CENTRE FOR WORKFORCE INTELLIGENCE

RSPH
ROYAL SOCIETY FOR PUBLIC HEALTH
VISION, VOICE AND PRACTICE

Understanding the wider public health workforce

July 2015

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Foreword

We are pleased to introduce this first collaboration between the Centre for Workforce Intelligence (CfWI) and the Royal Society for Public Health (RSPH), bringing together the CfWI's skills in quantitative workforce analysis with the RSPH's experience of workforce training and access to employer and community stakeholders.

This report comes at a time when the reorganisation of the public health workforce in England, the presence of public health within local government, and ongoing demands on the health system, offer a unique opportunity to encourage the 'non-traditional' public health workforce to have a greater role in improving the nation's health and wellbeing.

This is wholly consistent with the *Five Year Forward View* published by NHS England and partner organisations in 2014 which sets out a challenging vision for the future of the NHS and the public health system, including a call for a 'radical upgrade in prevention and public health'.

Innovative approaches to prevention, and designing new models of care are an important step, but an upgrade in public health is unlikely to become a reality without engaging the wider public health workforce with the right skills and competences, values, and behaviours to deliver innovation in practice across health and wellbeing in England.

The wider workforce can be found across the public, private and third sectors, working in a broad range of organisations and professions. This workforce is interwoven into the fabric of local communities, from unpaid volunteers, social care providers, police and fire officers, housing and education staff, to a wide breadth of healthcare staff, such as allied health professionals, midwives and pharmacists.

This diverse range of personal contacts offers many opportunities to promote healthy messages and initiate or embed behaviour change through having a 'healthy conversation' with a customer, client or patient, or signposting someone to a relevant service. The wider workforce is undoubtedly an instrumental part of the new public health landscape – we hope this report demonstrates the scale of the opportunity and the benefits already being delivered.

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Therefore, we believe this report is timely and look forward to working with agencies across the public health system and beyond to help the wider workforce have as much impact as possible.

July 2015

Executive summary

The *NHS Five Year Forward View* (NHS England, 2014), published by NHS England and partners, calls for a 'radical upgrade in prevention and public health' in England. It is widely recognised by public health bodies that many occupations outside the core public health workforce make a contribution to health and wellbeing.

In collaboration with the Royal Society for Public Health (RSPH) and Public Health England (PHE), the Centre for Workforce Intelligence (CfWI) has:

- identified key organisations and occupations for consultation,
- issued a call for evidence, which generated case study examples of the value of the wider workforce, and
- hosted two workshops with approximately 50 representatives from diverse professions, including fire services, teaching, midwifery, and health trainers.

Definition of the wider public health workforce

During the course of the project, we have developed the following definition for the wider public health workforce:

'Any individual who is not a specialist or practitioner in public health, but has the opportunity or ability to positively impact health and wellbeing through their (paid or unpaid) work' (CfWI and RSPH).

Importantly, this widens the workforce to those not knowingly engaged in public health activity as well as the unpaid and volunteer workforce.

Counting the wider public health workforce

Using national data from the Office for National Statistics' *Labour Force Survey* (ONS, 2014a), the CfWI estimates that there are approximately 15 million people in England employed in occupations that have the opportunity or ability to impact health and wellbeing though their work. The occupations included in this estimate of the wider public health workforce were confirmed through workshops. In addition, the UK Census (ONS, 2011) suggests that there are approximately 5 million people providing unpaid care and support to family or friends due to disability, illness or poor mental health.

This gives us an approximate range of between **15 to 20 million people in the wider public health workforce**.

The stakeholder workshops categorised occupations as either: *active, interested or unengaged with public health.* The CfWI also grouped occupations into 12 discrete groups, based on the type of work, for instance: *education, hospitality, welfare* etc. **The table below outlines this analysis.**

Headcount of the wider public health workforce by employment group and level of engagement

	Estimated Headcount (in thousands)			
Employment Group	**Active**	**Interested**	**Unengaged**	**Grand Total**
Administrative and management	347	976	223	1,547
Arts and media		372		372
Education	1,702	255		1,957
Environment	88	1,144	38	1,269
Health	1,683	74	55	1,813
Hospitality	327	1,078		1,405
Protection services	325			325
Retail and trade	64	704	1,684	2,452
Science and engineering		86	695	782
Sports and fitness	133	91		225
Transport		331		331
Welfare	1,392	185		1,577
Other professions		430	306	737
Grand Total	**6,061**	**5,728**	**3,002**	**14,791**

(Note the above table excludes unpaid care and support)

The largest workforces in each category are:

- **Active (6.1 million)** – education (28 per cent), health (28 per cent) and welfare (23 per cent), together comprising nearly 80 per cent of the total
- **Interested (5.7 million)** – environment (20 per cent), hospitality (18 per cent) and administration and management (18 per cent), together comprising over half the total
- **Unengaged (3 million)** – retail and trade (56 per cent) and science and engineering (23 per cent), again comprising nearly 80 per cent of the total.

While not every person in every category has the same interest in public health, and there is considerable subjectivity in the categorisation, we believe this analysis provide a good starting point for discussion about priority workforces and opportunities for more work.

Case studies

More than 30 case studies (see Annex B) were received from a diverse range of organisations including local authorities, housing services, occupational therapists and universities which responded to the CfWI/RSPH call for evidence. They contain information on how projects to engage workforces operated, and how to further

engage with people and organisations. They also explain the critical factors and drivers for change, and the overall impact of these projects.

There was a great range of programmes and projects covered by our case studies, including:

- Community-based projects
- Employment and/or housing service providers
- Emergency services
- Local authority whole system approaches to prevention and public health
- Schooling and education
- Acute care settings
- Integration of health and social care
- Environmental influence on health
- Care homes
- Community pharmacy
- Workplace programmes.

The main themes emerging from the case studies included:

- **Local strategic leadership** has driven engagement of the wider workforce in public health, often stemming from individuals who recognise their potential to improve health and wellbeing in their community.
- **Support to existing services** – the wider workforce is increasingly supporting partners to reduce demand for community health services through early intervention and other complementary approaches.
- **Partnership working across sectors** and organisations to reach target groups.
- **Working in local communities** – much of the wider workforce has strong ties to local communities.
- **To provide training to individuals –** for the wider workforce to realise its potential in positively impacting public health, it is essential that individuals are provided with effective training, ensuring they have the necessary skills and knowledge to support the public to lead healthier lives.
- **Health improvement** initiatives across the wider workforce extends beyond Making Every Contact Count (MECC) and many organisations are embracing a broader application that reflects the wider determinants of health.
- **Further developing the wider workforce –** many case studies identified similar needs in terms of supporting the further development of the wider workforce, through training, profile raising and networking.

The case studies and workshops identified the challenges arising for the wider workforce to be effective, including:

- Culture – articulating 'what's in it for me?' for staff and strengthening leadership.
- Language – focusing on 'wellbeing' rather than the less well understood 'public health'.
- Sustainability – building ways of ensuring that, for example, pilot work becomes embedded. This may include asset based community development or more commissioning for social value.
- Evaluation – linked to sustainability is the need to be able to demonstrate the effectiveness of pilot projects, mixing hard financials with softer qualitative factors.

Suggested actions

It is our hope that the project findings generate a debate across the public health system on how to maximise the contribution of the wider workforce.

We suggest a tiered approach to further engagement and development of the wider workforce, and that consideration be given to the following:

- **System leadership** – opportunities exist for RSPH, PHE and partners including the core public health workforce, to champion this disparate workforce, including building opportunities to share best practice, incorporation of public health objectives into policies, and working with the leadership of active or interested occupations.
- **Development and training interventions** – to improve the quality of wider workforce interventions and recognise its achievements, including a public health competency framework and incorporation of public health principles and practice into pre- and post- registration education across health and social care.
- **Ongoing research and evidence-gathering** – to demonstrate the value of the workforce and the progress it is making. This could include ongoing innovation and evaluation, an in-depth review of a segment of the wider workforce, or an assessment of the impact of the whole public health system at a local level.

1. Introduction

This report is a review of the wider public health workforce (wider workforce) in England and is based on intelligence jointly gathered by the Centre for Workforce Intelligence (CfWI), the Royal Society for Public Health (RSPH) and Public Health England (PHE).

This report arises from two separate commissions:

- The CfWI was commissioned by PHE, Health Education England (HEE) and the Department of Health (DH) to undertake a review of the wider public health workforce (wider workforce) in England;
- PHE and the RSPH ran a jointly funded six month research project to understand the development needs of the wider workforce.

Together, work commenced in October 2014 with an overall aim to develop a common and shared understanding amongst stakeholders of who the wider workforce are, their contribution to public health, and an identification of their skills, competencies and further training needs.

More information about the CfWI, RSPH and PHE can be found at www.cfwi.org.uk, www.rsph.org.uk and https://www.gov.uk/government/organisations/public-health-england respectively.

1.1 Project objectives

In 2014, the CfWI published a report *Mapping the core public health workforce*, identifying and counting the core public health workforce in England (CfWI, 2014). Whilst this research identified the most prominent sources for the provision of public health, it recognised that the public health workforce can be found across the public, private and third sectors, in a wide range of organisations and professions, as paid employees and as volunteers.

The DH, HEE and PHE subsequently commissioned the CfWI and RSPH to identify the size and scope of the wider workforce, any development needs this workforce may have, and opportunities for the wider workforce.

The objectives of this report are to identify the scale and scope of the wider workforce to develop an understanding of:

1. how the wider workforce has developed in recent years and the policies which have influenced that development;
2. how the effectiveness of the wider workforce in delivering public health outcomes has been measured;
3. how to quantify this wider workforce and make suggestions relating to:
    a. tracking the wider workforce as well as public health interventions, policies and programmes – to maintain visibility of the contribution the wider workforce makes to health and wellbeing
    b. initial training and continuous professional development (CPD) – to consider training and CPD programmes to complement existing training provision
    c. coordination of the wider workforce – to establish mechanisms for working with the relevant professional bodies to promote public health outcomes;
4. how to inform further work around building the capacity and capability of the wider workforce.

This work should help commissioners with planning further engagement and training of this wider workforce in order to deliver improvement in the nation's public health. It aims to identify key professions to engage in public health planning, and present possible areas where further research could be appropriate, such as in tracking the implementation of inputs to actions and outcomes.

By working together, the project partners hope that the combined findings can inform a system-wide debate around the need to involve more organisations and people in health improvement. It is hoped that this wider engagement will contribute to effective change in population wellbeing and potentially reduce financial burdens on health and social care systems in England.

1.2 Project approach

The report involved extensive stakeholder engagement and consultation which included:

- Consultation with the CfWI's public health reference group in October 2014 and February 2015 to gain expert advice and information on the proposed project approach;
- A workshop with the People in UK Public Health (PUKPH[1]) group in December 2014, where the initial wider workforce headcount estimate and the approaches for categorisation were presented – an interim report was produced in January 2015 to summarise the debate, and a further presentation and discussion took place in February 2015 to review its conclusions;
- A call for evidence (case studies) launched in January 2015, which was sent to a wide range of professional organisations, occupational networks and local authorities;
- Two workshops held in February 2015 with 50 participants from professional bodies and organisations representing the wider workforce. These workshops:
  - Confirmed the occupations included in the wider workforce
  - Assessed the level of engagement of each occupation group and
  - Discussed the issues and opportunities facing the wider workforce;
- Presentations to outline the work underway and open up discussion took place at a number of seminars and other events including an HEE public health event in London (January 2015), and PHE North in Leeds (March 2015);
- Meetings with wider workforce representatives to discuss development needs.

Further information about the approach is provided throughout this report. Details on occupation groups within the wider workforce can be found in Annex A.

1.3 Case Studies

To demonstrate the breadth and variety of activity undertaken by the wider workforce, example case studies are presented throughout the report, as shown below.

Further details on the case studies collected during this project can be found in Annex B.

[1] Senior stakeholders from across the public health sector in the UK charged by DH and PHE with providing system leadership and coordination.

Case Study

Wider workforce case study: Wigan Council

Following the transition of public health to the local authority in 2013, Wigan Council seized the opportunity to introduce a whole-system approach in line with the Marmot vision (see Section 2.2 for an explanation of the Marmot report: ***Fair Society Healthy Lives***). This approach has entailed the integration of the public health team throughout the council rather than as a standalone team, and also basing two senior public health analysts in the Joint Intelligence Unit.

Wigan has an extensive array of initiatives to improve the health and wellbeing of the local population, including a network of over 1,655 health champions, the introduction of Making Every Contact Count in several key organisations such as Bridgewater Community Healthcare Trust and Children's centres and a growing network of Healthy Living Pharmacies.

Since the transition of public health, there has been an acceleration in improvements in a number of major health indicators, which is partly attributed to this whole-system approach. Improvements include Wigan moving from 34th to 11th out of 39 in the North West for obesity rates and a significant decrease in the gap in life expectancy for men from 11.1 years in 2013 to 9.4 years in 2014.

