

The Health Promotion and Behavioural Change  
Workforce (HPBCW) Project

Report of the Workshops  
January – February 2010

| <b>Contents</b>                     | <b>Page</b> |
|-------------------------------------|-------------|
| Section 1. Summary                  | 1           |
| Section 2 Introduction              | 3           |
| Section 3. The Workshops            | 6           |
| Section 4. Discussion of Key Themes | 11          |
| Section 5. Conclusions              | 19          |
| Appendix I Participants Responses   | 21          |
| References                          | 29          |

## Section I Summary

This report presents the findings and views of participants taking part in a series of regional workshops (England) held during the period of November 2009 and February 2010. The workshops were facilitated and organised by the Royal Society for Public Health (RSPH), with attending participants coming from a cross section of members of the health promotion workforce. The project was originally commissioned by the Department of Health (DH) as part of the wider Public Health Workforce Review to provide insight into the role and related skills and competencies of specialists in health promotion (and where possible the wider behaviour change workforce), alongside recruitment and retention issues. It also was commissioned to provide an opportunity to question the basis – both academic and within the current NHS system, of the strength, focus and use of the current specialist health promotion workforce.

Participants from the workshops have specifically identified the ongoing need for specialists in health promotion – defining the role as one that can work strategically, bringing together and working within partnerships to tackle the determinants of health. The capability to communicate with and engage stakeholders in actions to improve health at the community and population level is seen as an important aspect of the specialist's role and something that emerged from a mix of experience, training and insight rather than as a result of any one specific skill or competency.

Participants also highlight the significance of the function of health promotion specialists in advocacy for health, enabling action for health and mediating for health. They are seen as having a central and integral role to play as part of a flexible and multi-disciplinary workforce in a rapidly changing health economy. Many participants believed that the function and role should be protected and those fulfilling it given the status and freedom to maximise its potential.

The term 'behaviour change workforce' was not commonly understood or accepted by participants – indeed there was a strong antipathy towards its usage and a call for DH to provide clarity of definition in terms of the roles, entry points and career pathways that the behaviour change workforce embraces. The report therefore is more limited in this area, none the less some useful participant feedback is included.

In terms of links to the educational and academic sectors, health promotion practice is seen as being firmly underpinned by theory, this theory being tried and tested over several decades. However there is a need to at least maintain and preferably increase health promotion research funding and for academic institutions to continue to ensure that the courses on offer are reflective of needs on the one hand and are encouraging the development of new knowledge and practice within the sector. For this reason alone, partnerships between the health and education sectors and other stakeholders are important and need to be fostered.

Practitioners' need for life-long health education training, must be integral to new DH workforce development programmes and in this context a funded and co-ordinated public health workforce development strategy is fundamental to ensuring a competent

workforce. This workforce needs to be culturally diverse and strengthened with cultural competence. We recommend that active consideration should be given as to how best to guard the reservoir of knowledge held by health promotion specialists. Ways in which this might be done include the development of a clear career pathway, a raised profile for the role, and a move, so far as is possible, towards embedded, long-term roles rather than short, project specific employment contracts.

‘Workforce development’ is now a core element of many organisations planning and improvement processes. It means developing the people in an organisation to improve the way that services and activities are delivered. Done well, the outcome of workforce development is a motivated, skilled, diverse and outward looking workforce capable of delivery high quality services. Workforce development may also include the work an organisation does to increase the recruitment and retention of high quality people. One of the fundamental prerequisites for workforce development is gaining an understanding of the development needs of the people who work in it.

## Section 2 Introduction

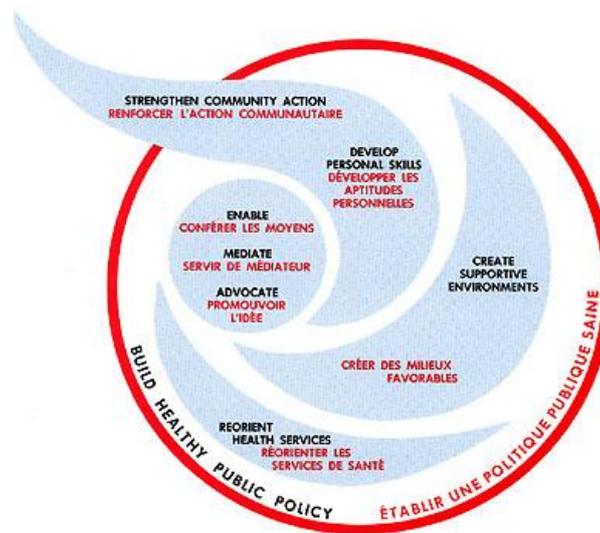
England is currently facing a number of significant health and demographic challenges. Among these tobacco use remains, and will continue to remain a risk to population health; alcohol and substance misuse are increasing in significance; and poor eating habits and low levels of physical activity are leading to increasing levels of obesity and a growing prevalence of Type II diabetes. When coupled with the ageing of the population, the impact of these behaviours is going to be significant with harmful outcomes for individuals, employers and society at large.

Such issues have not arisen suddenly – they have emerged over a considerable period of time. Action to improve the situation has already been taken. But action to bring about positive behaviour change at the macro (population, societal), meso (organisational / community e.g. school, hospital, workplace) and micro level (individual, family) must be continued, and where appropriate enhanced. The key to improving the health of the population is not to be found in treatment, important though that is, it is the prevention of disease in which the greatest gains will be seen.

