professionals Council.

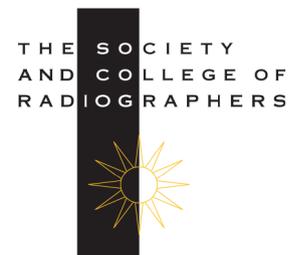
The Royal Society for Public Health, along with the Allied Health Professional Federation and professional bodies have issued a short statement in response to this report which includes a number of policy recommendations. This can be found here:

www.rsph.org.uk/ahps



8. Acknowledgements

With thanks to the support of the Allied Health Professional bodies and their members who helped promote the survey to their members.



9. Appendix

This section provides details of the online survey, focus group and interview outline structure and public polling questions.

A Online survey

The AHP survey was completed by 1013 individuals, and the breakdown of responses by profession is as follows:

	Number	Percentage
Speech and language therapist	147	14.5%
Radiographer	91	9.0%
Prosthetist or orthotist	18	1.8%
Podiatrist	68	6.7%
Physiotherapist	206	20.3%
Paramedic	29	2.9%
Orthoptist	117	11.5%
Occupational therapist	175	17.3%
Dietitian	100	9.9%
Music therapist	44	4.3%
Art therapist	2	0.001%
Drama therapist	16	1.6%

Demographic questions

- Please specify your profession:
 - Speech and language therapist
 - Radiographer
 - Prosthetist or orthotist
 - Podiatrist
 - Physiotherapist
 - Paramedic
 - Orthoptist
 - Occupational therapist
 - Dietitian
 - Music therapist
 - Art therapist
 - Drama therapist
- How many years have you been qualified?
- Which country are you based in?
 - England
 - Scotland
 - Wales
 - Northern Ireland
- Who are you employed by?
 - NHS
 - Local authority: social care
 - Local authority: public health
 - Education
 - Charitable sector
 - Private sector
 - Self-employed
 - Other
- Which type of venue would you be most likely to deliver your work in?
 - A person's home
 - Military
 - A hospital
 - A primary care facility
 - The community
 - A school
 - A prison
 - A hospice
 - A care home
 - A university
 - Industry
 - A range of settings
 - Other
- Which of the following best describes your role?
 - Management/leadership
 - Clinical/client/patient support
 - Education
 - Public health/community development
 - Research
 - Other?

Training

7. Have you received training in health promotion/health improvement?
- Yes – as part of my degree programme
 - Yes – as post-degree training (e.g. CPD)
 - No – but I'd like to
 - No – and I don't believe it is relevant to my role
 - Don't know
8. Do you view health promotion as an activity that is different to 'standard' AHP clinical practice?
- Yes
 - No
 - Don't know
9. Have you received training in 'making every contact count'?* (*will define this if deemed necessary)
- Yes
 - Yes – but don't think it is relevant
 - No – but I'd like to
 - No – and I don't believe it is relevant to my role

Healthy conversations

10. What proportion of your clients do you see more than once?
- None
 - Less than a quarter
 - Between one quarter and half
 - Between half and three quarters
 - More than three quarters
 - All
 - I don't see clients/patients
11. Of the clients you see more than once on average how frequently do you see them?
- Daily
 - Weekly
 - Fortnightly
 - Monthly
 - Every couple of months
 - Several times a year

12. On average what is the total volume of contact time you spend with each client?
- Less than 2 hours
 - 2-4 hours
 - 4-8 hours
 - 8-15 hours
 - 15+ hours
13. Is health improvement/preventing ill health incorporated into your daily practice? (e.g. falls prevention, promoting physical activity, healthy eating advice)
- Completely
 - To some extent
 - Not at all
 - Don't know
14. Do you currently engage in healthy conversations with your patients/clients?
- Yes
 - No
 - Don't know
15. To what extent are you confident having a healthy conversation with your clients?
- Very confident
 - Quite confident
 - Not very confident
 - Don't know
16. Do you feel comfortable discussing areas of health that do not relate to the condition the client is receiving care for?
- Yes
 - No
 - Don't know
 - Depends on the topic