1.4 Document structure

This report combines work generated by the CfWI, the RSPH and PHE, and independent research. The following sections contain:

- Context and policy drivers – explaining the importance of the wider workforce in public health and the recent relevant policy initiatives;
- Defining the public health workforce – a summary of work undertaken to define, categorise and count the public health workforce;
- The wider workforce in action – a review of case studies drawn from across the country which demonstrate the value of the wider workforce;
- Challenges for the wider workforce – a review of the issues and opportunities identified by stakeholders during stakeholder engagement activity;
- Conclusions and suggestions – suggested next steps to move forward the debate about the wider workforce.

Further details on occupation groups within the wider workforce can be found in Annex A and on the case studies in Annex B.

2. Context and policy drivers

In this section, we look at how the profile of the wider workforce has increased in recent years and the policy drivers which have influenced that development.

2.1 Context – the importance of the wider workforce

The wider workforce has an important contribution to make to the prevention agenda. With the reorganisation of the public health workforce in England in 2013 as part of the Health and Social Care Act (2012) legislation; the presence of public health within local government; and new demands on system change – the time is right to encourage the more non-traditional public health workforce to have a role in improving the public's health. The view of many stakeholders, including many in the wider workforce, is that the wider workforce should be considered as an integral part of the public health system, providing health and wellbeing services to the local communities which they serve, and recognised for the public health contribution they make.

This contribution is recognised by PHE and the RSPH, which jointly funded a Wider Public Health Workforce Development Manager for a period of six months from October 2014 to April 2015. This report is in part the outcome of that work which involved substantial engagement across the wider workforce. PHE is continuing to develop links and to support the wider workforce, and has committed to a wider workforce development post, part of the continued joint project with the RSPH on the wider workforce. The role will provide a national system focus for this workforce and progress actions that support the suggestions for the way forward set out in this report.

The burden of health inequalities in England is estimated at close to £60 billion per annum (Frontier Economics, 2010). The wider workforce has a great deal of potential to positively impact health and wellbeing, and may be well positioned to address health inequalities by creating the environment for action to be taken at a local level.

The wider workforce can be found across the public, private and third sectors, in a broad range of organisations and professions, as paid employees and as volunteers. This includes social care providers, police and fire services, housing and education, sports and leisure, local communities, as well as a wide breadth of non-core healthcare workforces such as allied health professionals, pharmacists and opticians. Through these diverse forms of direct contact with the public, many opportunities are available to promote healthy messages and initiate or embed behaviour change. This may be through having healthy conversations with individuals, or simply influencing those who have commissioning and system responsibilities to make better decisions to help improve population health and wellbeing.

Healthy conversations are opportunistic, and involve an individual being encouraged to consider their health and their lifestyle with a view to identifying small but important changes. This may involve offering brief advice or 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 (RSPH, 2014).

Making health and wellbeing everyone's business requires ensuring that many diverse sectors fully understand how they can, or already are, contributing.

2.2 Key policy drivers

Key policy drivers for greater investment in the wider workforce are summarised below. The number of initiatives and announcements shows the growing profile of the wider workforce and its increasing importance in improving the nation's health and wellbeing.

2.2.1 People in UK Public Health

The People in UK Public Health group is an advisory group providing independent, expert advice to the health departments of the four UK governments on an overarching strategy for the public health workforce. The vision of the group is to improve the public's health in the UK. This group has been reformed from the previous Public Health Workforce Advisory Group, comprising comprehensive membership of stakeholder groups concerned with public health workforce planning and development. It was renamed to reflect its focus on shaping a multi-disciplinary public health workforce fit for the 21st Century. This approach recognises that improving the health of the public involves a broad range of people in a variety of professions, communities and settings.

The People in UK Public Health group has been instrumental in this project, providing advice and review in the context of strategic oversight for future direction of the public health workforce.

2.2.2 Five Year Forward View

The *Five Year Forward View* for NHS England was published in October 2014 (NHS England, 2014). The report, which calls for a 'radical upgrade in prevention and public health', sets out the changes needed in the health service. It calls for a more engaged relationship with patients, carers, and citizens to allow for the promotion of wellbeing and prevention of ill-health. It also shows that public health prevention and promotion is a key priority for the NHS and partner organisations including NHS England, HEE, the Care Quality and Commission (CQC) and PHE.

Recommendations made in the report recognised the need to engage with communities and citizens, involving them directly in decisions about the future of health and care services. It introduced new care models which include multi-specialty community providers, primary and acute care systems, urgent and emergency care networks, and specialised care (NHS England, 2014). The scale of the system change needed offers a challenge to the public health system and represents an opportunity and impetus to increase collaboration with the wider workforce.

2.2.3 The NHS Mandate 2014–15

The NHS Mandate (NHS, 2012) published in November 2012, sets the objectives for NHS England, for the period April 2013 to March 2015. It stated that the Government had created the health and social care Integration Transformation Fund and made £3.8 billion available to support health and care services to work more closely together.

This directive challenged NHS England to focus on '…preventing illness with staff using every contact they have as an opportunity to help people stay in good health'. NHS England is fulfilling the mandate by implementing the National Institute for Health and Care Excellence (NICE) behaviour change guidance and has developed a Project Initiation Document (PID) (LGPS, 2014) to influence and support commissioning. This is also reflected in the Department of Health strategy *Living Well for Longer* (DH, 2014). The PHE priorities document, *From evidence into action: opportunities to protect and improve the nation's health*, expands on the Mandate and

sets out how to make greater progress on obesity, smoking, alcohol, assuring a better start in life, reducing dementia risk and robustly tackling TB and antimicrobial resistance.

2.2.4 *Fair Society Healthy Lives*: The Marmot review

On 11 February 2010, the report *Fair Society Healthy Lives*, also known as The Marmot Review, was published (Marmot et al., 2010). The Marmot Review looks at the differences in health and well-being between social groups and describes how the social gradient of health inequalities is reflected in the social gradient of educational attainment, employment, income, quality of one's neighbourhood and so on. In addressing health inequalities, the Review asserts that it is not sufficient just to focus on the bottom 10 per cent because there are poorer outcomes all the way down from the top.

The Marmot vision is towards a goal of environmental sustainability. Creating a sustainable future is compatible with action to reduce health inequalities though promoting sustainable local communities, active transport, sustainable food production, and zero carbon houses, all of which have health benefits.

The report concluded that reducing health inequalities would require action on six policy objectives:

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill-health prevention.

Key to this approach is to create the conditions for people to take control of their own lives. This places renewed emphasis on the role of local government who along with national government departments, the voluntary and private sector have a key role to play.

2.2.5 Making Every Contact Count

Making Every Contact Count (MECC) is a strategy to extend the delivery of public health advice and interventions by non-specialist staff from a broad range of organisations and settings within and beyond the NHS (Nelson et al., 2013). MECC encompasses a number of programmes across the country designed to encourage and help people to make healthier choices to achieve positive behaviour change. The implementation model helps organisations to build a culture which encourages and promotes prevention and health improvement by offering staff an environment that facilitates the skills and knowledge required to deliver MECC (NHS York and the Humber, 2014). There are three core components to the implementation of MECC:

- organisational readiness
- staff readiness and enabling
- empowering the public.

Each component provides a platform for the wider workforce to begin to think about implementation in their communities, enabling leaders in public health to commence the process of creating a wider workforce competency framework.

The Local Government Association (LGA) has promoted MECC as a vehicle for health information and improvement, and many local authorities are already fostering and commissioning MECC programmes (LGA, 2014). HEE's local education and training boards (LETBs) have helped to embed MECC in health worker core training, and into continuous professional development (CPD) and other training and development.

2.2.6 Healthy Conversations

The *Healthy Conversations* programme was launched in 2013 by the Foyer Federation (2013). The programme has created 20 Healthy Conversation Hubs and is aimed at young people to provide them with the understanding, opportunities and networks to improve the health and wellbeing of themselves, their peers and their communities. Working with organisations such as Youth at Risk and the Mental Health Foundation, the programme enables young people and their mentors to create healthy action plans; as well as hosting health taster days and healthy conversation group discussions. The programme widens networking for young peoples and gives them a 'Health Footprint' that connects them to more health-related services (Foyer Federation, 2013). The programme will impact those members of the wider workforce who work closely with youth organisations and in community settings.

2.2.7 The Public Health Outcomes Framework for England 2013-2016

The *Public Health Outcomes Framework for England 2013-16* (DH, 2012a) was produced by the DH in 2012 and is part of a series of policy updates as promised by the Government in *Healthy Lives, Healthy People: Update and the way forward* (DH, 2011). The framework is published in three parts:

- Part 1 introduces the vision of public health, outcomes to be achieved and indicators that help understand how well improvements and protection on health are being made.
- Part 2 specifies all the technical details currently supplied for each public health indicator and shows where further work is required to fully specify all indicators.
- Part 3 consists of the impact assessment and equalities impact assessment (DH, 2012a).

Part 1 of the framework focuses on two health outcomes: increased healthy life expectancy; and reduced differences in life expectancy and healthy life expectancy between communities. The indicators will make a direct impact on the delivery of the public health agenda and requirements of the wider workforce.

2.2.8 Review of PHSKF and the Public Health Skills Passport

The UK *Public Health Skills Knowledge Framework* (Skills for Health, 2008; PHORCaST, 2013) sets out a common standard of skills and knowledge needed by people working in the public health workforce (Public Health Online Resource for Careers, Skills and Training [PHORCaST]). The framework helps people working in public health to identify the skills and knowledge they have, what they need and where the gaps are. It enables employees to plan their career development pathway. The framework is structured into nine areas of work, with four core areas and five non-core areas and has nine levels of competence and knowledge within each of the nine areas.

The PHSKF is currently undergoing review to ensure that it remains relevant to the current and future public health workforce. Stakeholders hope the review will make the framework more accessible for the wider workforce, to help people identify their skills and track their development.

In parallel with the review of the PHSKF, the *Public Health Skills Passport* was piloted with agreed groups within the public health workforce in England between February and April 2015. The passport provided an online portal where individuals could record and track their career development (PHE, 2014). The skills

passport is mapped against the PHSKF and is called a 'passport' because the account information is transferable between employers and registration bodies. The tool helps workers to develop their careers, keep a record of their experience and demonstrate their expertise (PHE, 2014).

The PHSKF and the skills passport have been the subject of UK-wide consultation. Proposals for a revised skills framework are due later in 2015.

2.2.9 From evidence into action: opportunities to protect and improve the nation's health

In October 2014, PHE published *From evidence into action: opportunities to protect and improve the nation's health* (PHE, 2014a) calling on the public health system to 'think big', and inviting the health sector, local and national governments, the voluntary and community sectors and the wider public to engage in public health. This PHE report acknowledges that health is shaped by where and how we live: our homes, jobs, families and lifestyles, and advocates for a place based approach to public health lead by local authorities, but supported by national institutions.

This report sets out seven priorities for the next five years and a commitment to a programme of work that:

- ensures evidence-based advice is available on the key issues relating to the public's health
- develops the workforce's ability to engage and support the public in making healthier choices, and
- mobilises support for broader action on improving the public's health.

2.2.10The 'What Works Centre for Wellbeing'

This is the latest addition to the 'What Works Network', which was launched by the Government last year to improve public services through evidence-based policy and practice. In Spring 2015, the centre started commissioning universities to research the impact that different interventions and services have on wellbeing. The initial focus of research will be on what works for wellbeing in relation to work and learning, communities, cultural and sporting activities. Results will help government, councils, health and wellbeing boards, charities and businesses make decisions on what really matters for the wellbeing of people, communities and the nation as a whole. It has initial funding of more than £3.5 million over three years, funded by the Economic and Social Research Council, PHE and other partners, including government departments.

2.2.11Asset Based Community Development

Asset Based Community Development (ABCD) is an approach based on the principle of identifying and mobilising community assets rather than focusing on problems and needs in the community. Community health assets can be described as 'any factor or resource which enhances the ability of individuals, communities and populations to maintain and sustain health and well-being. These assets can operate at the level of the individual, family or community as protective and promoting factors to buffer against life's stresses' (Foot and Hopkins, 2010). The ABCD approach enables communities to build on what assets they have, to attain what they need and to make improvements to their community, resulting in improved health and wellbeing to individuals and at a community level.

2.2.12 Working in local communities

Communities are recognised as the key to achieving good public health. A community, characterised by a range of local organisations, community groups and social networks, provides a foundation upon which individuals are supported to make positive lifestyle choices. *A guide to community-centred approaches for health and wellbeing* (PHE and NHS England, 2015), jointly published in February 2015 by PHE and NHS

England, recognises the importance of communities in improving the health of the public and reducing avoidable illness and health inequalities. A method for scaling up these approaches amongst the wider workforce may be to extend community assets based training at the frontline, as well as for those in more senior positions across organisations.