Within the health services it can be strongly argued that the all staff who have face to face contact with patients have a role to play in the promotion of health and well-being. For some the opportunities to fulfil this role will be few, for others although there will be more opportunities the duration of the interaction will by necessity be short, while for the remaining group, the opportunities will be many and the time they can designate to it will be (relatively) considerable. Maximising the use of all these opportunities is vital.

However the approach outlined above is a health service, disease oriented model with the target audience often possessing a pre-existing illness or condition – the reason for their contact with health service staff. A different way of approaching the challenge of enabling people to take greater control of their health and to improve their health is address the determinants of health. This approach was first promoted within the World Health Organization's Ottawa Charter for Health Promotion (1986) which proposed a systems approach to health promotion, where public participation, supportive environments, strengthened community action, enhanced personal skills, and reoriented health services are all seen as integral.

Figure 1. The Ottawa Charter for Health promotion



Despite being 24 years in existence the principles and suggested practice of the Ottawa Charter remains relevant and current. WHO has taken forward the concept and a series of Global Conferences have addressed key elements of the Ottawa Charter – Adelaide (1988) Recommendations on Healthy Public Policy; Sundsvall (1991) Statement on Supportive Environments for Health; Jakarta (1997) Leading Health Promotion into the 21<sup>st</sup> Century; Mexico (2000) The Promotion of Health: From Ideas to Action; Bangkok (2005) The Bangkok Charter for Health Promotion in a Globalised World.

Influencing public policy, driving forward the creation of supportive environments, reorienting health services (from disease towards health), strengthening community action and developing personal skills for health among the population are issues that have been addressed by many stakeholders. The real added value / beneficial outcome is achieved when the approach is championed, coordinated across sectors and settings and has stakeholder engagement.

Health promotion has thus evolved to recognise the influence of broader social policies, environmental and specific workplace factors, not just individual factors in efforts to promote health. The key to health promotion is the commitment to evidence based decision making, collaboration with stakeholders, and especially, commitment to common values and assumptions about the importance of the upstream factors impacting health (Labonte and Spiegel, 2003). The traditional approach to health promotion with its focus on individual lifestyles has been replaced by a methodology that is system based and multi- level in nature.

In developing these activities leadership and the ability to work across boundaries, plus the ability to see the pattern in the jigsaw before the pieces are assembled are essential. Traditionally this leadership role has been fulfilled by health service staff with a specialism in health promotion, and in many instances this continues to be the case, even though job titles and roles may have changed as has the organisational and work environment in which those with responsibility for improving health operate.

In order to contribute to workforce standards and competence for future public health delivery the DH commissioned the RSPH to organise and hold meetings of the health promotion workforce on behalf of the DH, on five key themes:

1. *Should there be defined specialists in health promotion?*
2. *What features of the health promotion workforce's competencies are unique?*
3. *Does health promotion have a strong academic underpinning?*
4. *What issues are there in recruitment, retention and capacity in the current health promotion workforce?*
5. *What are the core skills of health promotion?*

The finding of the workshops will be summarised, and a synthesis provided of the main concerns, insights and implications for each of these thematic areas.

This project aims to:

- provide insight into the current sets of skills held by health promotion and behaviour change workforces;
- provide an opportunity for consideration of recruitment and retention issues for these workforces;
- create an opportunity to question the basis – both academic and within the current NHS system, of the strength focus and use of the current workforces. It is important, timely and undertaken in the context of the development of the workforce.

## **Section 3: The Workshops**

### **Process**

Workshops were held at four locations (London x2 workshops, Bournemouth, Birmingham and Leeds) during January and February 2010. Locations were chosen on the basis of convenience for those attending and to ensure reasonable geographic coverage across England.

Invitations to attend were sent out during December 2009 and January 2010 with the aim being to have 12 – 15 participants at each workshop.

The actual number of attendees was as follows:

- London 25<sup>th</sup> January – 15 delegates
- Bournemouth 3<sup>rd</sup> February – 7 delegates
- Birmingham 8<sup>th</sup> February – 15 delegates
- London 11<sup>th</sup> February – 11 delegates (all drawn from academic institutions)
- Leeds 22<sup>nd</sup> February – 19 delegates

The workshops were of 3.5 hours in duration and were shaped around a series of questions which were used to trigger and facilitate discussion. Participants worked in small groups and in responding to the questions were asked to reflect on their experience and consider current and future issues rather than historical ones.

### **Information Collection**

Each group discussed the questions, made a record of their responses on flip charts and then fed these back to the group as a whole, which in turn led to further discussion and debate.

The facilitator of the workshop made a written record of this discussion and the comments were also recorded digitally.

### **Assessment of Participant's Responses**

All the written and aural material was reviewed and the responses to each of the questions assessed and the themes that emerged from the responses identified.

In setting out the themes that emerged we have grouped them under each of the questions. Several themes apply across several questions and these are referred to in the discussion. It is important to note that these are our groupings of the reactions of the participants to the questions – other people might group the responses in an alternative way.

In discussing these issues we give more weight to the common themes, while acknowledging that very significant and equally valid issues were sometimes only identified in one workshop.

## **The Questions**

The following table sets out the questions used in each of the workshops. The significant difference between the questions used in workshops 1, 4 and 5 with those used in workshops 2 and 3 is due to a request from the client that the focus be oriented to include the behaviour change workforce. In practice however the use of the term created difficulty in the minds of the participants, and despite steps to clarify the meaning of the term for the third workshop the problems remained in place. This point is explored further in the section dealing with the themes that emerged.