17. To what extent would you agree that your role provides opportunities for healthy conversations?
- Strongly agree
 - Agree
 - Neither agree nor disagree
 - Disagree
 - Strongly disagree
 - Don't know
18. To what extent would you be confident discussing the following topics with clients (very confident, fairly confident, not very confident, no confidence)
- Smoking cessation
 - Alcohol
 - Substance misuse
 - Physical activity
 - Healthy eating
 - Obesity/overweight
 - Sexual health
 - Mental health
 - Domestic violence
 - Dementia
 - Stress
19. Would you know where to signpost clients for more information or support services for each of the following areas (Yes/No)?
- Smoking cessation
 - Alcohol
 - Substance misuse
 - Physical activity
 - Healthy eating
 - Obesity/overweight
 - Sexual health
 - Mental health
 - Domestic violence
 - Dementia
 - Stress
20. In the last month, how often have you discussed the following topics with clients:
- Smoking cessation
 - Alcohol
 - Drug abuse
 - Physical activity
 - Healthy eating
 - Obesity/overweight
 - Sexual health
 - Mental health
 - Domestic violence
 - Dementia
 - Stress
21. If you don't feel confident having a healthy conversation about one or more of the topics above, why is that? Please tick all that apply
- Not feeling that I am a role model for the health behaviour
 - Embarrassed about raising the subject
 - Language barriers
 - Difficult to weave into conversations
 - Impact on clinical treatment time and intervention
 - Starting a conversation on a sensitive topic that can't be withdrawn
 - Inadequate time to support the client
 - Inadequate skills or knowledge to support the client
 - Inappropriate for the patient/client at that time
 - Not regarded as a priority by employer
22. What would be the MAIN resource that would make it easier for you to have a health conversation about one of the topics listed?
- Ability to directly refer to services
 - Better signposting information
 - More time with the client
 - Training on how to have a healthy conversation
 - Accessible information to provide to the client (e.g. cue cards)
 - Prompts from client to enable me to raise the issue
 - Knowing that the time invested is worthwhile

23. To what extent do you agree your role should include an element of 'predicting and preventing' illness?

- a. Strongly agree
- b. Agree
- c. Disagree
- d. Strongly disagree
- e. Don't know

24. Are you involved in any community-level health promotion initiatives (rather than just at the individual level)?

- a. Yes
- b. No

25. To what extent do you formally evaluate your health promotion activities?

- a. Frequently
- b. Sometimes
- c. Rarely
- d. Never

26. How do you evaluate your health promotion?

- a. Audit
- b. Routinely collected data for all clients
- c. Survey
- d. Case studies
- e. Change in referral uptake rates
- f. Other

B Focus Groups / one to one interview themes

Theme 1 - Is health promotion a core part of an AHP role?

There was an approximate 50:50 split in responses to this (yes / no). Why do you think respondents would have answered either way?

Theme 2 –Barriers

Can we explore more about what helps or hinders you to have healthy conversations?

What would you like to see happen to improve this?

Theme 3 = Signposting

What type of services do you regularly signpost to?

What determines whether you would / wouldn't recommend a service?

How do you keep up to date with local services?

Is it a personal, department or organisational responsibility?

What more could help?

Do others refer to you as a result of MECC conversations?

Theme 4 = Training needs

What particular skills and knowledge do you feel are missing / need development?

What is the best way(s) of delivering this to AHPs and why?

C Public Polling Questions

1. To what extent would you trust or not trust the health promotion advice (e.g. on diet, exercise, stopping smoking, sensible drinking) given by each of the following professions? (Ranked by Trust completely/ Trust to some extent/Do not really trust/Do not trust at all/Don't know)

- a. Doctor
- b. Fireman
- c. Hairdresser
- d. Nurse
- e. Allied health professional (e.g. physiotherapist, occupational therapist, music therapist, podiatrist, paramedic, orthotist, dietitian)
- f. Shop worker
- g. Pharmacist

2. To what extent would each of the following make you any more likely, if at all, to trust the lifestyle health advice given by someone? (ranked by A lot more likely/ A little more likely/ No more likely/ Don't know)
 - a. If they have a recognised health qualification
 - b. If they were a member of a regulated professional body
 - c. If they wore a uniform
 - d. If they had successfully dealt with a similar issue
 - e. If they were already engaged with you or someone you know on a medical issue
 - f. If they were a role model for health themselves
 - g. If they worked as a healthcare professional for the NHS
 - h. If they worked as a healthcare professional, but not for the NHS (i.e. Independent sector)
 - i. Someone who has had similar issues with their lifestyle and health

3. If a healthcare professional other than a doctor or nurse (for example, a physiotherapist, paramedic, podiatrist) spoke to you about a lifestyle health issue (e.g. smoking, alcohol, exercise, diet), which of the below options would describe how would you respond?
 - a. It would make me feel embarrassed
 - b. I would welcome the conversation
 - c. I would feel that it was none of their business
 - d. I would report them to their boss or employer
 - e. It would make me feel that they cared about my health and wellbeing
 - f. I would listen politely to what they said but ignore it
 - g. It would have no effect
 - h. It would prompt me to consider taking action or take action
 - i. OTHER, please specify