The following legislation, mandates and strategies may influence the development of public health and the workforce that delivers it:

- The *Care Act 2014 (UK)*; Updating our care and support system
- *Delivering high quality, compassionate care: Developing the right people with the right skills and the right values, A mandate from the Government to Health Education England*: April 2013 to March 2015
- *Healthy Lives Healthy People: public health workforce strategy* – Department of Health, Public Health England, Health Education England (2011)
- Local Government – Public Health Mandate to Local Authorities (DH, 2012b)

Collectively, these initiatives show there is a clear rationale for building the capacity of the wider workforce, and a clear need to better understand the wider workforce components and potential. This is addressed in the following sections.

Case Study

Wider workforce case study: Ipswich Borough Council, in partnership with Suffolk County Council

Ipswich Borough Council and Suffolk County Council have been working in partnership with key employment and housing service providers to develop and deliver a training support package for frontline advisors. This programme provides the skills and knowledge for staff to deliver brief advice and signpost clients to relevant health or mental health services.

The driving force behind this work is a recognition of the critical importance to health and wellbeing, of securing and retaining employment and suitable housing. It recognises that employment and housing officers are ideally placed to reach those most in need, but traditionally have little engagement with health/mental health services. This work has generated huge enthusiasm and commitment within the organisations involved. So far, this has led to more integrated working between council services and a growing number of referrals.

3. Defining the wider public health workforce

There is currently no widely-agreed definition for the wider public health workforce. Without this, it is hard to have focussed discussions about workforce planning and development. We have worked with the People in UK Public Health group to create a definition of the wider workforce in England for the purpose of this report.

In this section we have set out:

- our definition for the workforce
- our approach to creating the definition
- our approaches to counting and categorising the workforce, including identifying the active workforce
- findings emerging from our analysis and stakeholder engagement.

3.1 Definition

3.1.1 Previous work to define the public health workforce

In 2001, the Department of Health published *The Report of the Chief Medical Officer's Project to Strengthen the Public Health Function* (DH, 2001) which defined three categories for the public health workforce which broadly translate to specialists, practitioners and the wider workforce. The description of the wider workforce category noted the variety of roles and sectors that contribute to health and wellbeing, as well as the contribution that can be made outside of the traditional public health workforce:

> *Most people, including managers, have a role in health improvement and reducing inequalities, although they may not have recognised this. This is true, for example, of teachers, local business leaders, social workers, transport engineers, housing officers, other local government staff, the voluntary sector, as well as of health care professionals. They need to adopt a public health "mind set", with greater appreciation of how their work can make a difference to health and wellbeing and of where more specialist support can be obtained locally*

Walters et al applied the three identified workforce groups to London in 2002, to map the city's public health workforce (Walters et al. 2002). The definition for the wider workforce required that 'work contributes to maintaining or improving the health of communities' and that 'health improvement is [not the] major objective of post'. The wider workforce included family planning doctors, salaried general practitioners, specialist nursing teams, district nurses pharmacists and pharmacy counter assistants.

In 2007, Sim et al published a paper in the Bulletin of the World Health Organization that included examples of the wider public health workforce across various sectors including politics, retail, hospitality, health care, child education, media and nongovernment organisations.

This paper noted that the specialist public health workforce is easiest to define, while the most diverse of the three categories is the wider workforce. There is perhaps a lack of clarity around the distinction between practitioners; responsible for influencing population health through front-line, operational interventions with individuals, families or local communities; and the wider workforce. Therefore it may be that some professions

may identify as public health practitioners, but be included in this report as wider workforce. It is the intention of this report to be as inclusive as possible.

3.1.2 Definition of the wider public health workforce

The definition for the wider public health workforce that we have used in this report is:

*'**Any individual who is not a specialist or practitioner in public health, but has the opportunity or ability to positively impact health and wellbeing through their (paid or unpaid) work.'***

This definition has passed through several iterations during discussions with the People in UK Public Health group, including a workshop in December 2014 and presentation/discussion in February 2015.

In creating this definition, the following factors were considered:

- We have followed a number of previous publications[2] in understanding **specialists** as people who work in public health at a strategic or senior management level or at a senior level of scientific expertise, as well as public health consultants and specialists. Specialists work at levels 8 and 9 of the PHSKF. **Practitioners** are those who spend a major part, or all of their time, in public health practice delivering public health at operational levels, and work at levels 5 to 7 of the PHSKF.
- We have assumed that public health specialists and practitioners are those that have been captured by our previous report *Mapping the Core Public Health Workforce* (CfWI, 2014). Therefore professions that were excluded from the core public health workforce report are included here, for example health trainers, midwives, GPs and AHPs.
- **Opportunity or ability** – some occupations may have the opportunity but lack the skills or confidence, others may have the relevant abilities but do not make the most of the opportunities available.
- **Health and wellbeing** – this term was preferred to 'public heath' because it was felt to be more inclusive and familiar particularly for the wider workforce, broadly encompassing the wider determinants of health.
- **Paid or unpaid** – this recognises the importance of third sector volunteers and family members and friends in providing valuable care and/or advice services.

3.2 Our approach to defining the wider workforce

Our approach to defining the wider workforce was completed in the stages detailed below:

- a definition of the core public health workforce
- a definition of the overall working population
- identification of potential members of the wider workforce, including volunteers and carers.

Figure 1 shows how these components are related:

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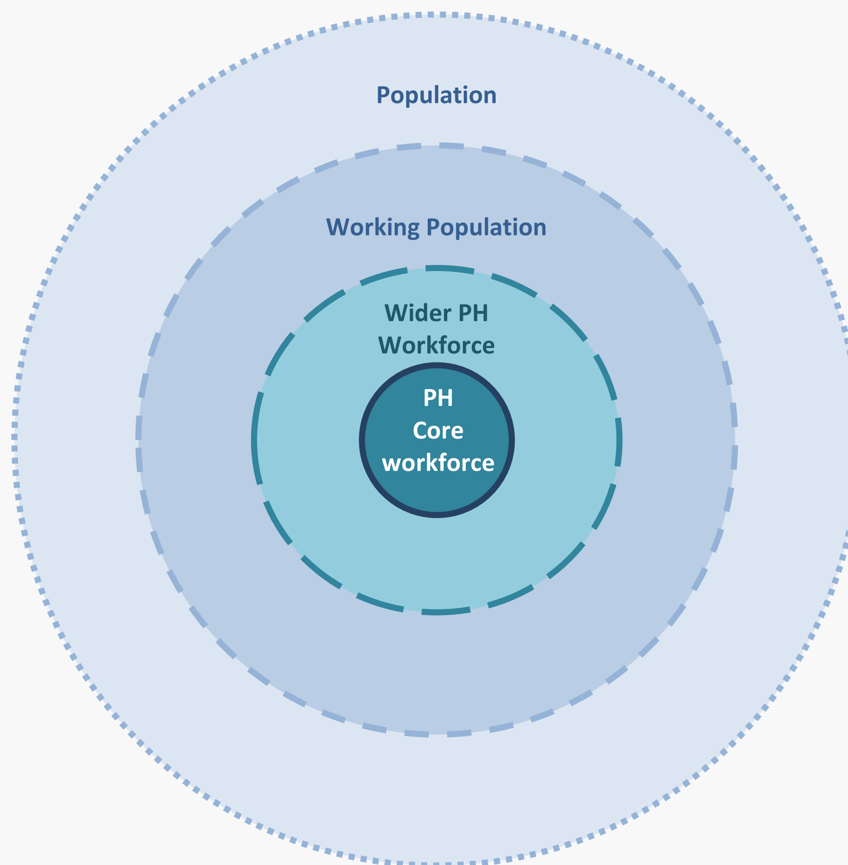
[2] Department of Health (1998), Chief Medical Officer's Project to Strengthen the Public Health Function in England: A Report of Emerging Findings (London: Stationery Office); Walters R., Sim, F., & Schiller, G. (2001), "Mapping the Public Health Workforce I: a tool for classifying the public health workforce", Public Health 116: 201-206; Skills for Health (2008), Introduction to the Public Health Skills and Career Framework (UKPHSCF), www.phorcast.org.uk/document_store/1367423598_MyBF_introduction_to_the_phskf.doc [Accessed March 2015]

Figure 1: Public health system model



Source: CfWI, 2015

3.2.1 Core public health workforce definition

The core public health workforce was defined in the CfWI report, *Mapping the core public health workforce* (CfWI, 2014), as:

'all staff engaged in public health activities who identify public health as being the primary part of their role'.

This definition has been supported by CfWI's commissioners – HEE, the DH and PHE – and has since been adopted by workforce experts: Public Health Online Resource for Careers, Skills and Training (PHORCaST), and others.

At the request of our commissioners, the definition for the core public health workforce specifically excluded:

- Staff working below level 5 of the Public Health Skills & Knowledge Framework.
- Professions with a significant role in promoting or delivering public health, such as GPs, occupational health nurses, community pharmacists, midwives and others in the wider workforce.

This is because although they fulfil important public health functions, their roles have a wider remit, and in most cases workforce numbers and roles are generally well understood. This definition of the core public health workforce also excludes public health focused roles that generally work below level 5 of the PHSKF.

Health trainers are an example of this. Any of the occupations that contribute to public health, but were excluded from the *Mapping the Core Public Health Workforce* report (CfWI, 2014), will be included here as part of the wider workforce.

The CfWI analysis gives an estimate for the core workforce of approximately 40,000 people.

3.2.2 Overall working population

The best data source identified was the Office for National Statistics' *Labour Force Survey Employment (ONS LFS) status by occupation, April - June 2014, Reference Table EMP04* (ONS, 2014b) , which publishes estimates for the total UK headcount for every profession with a Standardised Occupational Classification (SOC).

Descriptions for the SOCs are from the ONS publication *Standardised Occupational Classification 2010, Volume 1, Structure and description of unit groups* and are used within this report when referring to occupations (ONS, 2010).

ONS LFS data is presented for the entire UK. To account for this, we normalised the data to reflect workforce numbers for England alone. Normalisation of the data was performed using the following logic:

- ONS LFS data is representative of the UK's population in its entirety
- the population of the UK is 64.1 million (ONS, 2013)
- the population of England is 53.9 million (ONS, 2013)
- England represents 84 per cent of the UK's population (53.9/64.1 = 0.84 = 84 per cent)
- multiplication of each UK occupation by 0.84 – corresponding to England's population share within the UK – returns the corresponding workforce estimate for England.

It was assumed when normalisation was applied that:

- The ONS LFS is the most robust source of data available, by occupation, for the entirety of the UK workforce; it is used by the UK Government.
- All occupations are proportionately distributed across each of the four countries of the UK.
- As the ONS LFS is a representative survey of 41,000 households, weighted to represent the population distribution of the UK, it is reasonable to assume that workforces for England can be calculated by normalising the UK figures as outlined above.

This analysis gives a working population for England of 25.6 million people as shown in Table 1 below.

Table 1. Working population of England

	Self-employed Full-time	Self-employed Pat-time	Employees Full-time	Employees Part-time	Total
UK	3,230	1,329	18,942	6,764	30,537
England	2,713	1,116	15,911	5,682	**25,651**

Source: ONS, 2010

3.2.3 Unpaid care and support

It is important not to forget that there are many people who provide unpaid help and support to friends and family members because of illness, disability or old age. This group is an important part of the wider workforce, in part because they provide care and support to family and friends which would otherwise have to be picked up by state infrastructure. The ONS LFS does not provide any information about this part of the wider workforce. While the ONS LFS includes 'unpaid family workers', this is people working for no salary in a family business.

We have assumed the unpaid care and support workforce are those people identified in the UK Census (ONS, 2011) as the number of people in England providing 'unpaid help or support to family members, friends, neighbours or others because of long-term physical or mental ill-health or disability, or problems related to old age'

The UK Census gives an unpaid care and support workforce for England of 5.4 million people as shown in Table 2 below.

Table 2. Provision of unpaid care in England

All persons	Males	Females	Total
Provides 1 to 19 hours unpaid care a week	1,479,796	1,957,455	3,437,251
Provides 20 to 49 hours unpaid care a week	303,276	415,433	718,709
Provides 50 or more hours unpaid care a week	502,120	751,353	1,253,473
Total	2,285,192	3,124,241	**5,409,433**

Source: UK Census (2011)

It is not clear if these 5.4 million people are different people to the wider workforce that we have identified through the ONS LFS, although certainly they are different roles. To avoid double counting, and in recognition of the importance of unpaid care and support, we estimate our wider workforce as a range (see Section 3.3.1). At the lower end of the range, we assume that all unpaid care and support workers are also working in occupations that are captured as wider workforce in the ONS LFS data (and to avoid double counting them we do not add these 5.4 million people to the ONS LFS estimate). At the higher end of the range, we assume that none of the unpaid care and support workforce are also working in occupations captured by our analysis of the ONS LFS data. In reality it is likely to be somewhere in between.