For workshops 4 and 5 two questions in workshop 1 (Q's 2 and 5) were combined.

## Workshop Questions

|     | <b>London<br/>25<sup>th</sup> January</b>  | <b>Bournemouth<br/>3<sup>rd</sup> February</b>   | <b>Birmingham<br/>8<sup>th</sup> February</b>  | <b>London<br/>11<sup>th</sup> February</b>   | <b>Leeds<br/>22<sup>nd</sup> February</b>  |
|-----|--|--|--|--|--|
| Q1. | <p>Should there be defined specialists in health promotion?</p> <p>In your groups please identify three reasons why there should be defined specialists in health promotion and three reasons why there shouldn't.</p> <p>Please justify your reasons!</p> | <p>Should the behaviour change workforce which includes health promotion have a greater exposure to, and understanding of, illness, disease and health, and health care systems as an integral part of their training?</p> | <p>Should the behaviour change workforce which includes health promotion have a greater exposure to, and understanding of, illness, disease and health, and health care systems as an integral part of their training?</p> | <p>Should there be defined specialists in health promotion?</p> <p>In your groups please identify three reasons why there should be defined specialists in health promotion and three reasons why there shouldn't.</p> <p>Please justify your reasons!</p> | <p>Should there be defined specialists in health promotion?</p> <p>In your groups please identify three reasons why there should be defined specialists in health promotion and three reasons why there shouldn't.</p> <p>Please justify your reasons!</p> |
| Q2. | <p>What features of the health promotion workforce's competencies are unique?</p>  | <p>What features of the behaviour change workforce's, including health promotion competencies are unique? What are the core skills of behaviour change, including health promotion?</p>                                    | <p>What features of the behaviour change workforce's, including health promotion competencies are unique? What are the core skills of behaviour change, including health promotion?</p>                                    | <p>What features of the health promotion workforce's competencies are unique?</p> <p>In your opinion what are the core skills of health promotion?</p>   | <p>What features of the health promotion workforce's competencies are unique?</p> <p>In your opinion what are the core skills of health promotion?</p>   |

|     | <b>London<br/>25<sup>th</sup> January</b>   | <b>Bournemouth<br/>3<sup>rd</sup> February</b>  | <b>Birmingham<br/>8<sup>th</sup> February</b>   | <b>London<br/>11<sup>th</sup> February</b>  | <b>Leeds<br/>22<sup>nd</sup> February</b>   |
|-----|---|---|---|---|---|
| Q3. | <p>Does health promotion have a strong academic underpinning?</p> <p>If 'Yes', what needs to be done to strengthen this even further?</p> <p>If 'No' is this a problem, if it is how can it be rectified?</p> | <p>Is there a unique academic knowledge base underpinning practice in behaviour change, including health promotion?</p>                     | <p>Is there a unique academic knowledge base underpinning practice in behaviour change, including health promotion?</p>                     | <p>Does health promotion have a strong academic underpinning?</p> <p>If 'Yes', what needs to be done to strengthen this even further?</p> <p>If 'No' is this a problem, if it is how can it be rectified?</p> | <p>Does health promotion have a strong academic underpinning?</p> <p>If 'Yes', what needs to be done to strengthen this even further?</p> <p>If 'No' is this a problem, if it is how can it be rectified?</p> |
| Q4. | <p>In the context of the current health promotion workforce, what issues are being faced in terms of recruitment, retention and capacity?</p>   | <p>What issues are there in recruitment, retention and capacity in the current behaviour change workforces, including health promotion?</p> | <p>What issues are there in recruitment, retention and capacity in the current behaviour change workforces, including health promotion?</p> | <p>In the context of the current health promotion workforce, what issues are being faced in terms of recruitment, retention and capacity?</p>   | <p>In the context of the current health promotion workforce, what issues are being faced in terms of recruitment, retention and capacity?</p>   |

|     | <b>London<br/>25<sup>th</sup> January</b>                     | <b>Bournemouth<br/>3<sup>rd</sup> February</b>   | <b>Birmingham<br/>8<sup>th</sup> February</b>  | <b>London<br/>11<sup>th</sup> February</b> | <b>Leeds<br/>22<sup>nd</sup> February</b> |
|-----|---|--|--|--|---|
| Q5. | In your opinion what are the core skills of health promotion? | To what extent should we be concentrating on ensuring that our existing workforces have these competencies, verses developing a new workforce, verses modifying existing workforces? | To what extent should we be concentrating on ensuring that our existing workforces have these competencies, verses developing a new workforce, verses modifying existing workforces? |  |   |

#### Section 4: Discussion of Key Themes

During the workshop process several factors came to light. First and foremost among these was the willingness of the participants to contribute to the discussion and debate. The debate was lively, challenging and involved reflection and considered opinion as well as the expression of strongly held views.

The use of the term 'behaviour change workforce' created some difficulty as it is a term with which only one or two of the total number of participants were familiar. A review of the literature using the search term 'behaviour change workforce' was undertaken using Medline, Cinahl, Psychlit etc.