4. Which of the below, if any, would encourage you to have a conversation about lifestyle health advice with an Allied Healthcare Professional? Allied Healthcare Professionals are health care professionals separate from nursing, medicine, and pharmacy, for example physiotherapists, occupational therapists, music therapists, podiatrists, paramedics, and dietitians.
 - a. If an allied healthcare professional was to wear a badge stating that "You can ask me about your health and lifestyle"
 - b. Prompt cards available in the waiting room which you can complete and hand to the allied healthcare professional stating that you would like to discuss your weight, smoking, drinking etc.. today
 - c. If an allied healthcare professional engaged you in a topical conversation about something in the news on public health
 - d. If an allied healthcare professional had a non-judgemental approach
 - e. If an allied healthcare professional was relaxed and not rushing the consultation
 - f. If you had the privacy to raise an issue
 - g. If it was related to a condition you were already engaged with the healthcare professional on
 - h. Something else
 - i. Nothing would encourage you to have a conversation about lifestyle health advice with a healthcare professional

Editors note



Public Health
England

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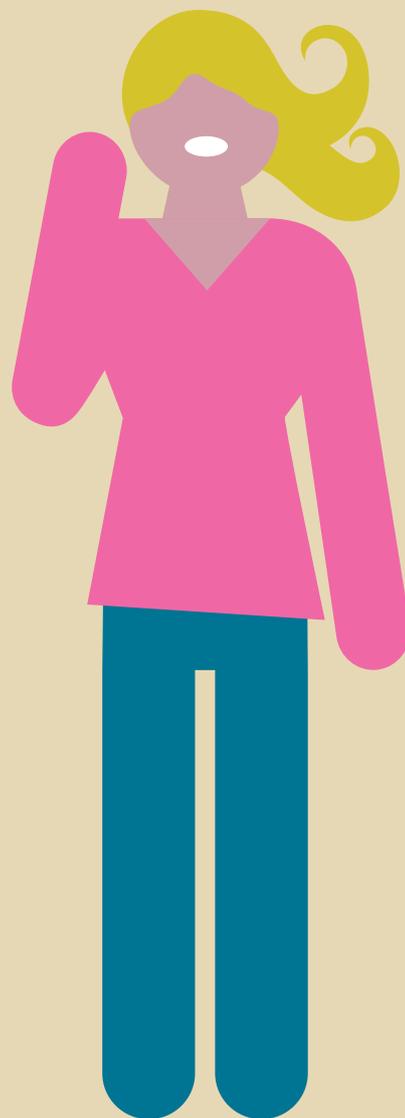
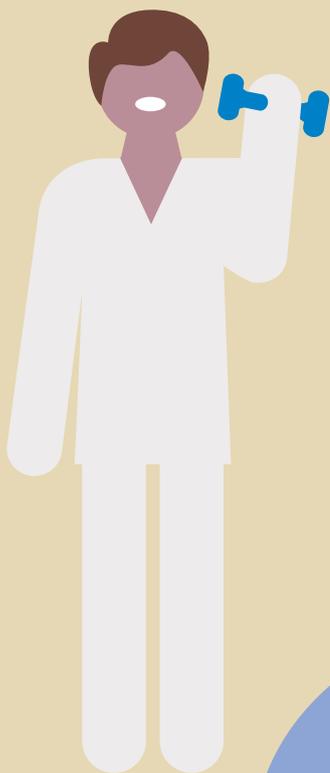
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The Royal Society for Public Health (RSPH) is an independent health education charity, dedicated to protecting and promoting the public's health and wellbeing. We are the world's longest-established public health body with over 6000 members drawn from the public health community both in the UK and internationally. Our operations include an Ofqual recognised awarding organisation, a training and development arm, health and wellbeing accreditation, and a certification service. We also produce a wide-variety of public health conferences; our publishing division includes the internationally renowned journal Public Health; and we are developing policy and campaigns to promote better health and wellbeing.

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twitter: @R_S_P_H



For more information,
please contact Duncan Stephenson
dstephenson@rsph.org.uk
Royal Society for Public Health
John Snow House
59 Mansell Street, London E1 8AN
Tel: +44 (0)20 7265 7300
www.rsph.org.uk
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