3.3 Counting and categorising the wider workforce

3.3.1 Counting the workforce

To count the wider workforce, as defined above, we examined the ONS list of occupations, and considered for each if the occupation contributes to any of the four domains of public health (DH, 2012a):

- Health improvement
- Health protection
- Healthcare public health

- Wider determinants of public health

In line with our definition we asked: 'Does a person working in this occupation, have the opportunity or ability to impact any of the following factors as listed in Table 3 below?'

Table 3: Factors of health and wellbeing used to identify the potential public health workforce

Factors that influence health and wellbeing
Lifestyle and behaviour
Social and community networks
Agriculture and food production
Education
Working environment, autonomy, stress
Living conditions
Unemployment
Water and sanitation
Housing conditions, supporting access to secure, affordable, safe housing
Early childhood development
Climate change
Provision of parks and green spaces

Source: Adapted from Dahlgren and Whitehead (1993) and The Kings Fund (2015)

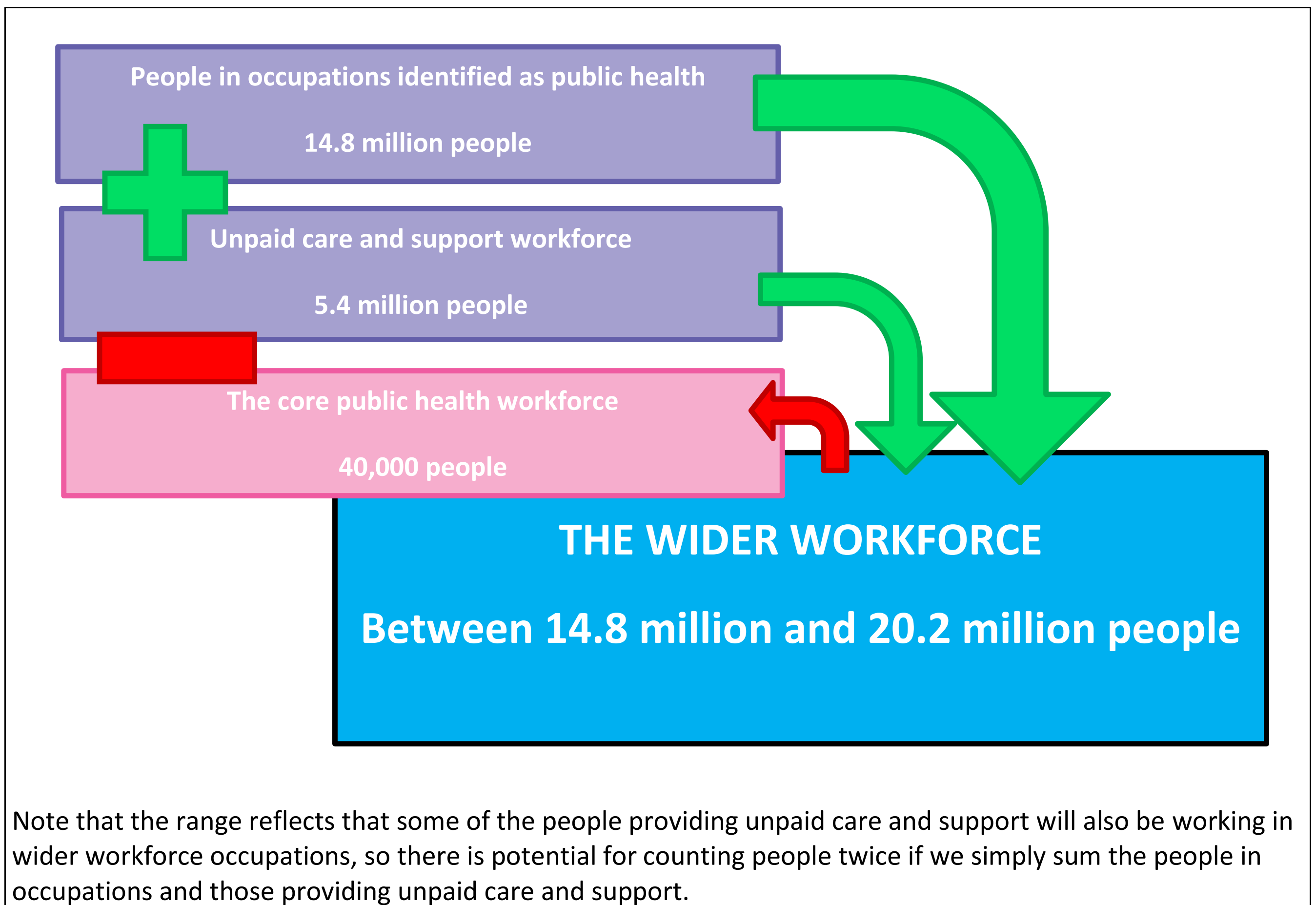
This approach yielded a large number of diverse occupations. In the first instance, CfWI analysts undertook this task. We then took these findings to the wider workforce workshops, to test our application of the definition. The workshops identified some additional occupations that have the opportunity or ability to contribute to health and wellbeing. The number of occupation groups (from the ONS), occupations, and the weighted headcount for England, is shown in Table 4 below.

Table 4: ONS Occupation lists

	Number of occupation groups	Number of occupations	Headcount (millions)
Public health	57	185	14.8
Not public health	43	184	10.7

Source: ONS LFS 2010, categorised by the CfWI/RSPH workshop

The calculation of the wider workforce is therefore:



Note that the range reflects that some of the people providing unpaid care and support will also be working in wider workforce occupations, so there is potential for counting people twice if we simply sum the people in occupations and those providing unpaid care and support.

3.3.2 Categorising the workforce

Our definition and approach has identified a substantial proportion (58-78 per cent) of the working population in England as being part of the wider workforce. Despite the varied remit of the wider determinants of health, the scale of this potential workforce was unexpected.

To better understand this workforce, we have proposed a number of ways of categorising and assessing occupations for potential for further engagement and development. Because the occupations in the wider public health workforce are so varied, we have attempted to identify the similarities between occupations. These different approaches each give quite different information, and may be adapted depending on the policy imperative. The suggested approaches to categorisation are:

- by degree of engagement in the public health agenda
- by occupational function
- is the occupation public facing, giving opportunities to have frequent and ongoing face to face contact with people in local communities?

The following sections show some of the high level findings from our initial analysis of these categorisation approaches. A full list of all the ONS occupations and our classifications is in Annex A.

Case Study

Wider workforce case study: Stoke Speaks Out

Local research in 2002 identified that 64 per cent of children in Stoke were already delayed in speech and language development by the age of 3 years and a high number of students were entering school with delayed speech and language, which in turn impacted their educational attainment, self-esteem and ultimately their life chances. These research findings led to the development of the Stoke Speaks Out programme, a multi-agency preventive approach bringing a range of expertise together to develop a shared training framework for all practitioners dealing with children.

Stoke Speaks out developed key public health messages, supports parents as champions within their communities and developed a sense that this issue is 'everybody's business'.

This is a long-running programme. By 2010, the incidence of speech, language and communication needs on entry to school had reduced by 39 per cent against the 2002 baseline. Despite subsequent reductions in funding, the numbers are still 20 per cent improved on 2002.

3.3.3 Data categorisation

The data presented is intentionally high level and general. Drawing more detailed conclusions risks spurious accuracy and hence should be treated with caution for reasons including:

- The assumptions noted above regarding the ONS LFS data set.
- The ONS LFS does not distinguish between public, private, independent and the voluntary sectors. This may be especially pertinent to health and welfare professions, but also to education.
- Data for unpaid carers and other voluntary public health activity is not included in the tables above as numbers may double count paid workers (e.g. those providing care whilst also working part- or full-time).
- The categorisation of occupations was determined by the workshop participants' experience and knowledge, and this will have informed these findings. A different group of people or further iterations based on additional data would produce a different result.
- The data does not indicate how easy it is to engage with a specific workforce e.g. via trade unions, employer groups, individual employers or individuals directly, although the number of occupations in each category is some indication of the relative complexity of the professional group.
- The data does not indicate the relative potential influence or impact of each occupation when discussing public health messages. This will vary with some having, for example:
  - greater positions of trust in society e.g. legal staff
  - more access to more individuals e.g. media workers
  - more contact time e.g. teachers with children, carers with their clients
  - contact with relatively restricted client groups (e.g. therapists) to quite random members of the public (e.g. taxi drivers or retail trades)
  - varying levels of general education and training, and ability to communicate.

Notwithstanding these caveats, we believe this analysis provides a good starting point for discussion about priority workforces and opportunities for more detailed work.

3.3.4 Approach one – identifying the degree of engagement in public health

This approach to classifying the wider workforce was undertaken by workshop participants at two events hosted by the project partners CfWI, RSPH and PHE on 24 and 25 February 2015. The purpose of this was to seek consensus on which elements of the workforce were already engaged with the public health agenda and to test whether, for example, to:

- increase investment in areas where occupation groups are already involved in public health, or
- increase support for those groups where there is interest or potential to get involved but perhaps no structure or leadership to encourage it.

The workshops were attended by a broad range of public health stakeholders, including representatives of local authorities, the Association of Directors of Public Health, national housing associations, professional bodies, fire and rescue services, sector skills councils, allied health professionals and PHE policy leads. A full list of workshop participants is in the acknowledgements of this report.

Using the SOCs (ONS, 2010), we created occupation group cards showing names of occupation groups, and the list of occupations in that group; for example:

Welfare and housing associate professionals

- youth and community workers
- child and early years officers
- housing officers
- counsellors

In this example, the *Occupation group* is: Welfare and housing association professions (Group 323 from the SOC), and the *Occupations* include youth and community workers, child and early years officers, housing officers and counsellors. For much of this report, we present data and analysis based on the individual occupations in the occupation group, however for this analysis of the engagement with the public health agenda, much of the analysis is done at the level of the occupation group instead.

Groups of participants were asked to place the occupation group cards into one of three categories[3].

- **Actively engaged** - occupations that are actively engaged/involved in the public health agenda.
- **Interested** - occupations that have low levels of engagement with the public health agenda but are open to 'doing more'.
- **Unengaged** - occupations that have the potential to positively impact health and wellbeing but are not engaged with the public health community.

[3] Note, this process was also used to identify the wider public health workforce: those occupations that have the opportunity or ability to positively impact health and wellbeing. The workshop included a fourth category 'Not public health' for occupations that fall outside the scope of this project.

In some cases, participants felt that the occupation group as a whole was not equally engaged with public health and so a number appear across multiple categories, however each *occupation* will only appear in one category. Table 5 below shows the number of occupation groups and occupations identified by the workshops by their level of engagement in public health. We have added the indicative headcount, taken from the ONS occupation data, weighted for England.

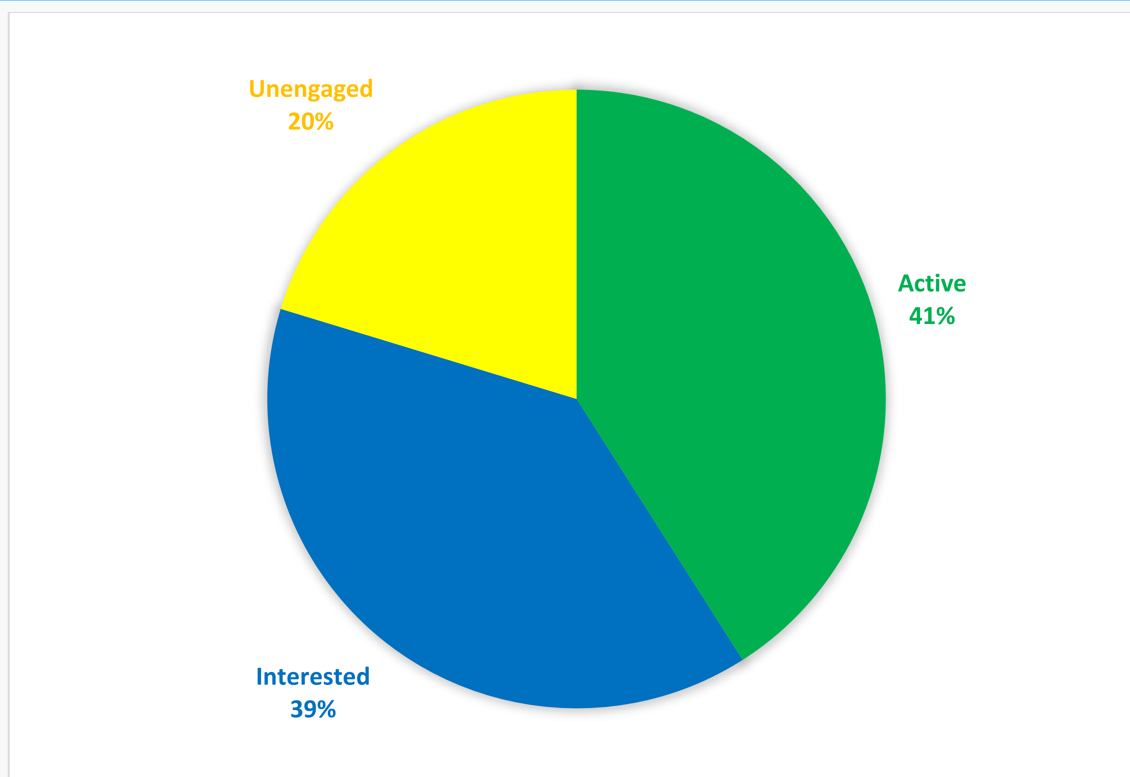
Table 5: Wider public health workforce, level of engagement public health

	No. Occupation Groups	No. Occupations	Indicative headcount '000s
Active	19	76	6,061
Interested	24	80	5,728
Unengaged	14	29	3,002

Source: ONS LFS 2010, categorised by the CfWI / RSPH / PHE workshop

Figure 2 shows the proportion of the total wider workforce. Note that this representation does not include unpaid care and support workers.