This revealed one use of the term in the UK and Europe, and that was in a document produced by South Yorkshire and Humber Strategic Health Authority, where it is stated that, 'Several South Yorkshire PCTs identified the enormous task ahead of them in skilling their wider public health workforce in the basic principles of behaviour change', and that in response to this, 'A *behaviour change* workforce competence framework including brief interventions, due for completion by summer 2009, has been commissioned from Sheffield Hallam University'. The document does not define the behaviour change workforce but it would seem to indicate that the potential role of the wider public health workforce in promoting positive behaviour change has been recognised and addressed. The issue which remains unaddressed is that of the positioning and remit of health promotion specialists.

Between the first London and the Bournemouth workshop a working definition of behaviour change workforce was developed by the RSPH team. This takes a broad view of the behaviour change workforce and is expressed thus, '*The Behaviour Change Workforce is an all embracing term referring to anyone who is professionally involved in promoting or assisting health related behaviour change either at the population, community or individual level*'.

Despite this, the participants in workshops 2 and 3 found the expression 'behaviour change workforces, including health promotion' difficult to relate to their experience, where behaviour change is part, but by no means all of the role of a health promotion specialist. This was seen to be a diminution of health promotion and was a major cause of contention and potential concern.

The final observation that warrants comment in this manner is the clearly expressed concern about the status, positioning and functioning of health promotion within public health as a whole.

## Discussion

### I. Structure, identity and function

The majority of participants from all 5 workshops identified the need for specialists in health promotion - partly because they provide a unique mix of skills and competencies and act as a reservoir of knowledge, skills and experience and also because they have an important strategic as well as an operational role.

In addition participants stated that health promotion specialists provide:

- Focussed leadership and act as champions for health improvement, health promotion and health and well being initiatives. There is risk, in terms of programme development / delivery and the reduction of inequalities, if they are not present
- A unique set of competencies and interdisciplinary knowledge
- A range of skills, knowledge, experience and action that is broader in nature than behaviour change alone. The consensus view was that behaviour change is part of health promotion practice, not the other way around
- An impact on population health rather than being focused on one individual
- A defined values system (social justice, rights, equity etc)

Traditionally health promotion services were recognised by the participants as having engaged with and involved communities (geographic – localities, and organisational – schools, workplaces, hospitals). This was recognised as being an important means of mobilising local resources for health. It was also felt that with increasing emphasis being placed on collaborative working the skills possessed by health promotion specialists (advocacy and mediation for example) facilitate the process of engagement of stakeholders and those they represent.

The need to formalise the links between and the involvement of the specialist health promotion service in policies and programmes which have health related elements (e.g. such as the emerging families and communities agenda) was seen as particularly critical.

When recognising the benefits of having a specialist health promotion workforce the lack of a national structure and framework upon which its role can be developed and maintained was felt to be a major gap. Is the specialist service in terms of its positioning within the NHS, its role within the commissioning and provider functions and its contribution to the achievement of better health for all through the public health service achieving all that it could?

In its truest form, health promotion is an upstream approach to health – it is about targeting and influencing the health related behaviour of the vast

majority of the population that is well, or that has well managed health conditions. From a societal perspective, keeping these groups well and economically active is an essential component of actions that need to be taken in order to maintain the UK's competitiveness. The challenge facing many commissioners, and indeed Government itself is that health is often measured by the public in terms of the number of medical interventions that are completed for those who are unwell, rather than on what is being done to prevent those who are well becoming ill. At times of economic constraint, this emphasis on societal action to promote health is in sharp contrast to the desire held by many to treat in as speedy and comprehensive a way as possible illness and disease.

It was noted that the census of health promotion specialists carried out in 2006 as part of the Shaping the Future initiative showed a 50% reduction in the number of health promotion specialists. This reduction had possibly further increased since the census publication and reinvestment in the specialist service is urgently needed to fulfil the well being agenda.

## **2. Role clarity and progression**

From the perspective of the participants there is not complete role clarity for health promotion specialists. This lack of clarity begins at entry into the specialism – where are the entry points, what qualifications are needed, how and where can these qualifications be obtained? A gap was also identified for those wishing to progress from roles located at levels 4/5 in the Public Health Skills and Careers Framework particularly in terms of how to progress towards specialist status.

The role of the specialist health promotion workforce within the current operating systems is also not clear in many instances – in some areas there is little or no service at all, and what there is reactive and focused on individual health needs rather than being proactive and focused on community or population health issues. In other areas however there is a distinct, proactive health promotion service that is fully engaged with its community and stakeholders in the delivery of health promotion programmes across settings and health topics.

Progression along a defined career pathway, or rather the lack of it, was seen as a major hindrance to the delivery of high quality health promotion services. For many health promotion specialists career enhancement means moving out of health promotion altogether. The consequent loss of knowledge, skill and experience to the service and to the services and interventions that these individuals lead or are involved in is costly.

Consideration might be given to increasing the amount of cross boundary (organisational boundaries) working e.g. between health services and local authorities. In this collaborative working specialist health promotion services could rightly be assumed to have a lead role so far as health improvement is concerned.

### **3. Recruitment, Retention and Capacity**

#### **Recruitment and Retention**

The major concern relating to recruitment is the lack of a career pathway for those who have specialised in health promotion, a situation compounded by a lack of clear entry points into the profession and an unclear entry path regarding training and qualification. Fixed term contracts are also seen as a barrier to recruitment alongside the positioning and attractiveness of health promotion as a career in comparison to other comparable public health and health related roles.

There was an almost unanimous view that the lack of a career pathway is having a negative effect on the retention of key skills, knowledge and experience. Often to progress health promotion specialists were seen as having to move out of their chosen arena into other roles, most notably into a more generic public health role.