Figure 2: Proportion of the wider public health workforce, by level of engagement



Source: CfWI, RSPH, PHE 2015

There was general consensus across both workshops on the categories of most occupational groupings. However, the analysis that follows does need to be treated with some caution due to the following:

- When the outcomes of the workshops differed, the rating for each occupation group was rounded 'up' to the highest level of engagement.
- Within specific occupations there will be a wide range of degrees of participation in public health, reflecting specific individuals, job roles and employers.
- The workshop exercise was necessarily highly generalised – on closer inspection it may be appropriate to move some occupations between categories.
- All employers have responsibility for the wellbeing of their employees, and could be a powerful channel for public health messages. For this reason no occupation is strictly considered 'not public health'.
- The categorisation of occupations was determined by the workshop participants' experience and knowledge, and this will have informed these findings.
- Although the terminology used in this report has been shared with some stakeholders, it may not be reflective of language used in other workforces such as medical specialties or those delivering social care.

Despite this caution however, we believe the occupation analysis to be sufficiently accurate to form the basis for debate and to move the discussion on to identify which occupations can be most effectively mobilised to improve the nation's health, and look at suggestions to identify how to do this.

Active

The workshop participants allocated occupation groups to the **Active** category if:

- It was thought that public health was explicitly part of their job e.g. health workers
- Participants could provide solid examples of those occupations knowingly delivering public health activities, or
- The occupation group was believed to be receiving MECC training.

The routes to active engagement in public health were varied and ranged from strategic leadership from professional organisations, to championing by a few key individuals or regional services. These occupations have, for example, already extended their remit to work alongside other services that currently link into the public health agenda. They do this through schemes such as offering incentives to their employees to highlight how their role could help others and can gain recognition for it. They may also already have an indirect impact on public health outcomes through delivering health and wellbeing messages, or already have the public health agenda in the forefront of their future plans.

The occupation groups identified as actively involved in public health are listed in Table 6, as well as the indicative headcount for England from the ONS LFS. As may be expected, this list includes a large number of those in caring and public service occupations, including teaching, healthcare and government.

Table 6: Main heading occupations listed in the active category

Category	Main occupation group	Headcount (000s)	Total (000s)
Active	Teaching and educational professionals	1289	6,061
	Caring personal services	1087	
	Childcare and related personal services	696	
	Nursing and midwifery professionals	530	
	Health professionals	443	
	Food preparation and hospitality trades	391	
	Administrative occupations: government and related organisations	347	
	Protective service occupations	292	
	Welfare and housing associate professionals	243	
	Welfare professionals	158	
	Sports and fitness occupations	133	
	Health associate professionals	127	
	Therapy professionals	124	
	Managers and proprietors in health and care services	64	
	Architects, town planners and surveyors	64	
	Health and social services managers and directors	44	
	Senior officers in protective services	23	
	Conservation and environmental associate professionals	7	

Source: ONS LFS categorised by the CfWI / RSPH / PHE workshop

The following summarises some of the workshop discussion about specific occupation groups included in this category:

- **Teaching professions** (including schools, further education and higher education) – workshop participants acknowledged many people in teaching professions were actively engaged in promoting health and wellbeing to their students throughout a child's educational life, by providing health-related messages as well as pastoral care and general guidance. This workforce may also have the opportunity to influence peers and family around the child; and the school or college environment has significant potential for influencing wider community behaviours.

- **Caring professions, medical staff** (especially in primary care settings) and **allied health professionals** – people in caring, medical and health professions are seen as actively engaged due to the nature of their role in taking care of others. The 12 allied health professions, have signed up to a collective ambition to be recognised as an integral part of the public health workforce.
- **Protective service occupations** (such as fire and rescue services) – there were many examples of public health being delivered by protective service occupations. For example, in parts of the country, the fire service have extended their remit and are now providing services such as community risk intervention teams (CRIT) and integrated network teams (INT), working alongside ambulance and GP services.
- **Sports and fitness occupations** – these occupations are viewed as actively engaged as their roles fall naturally into the public health remit of healthy lifestyle and behaviours.
- **Housing officers** – the workshops demonstrated that there is a lot of commitment to health and wellbeing in this workforce. Active involvement includes training staff to talk to individuals that come through the system, encouraging people to think about their lifestyle behaviours and needs. These health-related conversations encourage informed choices about managing health and wellbeing including self-care.
- **Food preparation and hospitality trades** – these people are able to influence the public's eating habits e.g. by promoting healthy food options.

Interested

The workshop participants allocated occupation groups to the **Interested** category if:

- participants could provide only limited examples of those occupations delivering public health activities
- participants knew of initial discussions or pilot projects involving some of the occupations within a specific occupation group
- participants believed the occupations already provided some public health services (e.g. basic information) and could easily do more (e.g. proactive health promotion).

The occupation groups identified as interested in public health are listed in Table 7, as well as the indicative headcount for England from the ONS LFS. In contrast to the active category, this list includes a diverse range of occupation groups which it is far harder to meaningfully group together. Also, most occupation groups are now more commonly found in the private sector rather than the public sector.

Table 7: Main heading occupations listed in the interested category

Category	Main occupation group	Headcount (000s)	Total (000s)
Interested	Other elementary services occupations	803	5,728
	Elementary cleaning occupations	639	
	Secretarial and related occupations	566	
	Managers and proprietors in other services	515	
	Public services and other associate professionals	452	
	Production managers and directors	385	

Category	Main occupation group	Headcount (000s)	Total (000s)
	Agricultural and related trades	326	
	Artistic, literary and media occupations	321	
	Road transport drivers	286	
	Managers and proprietors in hospitality and leisure services	234	
	Hairdressers and related services	222	
	Architects, town planners and surveyors	127	
	Leisure and travel services	121	
	Functional managers and directors	104	
	Elementary security occupations	92	
	Quality and regulatory professionals	86	
	Housekeeping and related services	86	
	Animal care and control services	73	
	Chief executives and senior officials	63	
	Cleaning and housekeeping managers and supervisors	54	
	Media professionals	51	
	Draughtspersons and related architectural technicians	49	
	Librarians and related professionals	30	
	Administrative occupations: records	22	
	Sales related occupations	20	

Source: ONS LFS categorised by the CfWI / RSPH / PHE workshop

The following summarises some of the workshop discussion about specific occupation groups included in this category:

- **Elementary service occupations** – this group includes bar staff, kitchen assistants and waiting staff. Workshop participants believed these staff could directly influence healthy eating/drinking choices through routine interaction with the public or targeted events (e.g. a bar holding men-only evenings to target male health issues).
- **Cleaning occupations** – workshop participants identified that cleaners were often working in a trusted position, as they were allowed into people's homes and places of work. The intimacy and trust required – particularly in the home – meant the attendees felt this type of relationship gave a good opportunity for

people in cleaning to promote public health through health-themed conversations. There may also be scope for these occupations to undertake risk assessments and help connect people with health and social services if required.
- **Managerial occupations** – these occupation groups encompass a wide range of managerial and proprietorial roles, all with significant opportunity for influencing their staff/employees through promoting healthy lifestyles at work. Often, there is a role for **secretarial and reception staff** to support these initiatives.
- **Hairdressers and related personal service occupations** – these occupations are found in all communities and, in some, are often seen as the central hub. Repeated interactions with the same people builds trust and provides many opportunities to have conversations about health issues.
- **Architects, town planners and surveyors** – the occupations identified by the attendees as active, include architects and town planning officers because they contribute to creating green spaces and public access. The occupations in the interested category group include chartered and quantity surveyors, and construction project managers who have a less direct role in public health.
- **Librarians and related occupations** – these occupations have repeated interactions with people in their local communities, often when people are seeking information. This may provide many opportunities to have healthy conversations or signposting to appropriate services.

The occupations in this category are recognised to have the potential to work in a collaborative way with other services and organisations around them to help deliver the public health agenda. The challenges are for these occupations to understand how they can contribute and recognise the public health impact that their actions can have. More importantly there is a challenge in ensuring they possess the appropriate skills to have the conversations in the first instance. Using examples from the active category, this group could be influenced to work in a more collaborative way, encouraged to include the public health agenda in their future strategies, and be given the confidence and/or ability to think creatively about promoting public health outcomes through their role.

Unengaged

The occupation groups that the workshop participants identified as being unengaged are those that have not yet made the links with public health. These are generally occupation groups that either:

- influence health and wellbeing without realising it, or
- may have the potential to influence health and wellbeing, but the workshop was not aware of any significant examples of the occupations doing so.

Workshop participants felt that some of these occupation groups might be a challenge for the public health community to engage because of the demands of their own service delivery. The occupation groups identified as unengaged in public health are listed in Table 8, as well as the indicative headcount for England from the ONS LFS. This list includes a large number of service occupations where the workshop recognised the potential for healthy conversations and connections with local communities, notably retail sales. There are also a number of technical occupations with potential environmental impacts.

Table 8: Main heading occupations listed in the unengaged category

Category	Main occupation group	Headcount (000s)	Total (000s)
Unengaged	Sales Assistants and Retail Cashiers	1,169	3,002
	Electrical and Electronic Trades	365	
	Customer Service Occupations	288	
	Engineering Professionals	184	
	Elementary Administration Occupations	181	
	Legal Professionals	161	
	Vehicle Trades	157	
	Natural and Social Science Professionals	131	
	Administrative Occupations: Office Managers and Supervisors	129	
	Customer Service Managers and Supervisors	110	
	Managers and Directors in Transport and Logistics	58	
	Conservation and Environment Professionals	38	
	Science, Engineering and Production Technicians	15	
	Assemblers and Routine Operatives	15	

Source: ONS LFS categorised by the CfWI / RSPH / PHE workshop

The following summarises some of the workshop discussion about specific occupation groups included in this category:

- **Sales assistants and retail cashiers, customer service occupations** and **customer service managers.** These occupations include call centre staff, retail cashiers and check out operators (and their managers). The roles have high numbers of interactions with the public, and sometimes repeated interactions where there may be potential for healthy conversations to influence lifestyle and behaviours. It was felt by the workshop participants that this may potentially be a challenging group to engage, but due to the size and reach of these occupations there may be great potential in these occupations to positively influence health and wellbeing.
- **Legal professionals.** The participants were particularly interested in the potential for people working in legal professions to assist clients, for example, with a mental illness and connect them to appropriate services. They are likely to have potential to impact health and wellbeing but it was felt that it was unlikely that most were aware of it.
- **Vehicle technicians and mechanics.** One participant described how a mechanic who was a prostate cancer survivor offered discounts to customers who could prove they had taken the appropriate test – a

powerful example of how one person's enthusiasm can be used to contact relatively hard to reach groups (middle-aged men) with a clear public health message.

- **Managers in transport and distribution.** People in these roles plan and coordinate freight and transport operations, manage road haulage and organise storage and distribution. They have relatively low levels of interaction with public heath, however the way in which they work may make an important contribution to health and wellbeing.
- **Natural and social science professionals** and **conservation and environment professionals.** Professionals in conservation and environment are concerned with qualitative research, physics, astronomy and earth sciences. While their work may influence public health, the workshop felt that it was likely that the focus of people in these professions was not on public health outcomes.

Many of the occupations in this category can exploit everyday contacts with the public. The challenges are in encouraging them to connect with health and wellbeing, to understand who they have contact with, and how their individual contact can make an impact.

Case Study

Wider workforce case study: health education in local pharmacies

Recognising the considerable potential of pharmacy staff to encourage healthier lifestyles throughout the population, the Thames Valley Local Pharmacy Committee Network introduced the Making Every Pharmacy Contact Count initiative. This project provides staff with the skills to deliver brief health and wellbeing advice and signposting to relevant services.

As part of this project, a wide range of training was offered to pharmacy staff, including training to develop pharmacy leaders, the training of health champions, dementia awareness training and the training of staff to identify unpaid carers. This training was widely attended, with 304 pharmacists attending the leadership training/consultation skills or medicines optimisation training; 238 team members attending the health champion training; 253 attending dementia awareness training; and 194 attending carer support training.

3.3.5 Approach two – employment groups

Our second approach to grouping occupations involved the sub-division of the ONS LFS data into 13 employment categories. Necessarily, the grouping of occupations is relatively crude and there will be significant variation of roles within such broad employment categories. The groupings proposed are intended to identify the major employment sectors or professional roles in the wider workforce, in order to draw out the primary characteristics of each group, in terms of how they may support delivery of public health outcomes as specified in the four domains of the Department of Health's 2013 *Public Health Outcomes Framework (PHOF)* (DH, 2012a). The proposed groups are:

- **Administration and management –** these are occupations which provide leadership in political and professional life, and have the capacity to influence healthy behaviour and influence planning decisions.

Professions in this category include chief executives, elected officials, and staff in the civil service and local government.

- **Arts and media** – these are professions which provide leadership in cultural and intellectual life, and therefore have the capacity to influence and promote healthy behaviour (for example, through reducing social isolation or improving mental or physical wellbeing). Professions in this category include people working in journalism and in the arts.
- **Education –** these are professions that have a primary focus on teaching and learning, including the management of educational establishments and nursery staff. With respect to the PHOF these contribute primarily to improving education outcomes, and therefore some indicators related to health improvement and the wider determinants of health (for example, through increasing school readiness and reducing pupil absence and the number of 16 to 18-year-olds not in education or training).
- **Environment** – these are occupations that directly interact with the environment, primarily through contributing to the wider determinants of health. Examples of occupations in this group are town planners, architects, sanitation workers, housekeepers and pest control officers. Examples of wider determinants of public health, to which they contribute directly, include reducing noise population, homelessness and social isolation and increasing the amount of green space provided locally.
- **Health** – this includes all medical and dental staff, nursing and midwifery staff, allied health professionals and other direct support staff. These staff provide a wide range of health services in hospital, primary care and community settings, and support work in all four domains of the PHOF.
- **Hospitality** – these include staff working in hotels, restaurants and tourist resorts. These play central roles within communities through improving health and wellbeing, and at the very least are present within a majority of communities. They therefore contribute to a variety of outcomes in health improvement (for example, diet, healthy weight and smoking prevalence) and in improving the wider determinants of public health (for example, reducing social isolation and improving community safety).
- **Protection services** – this includes the police, fire and prison service workforces. With respect to the PHOF, these may work in either health protection (for example, in responding to health protection incidents and emergencies) or in improving outcomes related to the wider determinants of public health (for example, through working in youth justice, community safety, and crime and reoffending rates).
- **Retail and trade** – these are occupations in trading and retail which contribute to community life and therefore the wider determinants of health. As with hospitality occupations, they often play central roles within communities or, at the very least, are expected to be present within the majority of communities. These include professions such as hairdressers, bakers, and retail workers. They therefore contribute to a variety of outcomes related to both health improvement (for example, diet and healthy weight) and especially the wider determinants of public health (for example, reducing social isolation and improving community safety).
- **Science and engineering** – these include physical, chemical and biological scientists, and engineers. These have the potential to shape public health outcomes through reducing premature mortality (for example, through scientific research), through helping protect the public's health in case of major incidents and emergencies, or through improving wider determinants of health (for example, through design of buildings).
- **Sports and fitness** – these are occupations which directly contribute to health improvement through encouraging people to live their lives more healthily through greater physical activity and better awareness of healthy lifestyles. These include sports coaches, fitness instructors and leisure centre employees. These therefore contribute primarily to outcomes related to health improvement (for example, diet, healthy weight, physical activity), but also contribute to reducing premature mortality and to improving the wider determinants of health (for example, through reducing social isolation).
- **Transport** – these are occupations in the transport sector which contribute to community life and therefore the wider determinants of health. As with retail and trading occupations, these play central roles within communities and are expected to be present within the majority of communities. These

include professions such as bus and coach drivers, as well as staff working in rail and airline companies. These contribute to outcomes related to the wider determinants of public health (for example, through reducing noise pollution and social isolation, and improving community safety).

- **Welfare** – this grouping refers to all occupations that contribute to non-physiological or non-psychological wellbeing of the population. Examples of occupations that fall into this category are housing officers, social workers and other care professions, and youth and community workers. With respect to the PHOF these staff will work predominantly in health improvement, in preventing premature mortality, and in improving indicators related to the wider determinants of health (for example, sickness absence rates, social isolation, homelessness, domestic abuse and mental illness).
- **Other professions** – these are occupations that do not comfortably fit in the categories outlined above. These include legal professions, postal workers and human resources staff.

A table showing the occupation codes and the number of people included in each employment group is included in Annex A.

Table 9 below shows the number of occupation groups and occupations that we allocated to each of the employment categories. We have added the indicative headcount, taken from the ONS occupation data, weighted for England.

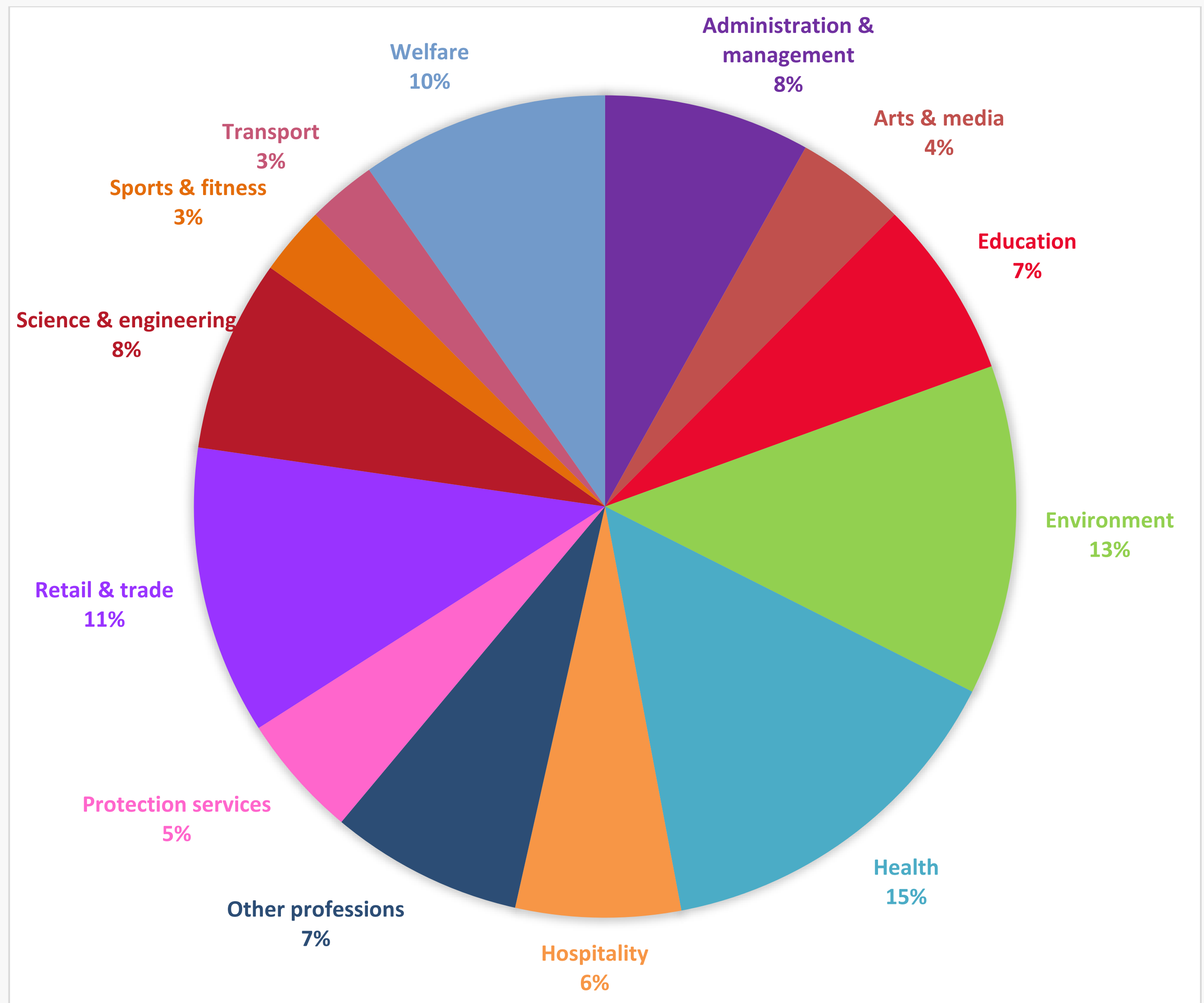
Table 9: Wider public health workforce, level of engagement public health

Employment Group	No. of Occupation Groups	No. of Occupations	Indicative Headcount '000s
Administration and management	8	15	1,547
Arts and media	2	8	372
Education	5	13	1,957
Environment	9	24	1,269
Health	10	27	1,813
Hospitality	5	12	1,405
Protection services	3	9	325
Retail and trade	12	21	2,452
Science and engineering	5	14	782
Sports and fitness	3	5	225
Transport	2	5	331
Welfare	8	18	1,577
Other professions	8	14	737
Total	**80**	**185**	**14,791**

Source: ONS LFS categorised by the CfWI / RSPH / PHE

The pie chart in Figure 3 shows the proportion of the wider workforce (by headcount) in each of the employment groups. Note that this representation does not include unpaid care and support workers.

Figure 3: Proportion of the wider public health workforce, by employment group



Source: CfWI / RSPH / PHE, 2015

3.3.6 Approach three – public interactions

Our third approach to grouping occupations involved identifying those occupations that had regular interactions with the public, and/or those, which were likely to develop trusted relationships through repeated interactions with people. This classification system is based on a large number of assumptions and we do not expect that it would hold true for every person in each occupation. However, we believe it may provide a useful way to identify opportunities to upskill people in the wider workforce for programmes such as MECC or healthy conversations.

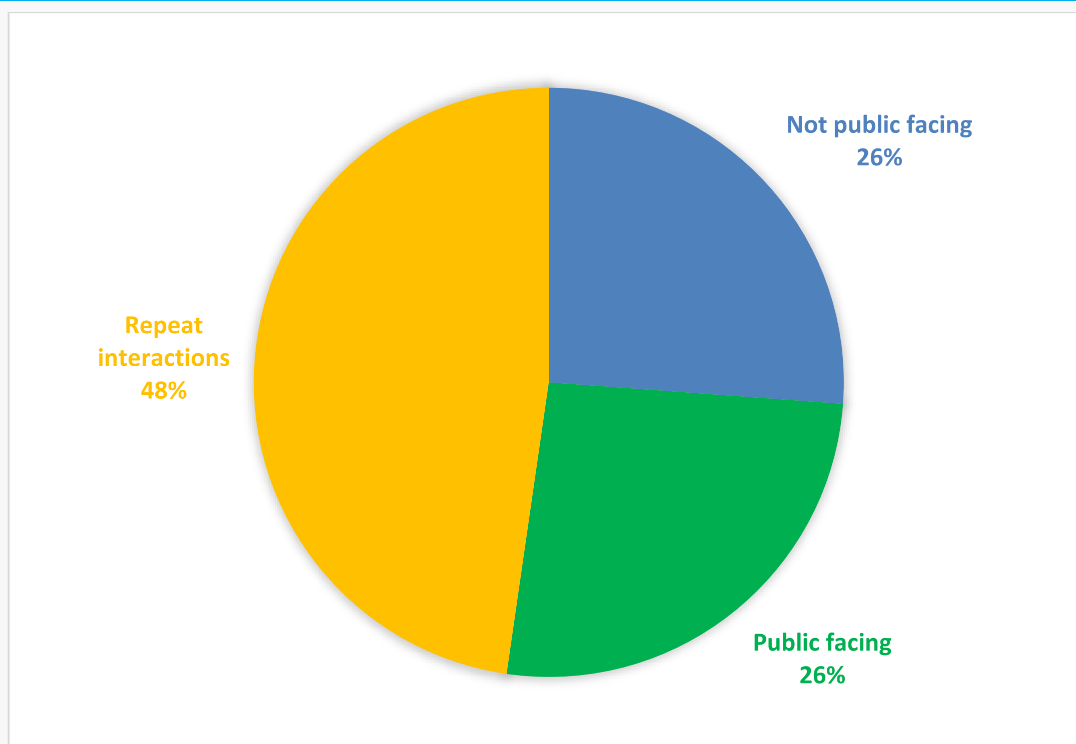
In classifying the workforce for opportunities for public interactions, we have considered the following:

- Through the course of their work, do typical people in this occupation regularly come into face-to-face contact with members of the public?
- Do these occupations have repeat interactions, for example by building up a list of regular clients (e.g. health professionals or hairdressers)? Are those contacts at random (e.g. a cab driver)?