The focus on short term / project based funding whilst enabling the achievement of specific goals and programme outcomes is also perceived as a barrier to retention of key staff and embedding of knowledge and skills within employing organisations.

For the behaviour change workforce the critical issue for participants was the urgent need for a career framework for those working in this area – alongside a clarification of what roles and qualifications / CPD the framework would encompass. Other recruitment and retention issues participants identified include:

- Funding for the behaviour change workforce is often in the form of discrete project funding rather than core resources
- Behaviour Change type roles are not always embedded in the organisation – again funding is short term, and so people have to move to other positions as they approach the end of their project / and fixed term contract
- Registration and regulatory requirements – this doesn't exist for some roles and if introduced may be a barrier to recruitment
- Career progression for staff on lower salary bands is limited, those with or who gain additional qualifications move into new roles as soon as they can

#### **Capacity**

In general, capacity was not felt to be such an issue, largely as a result of the way in which health promotion was now delivered i.e. short term, setting or topic specific projects for which people with relevant experience could be found.

However in the context of the more strategic, proactive roles capacity was felt to be an issue in terms of relevant experience and expertise. Defined gaps

in the skill level of some of those in higher band roles were identified and it was perceived as being difficult to gain experience in health promotion in these types of role and this impacted on a whole system approach to capacity building.

Potential over skilling of lower bands within the NHS Skills Framework and the Public Health Skills and Careers Framework were also highlighted as a potential capacity issue. Conversely, it was felt that high pressure is placed on lower bands and is created by the expectation that staff in these grades 'can do anything', even when what they are being asked to do is outside their level of competency and/or experience.

#### 4. Unique Competencies and Core Skills

Identifying the unique competencies and skills of both the behaviour change workforce and the specialist health promotion service was difficult. The consensus view was that for both groups of workers communication skills were at the fore. For the latter group it was the unique combination of skills and competencies that was specifically highlighted. The elements of this mix included, community development, change management, knowledge of disease and the determinants of health, epidemiology, social marketing and the theory and practice of behaviour change. The need to focus on prevention to be able to use skills and transfer knowledge from one health topic to another, and to be capable of working in a client led situation were also seen as important.

##### **Unique Competencies (Specialists in Health Promotion):**

- Understanding of health, the ecology of health and the salutogenic approach to health
- Upstream thinking on health and wellbeing and wider determinants of health
- The knowledge and skills to work in a strategic way
- Communication (using a range of tools and approaches)
- The ability to work **with** organisations and groups rather than **on** them in a way that is inclusive and collaborative in nature and results in capacity building and community engagement and empowerment
- The ability to design appropriate inter-sectoral, cross boundary and cross cutting interventions
- The ability to use metrics - assessment, synthesis, evaluation, monitoring
- The ability to take evidence from different disciplines and methodologies and apply it in a health promotion context / develop appropriate interventions at national, local and individual levels

## **Core Skills (Specialists in Health Promotion):**

The discussion in each of the three workshops that addressed this question centred on the mix of skills that health promotion specialists bring to their role. 'Soft skills' were mentioned repeatedly, such as the ability to appreciate and understand others perspectives, and then use these perspectives as a starting point from which to develop actions (setting goals and understanding how and what is being done will operate in the complex field of social, political, and religious forces).

More directly communication skills and the ability to assess complex situations and derive an appropriate way forward were also mentioned once again.

Other skills that were noted were:

- The ability to incorporate theories / models that impact on health related behaviour change into programme development
- The skills associated with successfully bringing about change at an organisational and individual level
- The skills of enabling and empowering organisations and individuals

## **Behaviour Change Workforce**

For the behaviour change workforce key competencies were seen as including the theory and practice of behaviour change, needs assessment and skills such as motivational interviewing.

Whilst all participants voiced their concern about the lack of definition of what roles / functions were included within the behaviour change workforce it was generally agreed that there is a need to create and maintain an adaptable workforce who could use their knowledge and skills and transfer these to different health topics. Any worker in this category was seen as requiring the skills to enable them to participate in client led interactions.

To enable this to happen, core communication and facilitation skills were required so that in any 1:1 situation the right information is conveyed in an appropriate manner at the right time. Assessment of a person's readiness to change, understanding of behaviour change theory and practice (including mentoring and signposting information), and the use of social marketing to promote behaviour change were also viewed as important skills. The key point being that in order to maximise the potential of their role the behaviour change workforce is able to put into practice in the best possible manner the competencies it possesses at a collective level.

Other issues raised by participants included:

- The need to ensure the competency of the behaviour change workforce; to do this in a consistent manner across the workforce and to utilise the public health skills and career framework
- That the existing workforce has competencies and these need to be defined, monitored and evaluated and progression needs to be built into the behaviour change careers pathway
- The role of social marketing in behaviour change needs to be promoted
- New people should be attracted to the behaviour change workforce as fast as is practicable but this can only be done if at national level there is clarity of roles, entry points and qualifications.

## 5. The role of academic institutions

With a strong institutional base, it could be argued that health promotion specialists, and health promotion in general are well served. However enabling new research into health promotion, the creation of new knowledge and an enhancement of the dissemination of excellence in terms of practice would directly impact on service delivery. In addition an increase in the number of academic programmes directly addressing a health promotion (rather than a public health) curriculum would be hugely advantageous. To do this, the health promotion departments within academic institutions need to be secure and free to take the health promotion agenda forward. Access to research funding is an essential aspect of this development.