By these questions, we mean do these occupations have contact with people on a personal level rather than professional. Accountants for instance would not have public interactions as even though they may talk to many people through the course of their work, those interactions are likely to be with other people also in their professional capacity.

Figure 4 shows the proportion of the wider workforce that we have assessed as possibly having the opportunity to participate in programmes such as MECC, as they have contact with members of the public through their work, some through repeated interactions with the opportunity to build trusted relationships.

Figure 4: Proportion of the wider public health workforce, by type of public interatctions



Source: CfWI / RSPH / PHE, 2015

3.4 Findings

3.4.1 Summary of findings

Our findings suggest the wider workforce consists of potentially 14.8 million people – or up to 20.2 million people if providers of unpaid care and support are included. It is worth noting that our wider workforce

definition and initial estimate excludes the core public health workforce, such as school nurse, health visitors, public health scientists and people working in environmental health (CfWI, 2014).

The unpaid care and support workforce typically provide care to members of immediate family and friends, often outside of institutional settings. Volunteers and third sector workers are usually associated with an organisation or charity to provide care typically to those outside of their immediate family. ONS LFS data only includes paid third sector workers. The estimates for unpaid care and support workforces come from the UK Census 2011. These data limitations mean that this group does not have the granularity of data required to separate this group into employment groups below. Table 10 shows each engagement category identified by our workshop participants, by the workforce group identified in approach two of our categorisation. The final column shows each group as a percentage of the total wider workforce.

Table 10: Proportion of the wider public health workforce by employment group and level of engagement

Employment Group	Active	Interested	Unengaged	Proportion of total workforce
Administration and management	6%	17%	7%	10%
Arts and media	0%	7%	0%	3%
Education	28%	5%	0%	13%
Environment	1%	20%	1%	9%
Health	28%	1%	2%	12%
Hospitality	5%	18%	0%	9%
Protection services	5%	0%	0%	2%
Retail and trade	1%	12%	56%	17%
Science and engineering	0%	2%	23%	5%
Sports and fitness	2%	2%	0%	2%
Transport	0%	6%	0%	2%
Welfare	23%	3%	0%	11%
Other professions	0%	7%	10%	5%
Column total	**100%**	**100%**	**100%**	**100%**

Source: CfWI / RSPH / PHE analysis of ONS LFS 2010

These tables show that the largest professional groups within each engagement category are:

- 'Active' – education (28 per cent), health (28 per cent) and welfare (23 per cent), comprising nearly 80 per cent of the total.
- 'Interested' – environment (20 per cent), hospitality (18 per cent) and administration and management (18 per cent), comprising over 50 per cent of the total.

- ‘Unengaged’ – retail and trade (56 per cent) and science and engineering (23 per cent), again comprising nearly 80 per cent of the total.
- Many of the occupations identified as part of the wider workforce are those that have direct and regular contact with members of the public. Our initial estimation indicates that almost half (48 per cent) of the wider workforce may have the opportunity to build trusted relationships through repeated interactions with the public. This could either be through an established client list (e.g. hairdressers, midwives, teaching assistants), or close links to a local community (e.g. elected officials, librarians, police officers).

Case Study

Wider workforce case study: emergency services

The emergency services have been hugely proactive in introducing a new public health focus to their work, demonstrating their potential to tackle the wider determinants of health, offer brief health advice and relieve the workload of other services.

The Greater Manchester Fire and Rescue Service (GMFRS) has introduced a wide range of programmes; one example is the Fire and Falls Prevention Service. Through more integrated working, fire crews and falls teams have been able to identify those at risk of falls and/or fire and refer them to the appropriate services. This work has yielded impressive results with increased referral rates; between September 2014 and January 2015, GMFRS delivered 602 home safety checks, 37 per cent of which were identified of at risk of falls and 52 per cent of these had their details passed to the falls prevention service.

The West Midlands Fire Service has also had success with their Aurora youth development programme, a 10 to 12 month programme aimed at those aged between 12 to 17 years, who are already young offenders, at risk of becoming a young offender or not in education, employment or training. Of those who completed the course, four attended full time sixth form, four attended mainstream school and all students ceased offending by the end of the programme.

Royal Berkshire Fire and Rescue Service has introduced a Making Every Contact Count pilot, with fire fighters trained to deliver the ‘3 As’ – Ask, Advise, Assist. So far, there has been an increase in the knowledge of fire fighters and an increase in their confidence to deliver these interventions.

3.4.2 Further analysis

Further analysis to improve the quality of this data could focus on:

- Targeted workshops for specific (priority) employment groups to break down the workforce into smaller components and understand more fully who is engaged and in what ways. For example, within education, to quantify which settings are most active (e.g. primary, secondary), or the impact of specialist teaching (e.g. PHSE)

- Repeating the stakeholder workshops with a wider participation (e.g. invited specialists) to reduce the risk of attendee assumptions being wrong and to deliver a more detailed set of results
- For those participants not attending workshops, a series of targeted phone calls or interviews could be conducted
- Identifying detailed data sources for priority workforces (e.g. professional associations or trade unions, major employers such as the NHS or local government) would benefit to some extent
- Further investigation into other sources of workforce data for unpaid care and voluntary sectors that may give a more accurate estimate of the size of this workforce.

4. Case studies: the wider public health workforce in action

This section contains:

- A summary of the approach taken to the collection and analysis of case studies
- A list of the main themes or areas of focus for the case studies, and key lessons emerging.

This section sheds light on the work of the wider workforce and complements the variety of programmes flourishing across different communities at a local level.

It is not possible to describe each project in detail in this report, but we have presented a representative sample across this report and a full list of all case studies received through our call for evidence can be found in Annex B.

The context and details vary, but there is much to learn from each example about how people have found common ground and overcome challenges to build effective models of joint working; and about the powerful role that wider workforce teams can play in integrated services. Each of the examples describes a particular programme or close partnership between a local authority and local public health or health care team, or a wider workforce organisation. The examples come from different parts of the country, they are aimed at different sections of the population (e.g. children, working-age adults, older adults) and they reflect different local priorities that have been mapped to public health, NHS outcomes and the Marmot Review, which addresses health inequalities, and how to eliminate them.

4.1 Approach

The project partners issued a national 'call for evidence' in January 2015. This was distributed geographically, as a formal, online, data gathering tool to a representative sample of wider workforce professions across England. The purpose for the call for evidence was three fold:

- To showcase the effect, success and contribution of public health projects delivered by the wider workforce and the positive impact they have on the public health and wellbeing system.
- To embrace the learning of how such an asset-based approach can benefit and add value to the wider public health system and inform the development of a wider workforce framework.
- To disseminate wider public health practice and seek opportunities for growth and development of local models and approaches nationally, to illustrate effective capacity building of the wider workforce.

A pragmatic, rather than a scientific, approach was taken in disseminating the request for case studies via local authorities, employment and housing providers, fire and rescue services, local partnerships, community pharmacies, education providers and allied health professionals.

More than 30 case studies were received. Organisational responses included information on who the wider workforce are, how projects operate, the relationships that have been built, engagement with people and organisations, and the critical success factors and drivers for change and their overall impact.

A summary of the case studies is provided in Annex B. This divides the case studies into the following categories:

- Community-based projects
- Employment and/or housing service providers
- Emergency services
- Local authority whole system approaches
- Schooling and education
- Acute care settings
- Integration of health and social care
- Environmental influence on health
- Care homes
- Community pharmacy
- Workplace.

Case Study

Wider workforce case study: I Will If You Will

Driven by concerning data showing low activity levels of many women and girls in Bury, the I Will If You Will (IWIYW) programme was introduced by Bury Council with the aim of overcoming the many physical and emotional barriers to exercise experienced by women and girls. This programme sought to address basic requirements for undertaking exercise, such as time and money and also, building motivation, creating a supportive community and celebrating and rewarding the achievements of participants.

The programme has yielded impressive results with increased awareness of the programme. When evaluated, 68 per cent of the borough were aware of IWIYW and, critically, the number of women and girls taking part in regular activity had increased by 2,500.

4.2 Emerging themes

This section presents the main findings from a review of the case studies. Key themes have been identified for discussion below.

4.2.1 Drivers for change

The prominent factor that appears to have facilitated the wider workforce's engagement with public health is that of local strategic leadership, often stemming from individuals recognising their potential to contribute to health and wellbeing. The reasons why progress is accelerating are attributed to a number of differences in pursuing public health across a number of settings; ability to pursue a whole-system approach through the

local authority's wider remit for civil leadership and promoting partnerships; swift decision making by transformational leaders across wider professions e.g. fire and rescue services and; more freedom to pursue local objectives with a predominantly local, rather than national, performance regime.

4.2.2 Providing support to existing services

Healthcare services in England are under ongoing pressure to deliver quality, patient focused services under tight budgets. Much of the discussion around the wider workforce has centred on its potential to support existing services or to reduce community health service need through encouraging healthy lifestyle changes.

This is clearly reflected in the case studies with many demonstrating their success in training health champions to deliver healthy conversations, increase referrals to other services and support positive behaviour change. An example of this is the *I Will If You Will* campaign delivered by Bury Council, which increased the number of women and girls taking part in regular activity by 2,500.

Alongside this, many of the case studies demonstrate some of the more direct ways in which the wider workforce is supporting traditional health services. We gathered several examples from across England of initiatives leading to a reduction in, for example, the workload of other services and an increase in referrals, thus reducing costs and workload over the longer term. A clear example of this is the work led by the fire and rescue services.

The Aurora youth development programme developed by the West Midlands Fire Service found that all the students who completed the full course ceased offending by the end of the programme. In addition, the fire and falls prevention initiative delivered by the Greater Manchester Fire and Rescue Service (GMFRS) resulted in a large increase in individuals being referred to the falls service. This referral function is possible because the fire services are in the privileged position of being allowed into people's homes for fire risk assessments and have seen this as an opportunity to do a broader assessment of safety for elderly people. Of the 602 fire safety checks delivered by the GMFRS, 37 per cent identified individuals at risk of falls, allowing preventative measures to be put in place. The community risk intervention teams, an initiative jointly delivered by GMFRS, North West Ambulance Service (NWAS), Greater Manchester Police (GMP) and Greater Manchester local authorities have also started responding to calls relating to falls in the home, cardiac arrests and mental capacity on behalf of NWAS and GMP.

Within the case studies, there is also an example of the wider workforce providing a more cost efficient model of service delivery. For instance, by providing personal, social and health education (PSHE) training to teachers, the Medway Council Public Health Directorate is ensuring students continue to receive support and information on various public health issues following a reduction in funding of local teenage pregnancy services.

4.2.3 The importance of partnership working

Many factors impact public health, from the environment and housing to employment and education. A clear theme emerging from these case studies is a growing recognition of the importance of partnership working between different professions and departments.

Many of the case studies demonstrate that this can be a more effective way of meeting both individual and shared goals. A clear example of this is the partnership between GMFRS and Pennine Care NHS Foundation Trust (PCFT), which focuses on the issues of mental health and substance use. Recognising that those at greatest fire risk are those who are likely to be already known to PCFT (providers of mental health and community services), a formal partnership agreement was signed in 2013. The partnership believes this has led

to 'safer working practices and increased knowledge of each other's role and areas of work'. Importantly, the partners believe that by working together they have improved referral pathways and have delivered person-centred home safety interventions for service users.

Many case studies demonstrate that partnership working can be a catalyst for the development of further initiatives and information sharing. Partnership working as part of the Better Medway Champions initiative delivered by Medway Council Public Health has, according to the council, led to relationships being 'formed and strengthened with partners (internal departments and external agencies), which has facilitated joint working and further development of the wider workforce'.

4.2.4 Training needs of the wider workforce

For the wider workforce to realise its public health potential, it is essential that individuals are provided with effective training, ensuring they have the necessary skills and knowledge to support the public to lead healthier lives. The case studies demonstrate that for many non-public health professions, their initial understanding of public health and the wider determinants of health is fairly low. The primary training need for much of the wider workforce is to increase their general understanding of public health. For those working with young people, the case studies indicate a need to have training in the specific health issues and concerns of younger people.

To effectively deliver public health messages, it is essential that individuals are provided with training in behaviour change techniques, such as motivational interviewing and health coaching and also, communication skills. To a lesser extent, the case studies demonstrate a need for training in the day-to-day concerns of delivering programmes and projects, such as equality and diversity, safeguarding and the recruitment of participants.

To increase buy-in from staff, the case studies indicate that the training must meet two main requirements. Firstly, the training must be linked back to their role and the particular issues faced within the local area. This includes training on local services and referral pathways. Wigan Council found that 'training customised to the needs of individuals and groups help make public health messages real to both individuals and organisations'.