The overwhelming view of the participant indicated that there is a strong academic underpinning of health promotion action. Current strengths included:

- A clear evidence base
  - A clear theoretical base
  - A strong academic institution base (there are currently 65 Professors of Health Promotion in the UK)
  - The existence of several peer reviewed journals addressing health promotion issues
  - The existence of professional and registration bodies (RSPH, UKPHA, Faculty of Public Health) to support health promotion practice and continuous professional development
- c. Participants suggestions on actions that should be taken to further strengthen the academic underpinning of health promotion practice included:
- Increased research and capacity development within the health promotion practice, especially an increase in the funding to undertake randomised control trials related to health promotion impact assessment and translating this research into practice
  - The funding of health promotion research – several participants stated that the lack of research funding was a major issue for academic

institutions and mitigated against the ongoing development of the academic body of knowledge and theoretical basis that underpins, challenges and develops health promotion practice

- Encouragement of academic institutions to include more health promotion research within the 2013 Higher Education Funding Council for England (HEFCE) Research Excellence Framework (REF) assessment - particularly in terms of its measurable impact
- Increasing the number of health promotion academics on the NHS Research Register – this would it was felt benefit health promotion research and in turn practice
- Increasing the number of academic programmes specifically focused on health promotion (rather than being shoe horned into other programmes which may have one or two modules devoted to health promotion)
- Recognition that health promotion is an eclectic discipline drawing on the knowledge and skills from other disciplines
- Acknowledgement that some aspects of practice are not well underpinned by theory or research led evidence base

## Section 5 Conclusions

It is worth remembering that in fulfilling its role the health promotion workforce engages the public as a resource, not as a target group, and it is this giving of ownership and enabling of action that highlights the potential of this workforce to make a sustained contributing to the improvement of health in England. It is in the development of upstream, disease prevention initiatives that population health will be maintained and improved, but in times of economic restraint the expectation of many is that front line treatment services should be maintained above all others – often at the costs of disease prevention and health promotion activities.

The definition of essential public health services (as opposed to specific public health system professions) is important. In considering how best to contribute to workforce standards and competence for future public health delivery the following points should be borne in mind:

- The need for specialists in health promotion continues – these are individuals who can work strategically, bringing together and working within partnerships to tackle the determinants of health. This group is able to communicate with and engage stakeholders in actions to improve health at the community and population levels and brings to the process a wide range of skills and competencies – it is the mix of these rather than any one specific skill or competency that is key. Those working in 1:1 situations with patients / clients and dealing with important disease related risks are equally important, but are fundamentally different in nature.

The significance of the function of health promotion specialists in advocacy for health, enabling action for health and mediating for health cannot and should not be underestimated. They have a central and integral role to play as part of a flexible and multi-disciplinary workforce in this rapidly changing environment. This function and role should be protected and those fulfilling it given the status and freedom to maximise its potential.

- In terms of links to the educational and academic sectors, health promotion practice is firmly underpinned by theory and this theory has been tried and tested over several decades. However there is a need to at least maintain, and preferably increase, health promotion research funding and for academic institutions to continue to ensure that the courses on offer are reflective of needs on the one hand and are encouraging the development of new knowledge and practice within the sector. For this reason, partnerships between the health and education sectors and other stakeholders need to be fostered.

Practitioners' need for life-long health education training, must be integral to new DH workforce development programmes and in this context a funded and co-ordinated public health workforce development strategy is fundamental to ensuring a competent workforce. This workforce needs to be culturally diverse and strengthened with cultural competence.

- Consideration should be given as to how best to guard the reservoir of knowledge held by health promotion specialists. Ways in which this might be done include the development of a clear career pathway, a raised profile for the role, and a move, so far as is possible, towards embedded, long term roles rather than short, project specific employment contracts.

## Appendix I Participants Responses by Question

- I. Responses to question I (Workshops 1, 4 & 5)**
- a. Should there be defined specialists in health promotion?**
  - b. In your groups please identify three reasons why there should be defined specialists in health promotion?**
  - c. Three reasons why there shouldn't.**
  - d. Please justify your reasons (included in the responses to b and c)**

- a. The overwhelming answer from all workshops and all groups was 'yes'.
- b. The reasons for this view included:
  - They provide a unique mix of skills and competencies and act as a reservoir of knowledge, skills and experience
  - They play an important strategic as well as an operational role
  - They provide focused leadership and act as champions for health improvement, health promotion and health and well-being initiatives, and there is risk, in terms of programme development and delivery and the reduction of inequalities, if they are not present
  - They bring a unique set of competence and interdisciplinary knowledge
  - Health promotion offers a range of skills, knowledge, experience and action that is broader in nature than behaviour change alone. The consensus view was that behaviour change is part of health promotion practice, not the other way around
  - Health promotion specialists impact on population health rather than being focused on one individual
  - They share and bring a defined values system (social justice, rights, equity etc)
  - Traditionally health promotion has engaged with and involved communities (geographic and organisational – schools, workplaces, hospitals). This is an important means of mobilising local resources for health
  - That with increasing emphasis being placed on collaborative working, the skills they possess facilitate the process (advocacy, mediation)
- c. Reasons for not having specialists in health promotion included:
  - The lack of a career pathway undermines the need for (and ability to recruit and retain) health promotion specialists
  - Significant issues around value for money, effectiveness, return on investment and impact, counteracted by the argument put forward that there has been disinvestment in health promotion per se

- That the need for a specialist service is replaced by everyone (in the health service) being engaged in health promotion – but this was not a unanimous view

**1a. Responses to question 1 (Workshops 2 & 3)**

**Should the behaviour change workforce which includes health promotion have a greater exposure to, and understanding of, illness, disease and health, and health care systems as an integral part of their training?**

Following a discussion about the meaning of the term ‘behaviour change workforce’, both groups who considered this question considered that training was an important aspect of equipping this group to fulfil its role, and that this training should address the issues of illness, disease and health and health care systems. Also to be included should be training in core competencies, with the training tailored to the job and role of the person and the skill mix they need to be able to carry out this role.

**2. Responses to questions 2 and 5 (Workshop 1)**

- What features of the health promotion workforce’s competencies are unique? (Q2)**  
and
- In your opinion what are the core skills of health promotion? (Q5)**

**Responses to question 2 (Workshop 4 and 5)**

- What features of the health promotion workforce’s competencies are unique?**
- In your opinion what are the core skills of health promotion?**

**Unique competencies:**

- Understanding of health, the ecology of health and the salutogenic approach to health
- Upstream thinking on health and wellbeing and wider determinants of health
- The knowledge and skills to work in a strategic way
- Communication (using a range of tools and approaches)
- The ability to work **with** organisations and groups rather than **on** them in a way that is inclusive and collaborative in nature and results in capacity building and community engagement and empowerment

- The ability to design appropriate inter-sectoral, cross boundary and cross cutting interventions
- The ability to use metrics - assessment, synthesis, evaluation, monitoring
- The ability to take evidence from different disciplines and methodologies and apply it in a health promotion context / develop appropriate interventions at national, local and individual levels

The responses to this question were more limited in nature. However, the following were noted as being important:

- The need to ensure the competency of the behaviour change / health promotion workforce; to do this in a consistent manner across the workforce and to utilise the public health skills and career framework
- That the existing workforce has competencies and these need to be monitored and evaluated and progression needs to be built in to the role
- The role of social marketing in behaviour change needs to be promoted
- New people should be attracted to the behaviour change / health promotion workforce as fast as is practicable

If health improvement training were to be placed within the core elements of health courses then this could be used to modify the existing workforce

### **Unique skills:**

The discussion in each of the three workshops that addressed this question centred on the mix of skills that health promotion specialists bring to their role. 'Soft skills' were mentioned repeatedly, such as the ability to appreciate and understand other's perspectives, and then use these perspectives as a starting point from which to develop actions (setting goals and understanding how what is being done will operate in the complex field of social, political, and religious forces).

More directly communication skills and the ability to assess complex situations and derive an appropriate way forward were also mentioned once again.

Other skills that were noted were:

- The ability to incorporate theories / models that impact on health related behaviour change into programme development
- The skills associated with successfully bringing about change at an organisational and individual level
- The skills of enabling and empowering organisations and individuals

**2a. Responses to question 2 (Workshops 2 & 3)**

- a. What features of the behaviour change workforce's, including health promotion competencies are unique?
- b. What are the core skills of behaviour change, including health promotion?

The issue of the behaviour change workforce, along with the health promotion workforce having 'unique' competencies was discussed at length. The view was expressed that it might be more appropriate to refer to the unique 'set' of competencies required to fulfil the roles i.e. it is the combination of competencies that is important.

Within this set of competencies was the need to focus on prevention to be able to use skills and transfer knowledge from one health topic to another, and to be capable of working in a client-led situation.

To enable this to happen, the worker needs to possess communication skills so that in any 1:1 situation the right information is conveyed in an appropriate manner at the right time. The worker also needs to be able to assess a person's readiness to change and should have an understanding of behaviour change theory and practice and the use of social marketing to promote behaviour change. The key point being that in order to maximise the potential of the role, the workforce is able to put into practice in the best possible manner the competencies it possesses.

The skills required for the role included:

- Communication
- Needs assessment
- Behaviour change / motivational interviewing
- Empowerment and enabling

Reference was also made to the skills described in the Public Health Skills and Career Framework and in Skills for Health

**3. Responses to question 3 (Workshops 1, 4 & 5)**

- a. Does health promotion have a strong academic underpinning?
- b. If 'Yes', what needs to be done to strengthen this even further?
- c. If 'No' is this a problem, and if it is, how can it be rectified?

- a. The overwhelming view of the participants was that there is a strong academic underpinning of health promotion action. Current strengths included:
  - A clear evidence base
  - A clear theoretical base

- A strong academic institution base (65 UK professors of health promotion)
  - The existence of several peer reviewed journals addressing health promotion issues
  - The existence of professional bodies (RSPH, UKPHA) to support health promotion practice
- b. Suggestions on actions that should be taken to strengthen this further included:
- There is a need for research and capacity development within the sector, especially an increase in the funding to undertake randomised control trials and then translating this research into practice
  - The funding of health promotion research – several participants stated that the lack of research funding was a major issue for academic institutions
  - Inclusion in the research excellence framework (REF) would facilitate the development of health promotion
  - Increasing the number of health promotion academics on the NHS Research Register would benefit health promotion research and in turn practice
  - Increasing the number of courses specifically focused on health promotion (rather than other courses which have one or two elements devoted to health promotion)
  - However this needs to keep moving forward in terms of the creation of new knowledge and sustaining and building capacity within academic institutions
- c. Several ‘problems with the current position were identified, but a solution was not identified for all:
- A lack of benchmarking of health promotion as a discipline
  - That health promotion is an eclectic discipline drawing on the knowledge and skills from other disciplines
  - That knowledge and skills have stagnated
  - That some practice is not well underpinned by theory

**3a. Responses to question 3 (Workshops 2 & 3)**

Is there a unique academic knowledge base underpinning practice in behaviour change, including health promotion?

Participants were agreed that there was a solid theoretical base for actions of the behaviour change and health promotion workforces.

#### **4. Responses to question 4 (Workshops 1, 4 & 5)**

In the context of the current health promotion workforce, what issues are being faced in terms of recruitment, retention and capacity?

##### **Recruitment**

The major concern over recruitment issues was the lack of a career pathway for those who have specialised in health promotion, a situation that was seen to be compounded by a lack of clear entry points into the profession and an unclear entry path regarding training and qualification.

##### **Retention**

There was an almost unanimous view that the lack of a career pathway was having a negative effect on the retention of key skills, knowledge and experience. Often health promotion specialists have to move out of their chosen arena into other roles in order to progress. This, most notably results in them moving into a more generic public health role.

Associated with short term / project based funding enables the achievement of specific goals, and programme outcomes but the knowledge and skills of those working on the project is then dissipated.

##### **Capacity**

In general, capacity was not felt to be such an issue, largely as a result of the way in which health promotion was now delivered i.e. short term, setting- or topic- specific projects for which people with relevant experience could be found. However in the context of the more strategic, proactive roles capacity was felt to be an issue in terms of relevant experience and expertise.

#### **4a. Responses to question 4 (Workshops 2 & 3)**

What issues are there in recruitment, retention and capacity in the current behaviour change workforces, including health promotion?

A number of issues were identified by both the workshops who addressed this question, namely:

##### **Recruitment**

- The impact of fixed term contracts
- Less attractive jobs as there is no career structure

##### **Retention**

- The need for a career framework for those working in behaviour change
- The funding for the behaviour change workforce is often in the form of discrete project funding rather than core resources

- The roles are not always embedded – again funding is short term, and so people have to move to other positions as they approach the end of their project / and fixed term contract
- Career progression for staff on lower salary bands is limited, those with or who gain additional qualifications move into new roles as soon as they can

### Capacity

- Potential over skilling of lower bands
- Conversely, high pressure is placed on lower bands and is created by the expectation that staff in these grades ‘can do anything’, even when what they are being asked to do is outside their level of competency and or experience
- There are defined gaps in the skill level of some of those in higher bands and it is difficult to gain experience in these types of role

#### 5. Responses to question 5 (Workshops 1)

In your opinion what are the core skills of health promotion?

Please refer to the responses to question 2 above

#### 5a. Responses to question 5 (Workshops 2 & 3)

To what extent should we be concentrating on ensuring that our existing workforces have these competencies, verses developing a new workforce, verses modifying existing workforces?

The responses to this question were more limited in nature. However, the following were noted as being important:

- The need to ensure the competency of the behaviour change / health promotion workforce; to do this in a consistent manner across the workforce and to utilise the public health skills and career framework
- That the existing workforce has competencies and these need to be monitored and evaluated and progression needs to be built in to the role
- The role of social marketing in behaviour change needs to be promoted
- New people should be attracted to the behaviour change / health promotion workforce as fast as is practicable

If health improvement training were to be have placed within the core elements of health courses then this could be used to modify the existing workforce.

## References

R. Labonte and J. Spiegel, "[Setting global health research priorities](#)", *British Medical Journal*, 326, 5 April 2003: 722-723.

Third International Conference on Health Promotion, Sundsvall, Sweden, 9-15 June 1991. Sundsvall Statement on Supportive Environments for Health  
<http://www.who.int/healthpromotion/conferences/previous/sundsvall/en/index.html>

Second International Conference on Health Promotion, Adelaide, South Australia, 5-9 April 1988. Adelaide Recommendations on Healthy Public Policy  
<http://www.who.int/healthpromotion/conferences/previous/adelaide/en/index.html>

Third International Conference on Health Promotion, Sundsvall, Sweden, 9-15 June 1991. Sundsvall Statement on Supportive Environments for Health (WHO/HPR/HEP/95.3) [http://www.who.int/hpr/NPH/docs/sundsvall\\_statement.pdf](http://www.who.int/hpr/NPH/docs/sundsvall_statement.pdf)

Jakarta Declaration on Leading Health Promotion into the 21st Century  
[http://www.who.int/hpr/NPH/docs/jakarta\\_declaration\\_en.pdf](http://www.who.int/hpr/NPH/docs/jakarta_declaration_en.pdf)

The Fifth Global Conference on Health Promotion Health Promotion: Bridging the Equity Gap . Conference Report. 5-9th June 2000, Mexico City  
[http://www.who.int/hpr/NPH/docs/mxconf\\_report\\_en.pdf](http://www.who.int/hpr/NPH/docs/mxconf_report_en.pdf)

The Bangkok Charter for Health Promotion in a Globalized World (11 August 2005)  
[http://www.who.int/healthpromotion/conferences/6gchp/bangkok\\_charter/en/](http://www.who.int/healthpromotion/conferences/6gchp/bangkok_charter/en/)