Moreover, the training must be flexible so that it does not interfere with the daily business of the wider workforce. Ipswich Borough Council (working with key employment and housing service providers to engage with the most vulnerable groups) found that the training needed to 'offer a range of different training solutions to ensure relevance to diverse organisational sizes, structures and systems'. Many of the case studies stressed the importance of ensuring that training fits around the busy work schedules of staff. The *Eat...Drink...Move...!* programme delivered by the Heart of England NHS Foundation Trust found that on-the-job training was essential for hospital staff that could not leave their wards. This was also an issue faced by the health education in local pharmacies work undertaken by the Thames Valley Local Pharmaceutical Network, which found that releasing staff for training was a particular challenge. The wider workforce is hugely diverse and it is clear from the case studies than a one-size-fits-all model of training is not appropriate or effective.

4.2.5 Development of the wider workforce beyond brief advice (making every contact count)

It is evident from the case studies that the concept of Making Every Contact Count (MECC) has been embedded within key organisations as a behaviour change approach, including fire services, social housing and local authorities. However the potential for the wider workforce extends beyond MECC and many organisations are embracing broader opportunities that reflect the wider determinants of health. Motivations to change lifestyle includes tackling social isolation, improving support networks and providing access to a wider range of support services. It is suggested that this broader use of MECC is encouraged and considered as

a MECC plus programme. Wigan Council has adapted MECC for a 'Making health everyone's business' programme within its public health system and in Warwickshire; the aim is for every frontline member of staff to be trained over five years so healthier lifestyles can be promoted by all, whatever their role.

The wider workforce is particularly active in developing community assets, by supporting development of community groups and increasing the knowledge and skills of local people. Alongside this, much of the wider workforce is focused on supporting hard to reach and or vulnerable populations who may be experiencing a range of emotional wellbeing issues as well as faced with stark inequalities. For this reason, there is a growing trend for the wider workforce being given more in-depth training in areas such as communication, understanding the wider determinants of health, or issues faced by particular groups, and other techniques such as social mobilisation and motivational interviewing techniques.

4.2.6 Supporting further development

Whilst the case studies come from a wide range of professions, they all have similar needs in terms of supporting the further development of the wider workforce. Case study authors seek further support to raise the profile of the work being undertaken. This could be achieved through the dissemination of publications through the networks of organisations such as the RSPH, the CfWI and others, and also speaking at events. Several case studies highlight the need for guidance in making the case for further development and funding.

Alongside this, many stress the potential role of organisations like the RSPH in facilitating discussions between potential partners and building a network for the wider workforce, thus enabling the sharing of best practice. Some of the case studies also raise the possibility of developing multi-disciplinary training and a common framework.

5. Challenges for the wider public health workforce

We asked the workshop participants to consider how the wider workforce might be developed in future. Issues we asked them to consider included:

- How might occupations that are interested in public health be supported to become actively involved?
- What support is required by occupations that are already active?
- What might we learn from wider workforce occupations that have, or are already, engaged in public health?
- What are the issues and challenges in engaging and developing the wider workforce?

We also asked the wider workforce about their development needs and challenges through our call for evidence. A summary of the key advice from the wider workforce is presented in this section.

5.1 Tiered approach

Participants from both workshops suggested that in engaging with the wider workforce, it may be useful to develop a two tiered approach to the wider workforce. Tier 1 would include frontline occupations which could engage in appropriate healthy conversations, and tier 2 would comprise those capable of commissioning or leading programmes aimed at improving health outcomes, with an emphasis on public sector commissioners.

Within tier 1, it may be most useful to prioritise workforces with the ability to gain access to hard-to-reach groups, as these are often the communities with poorer public health outcomes. For example, this could be by taking health education messages to hairdressers' or other places where people meet and they 'trust the messenger'. There is also a need to focus on communities and develop and strengthen grassroots partnerships to respond to local rather than national need. Within this context, there may also be opportunities for schools to raise the profile of PSHE, with the support and involvement of staff, pupils and their families.

Occupations that are interested in public health, or already engaged in public health, need to be provided with the right skills for engaging in 'healthy conversations'. Training and support would need to be focused, and this may be through developing a suite of competencies (where there is potential for links into a revised PHSKF). There is a need to identify the 'functions' that might be carried out by the wider workforce (rather than occupations or groups), and identify the competencies that might be required to deliver on these functions. There are many preconceptions about what specific occupation groups do and how they can contribute.

There was some discussion at the workshops that an examination of the wider workforce, should start with a place or community, which is consistent with PHE's *From evidence into action*. An analysis of the population's health and wellbeing needs at a local level could inform an assessment of the appropriate opportunities to engage the wider workforce in delivery. This approach to understanding the wider workforce could certainly be useful and may be a helpful next step. We expect that by identifying the potential wider workforce as we have here, we have helped develop a foundation for a local needs and opportunity assessment by local authorities and other agencies.

5.2 Cultural shift

Culture change takes time and effort – staff at all levels need to understand the benefits of such work. The development of the wider workforce requires non-public health professions to adapt their ways of working and incorporate a new focus on health and wellbeing. There may be challenges in regards to the allocation of resources for this work. However, many of the case studies demonstrate that, rather than increasing workload, this can actually be a natural extension of their work and over the long term make their work more rewarding.

A strong theme emerging from the case studies and the workshops is that engaging the wider workforce in public health will require a significant change in working culture. Kemble Housing (a housing association covering Hertfordshire) for example, found that their staff were initially uneasy about having healthy conversations and were concerned that they may be seen to be 'judging people' and telling them what to do.

To overcome this challenge, the case studies demonstrate that involving staff in the development of wider workforce initiatives is key. This encourages a feeling of ownership and also aids understanding of the projects. The GMFRS found that it was important to 'ensure that a uniformed member of staff is seen to support the initiative and preferably be present during the initial briefing sessions'. This issue emerged from the workshops where discussion focused on the importance of communicating 'what's in it for me'.

The case studies also demonstrate that it is vital to ensure that there is strong strategic leadership. The Community Risk Intervention Team initiative delivered by the GMFRS, North West Ambulance Service, Greater Manchester Police and Greater Manchester local authorities found that 'full stakeholder buy-in at a strategic level was essential to delivering the concept and change across all organisations'.

5.3 Language of public health and wellbeing

A primary concern identified across the entire engagement process was the concept of needing to learn to speak the same language across different wider workforce settings. The term public health is not generally fully understood within the wider workforce across local authorities, voluntary and community sectors or across sector specific groups such as housing, teaching and the unpaid workforce. Many do not associate with the term public health and therefore may not engage with the vision of utilising the wider workforce to contribute to health outcomes. Positioning the contribution of the wider workforce to public health outcomes as promoting 'wellbeing' instead of 'public health' is supported. 'Wellbeing' has been identified as a term that the wider workforce may be more familiar with, making it more likely that they would be willing to participate in public health programmes positioned in this context.

5.4 Sustainability

Across many of the case studies there were general anxieties about funding for the future, as council and other public sector budgets continue to reduce. There was also a view that the wider workforce needs to contribute to whole-scale system reform across health and social care if the public health system is to be sustainable in the face of pressures of demand and finance.

A further issue of sustainability, and one directed to policy leads and commissioners, was that of commissioning for social value and prevention, as opposed to the traditional clinical model. It was indicated that commissioners need to better understand the role and the impact of wider workforce approaches in

delivering positive extrinsic outcomes based on social and community based approaches. One way this might be achieved is to incorporate public health objectives into the policy and leadership and service specifications of the active and interested occupations. Policy initiatives and concerted campaigns to advance specific policies around wider workforce were also recommended.

Much of the engagement with stakeholders has challenged traditional approaches to tackling poverty, where need is defined by external organisations and experts determining targets and proposed solutions. The criticism was that this approach created a culture of dependency in deprived communities, with people lacking confidence to take charge of their communities' future, instead becoming reliant on external agencies for solutions.

Asset Based Community Development (ABCD) is an alternative, community based approach, which uses resources of local people, their knowledge of their own communities and existing community resources, to encourage and support change. ABCD initiatives are emerging across the country. The *I Will If You Will* programme is a clear example of how a project is adopting sustainable change through an ABCD approach.

A fundamental shift towards preventative and community assets based working is required from the NHS, local authorities and partners in order for the wider workforce to be able to deliver to its fullest potential. Identifying and linking with change agents, and other trusted badges of professional credibility who have an enthusiasm for promoting health and wellbeing, is a good way of building system-wide commitment.

5.5 Evaluation – evidencing success

Despite the early adopters of the wider workforce (which includes AHPs, fire services, community pharmacists, health trainers and housing sector), evidencing the value of their wider reach and contribution to public health is currently limited. The effectiveness of preventative work is hard to measure. Without available evidence for its effectiveness, future commissions for developing the wider workforce may not be feasible.

Many larger providers are starting to measure the impact of their wellbeing activities (e.g. in the housing sector) and whilst there are some synergies with health outcomes, the tools and the language used do not always read across to public health outcomes and domains. Skills and training in evaluation may assist the wider workforce to develop an evidence base for their impact and extend the scope and reach of their contribution to health and wellbeing.

The workshops recommended that it is important to educate commissioners of the benefits of investing in prevention. To encourage further development of the wider workforce, being able to demonstrate the positive impact of a project through robust evaluation is vital, both for gaining further funding and resources and also encouraging greater take up by staff who can more clearly demonstrate the impact of their work.

For many of the case studies, evaluation is either ongoing or yet to be conducted and, therefore, demonstrating 'impact' is restricted to 'soft' outcomes at this stage. Overall, however, the case studies demonstrate that the evidence base could be strengthened in some areas. Much of the evaluation centres on the use of quantitative data, such as the number of participants. Whilst this information is vital, many of the benefits of health improvements cannot be quantified, such as strengthening community capacity and developing community resources. For this reason, it is important to build in qualitative research into evaluation to ensure a more rounded picture of a programme's impact.

Where quantitative data has been used, it is primarily with a short term focus. To strengthen the evidence base, it is important for an evaluation to consider the longer term impact of a programme and whether

behaviour change has been maintained. There may be scope for organisations such as PHE or RSPH to support the wider workforce in developing techniques to evaluate the impact of their health and wellbeing programmes.

Case Study

Wider workforce case study: workplace challenge

It is estimated that adults spend up to 60 per cent of our waking hours at work, therefore the workplace offers the ideal environment for health improvement activity. The Workplace Challenge, delivered by the County Sports Partnership Network, seeks to increase physical activity levels of staff through a combination of a free online activity log and a range of products and services for workplace access, such as training and events.

Evaluation of this initiative is ongoing; however, results so far indicate an increase in participation by inactive people and an increase in overall weekly participation in sport and physical activity. The overall goal for this project is for 2,000 workplaces and 20,000 employees to take part in the challenge. The project is on track to meet these targets and the final project report will be available in December 2015.

6. Discussion

6.1 Discussion

Our experience in researching and drawing together this report has demonstrated that there is great enthusiasm for improving health and wellbeing outside of the core public health workforce. While much of the analysis in this report offers high level generalisations about the potential of the wider workforce, the case studies highlight the spectrum of potential and innovation already being exhibited by the wider workforce.

When we initially estimated a wider workforce of up to 19.5 million people in December 2014 we were surprised at its scale and expected significant challenge to our estimate. We took our assumptions and methodology to our workshops in February 2015, where a cross-section of the wider workforce provided an even broader interpretation of public health, and increased this estimated workforce to up to 20.2 million people. Workshop participants supported the benefits of looking widely so that we know the full extent of the potential workforce and can make a rational decision about where to focus.

What has been identified here is that there are potentially millions of people who work in occupations that have the opportunity to positively influence health and wellbeing through their work. Five million people provide unpaid care and support to family and friends, further taking pressure off the health and social care systems. While we have made some attempt to identify those occupations that are currently actively involved in public health, the scale of the workforce identified highlights the enormous potential for thinking outside the core public health workforce for public health service delivery.

In view of the enormous size of this potential workforce, a tiered approach to further development and engagement with the wider workforce is recommended. This report suggests some ways to identify which segments of the workforce might offer the best opportunities for potential engagement and development. There are a number of factors that can be considered, including:

- the sector
- the function
- current level of engagement with public health and
- the opportunity for healthy conversations.

The opportunities for public health engagement may vary depending on any one of these factors. We suggest that in planning the up-skilling and up-scaling of the wider workforce, consideration should be given to the desired outcome, and these factors may help identify occupations well suited for engagement. We also acknowledge that, to date, much of the public health contribution from the wider workforce has been initiated by these professions and organisations themselves, where they have identified an opportunity to make a difference to a community.

There are some immediate opportunities that became apparent through this project. There are a few occupations that appear to be more prominent in terms of current contribution to health and wellbeing, and/or enthusiasm to be acknowledged as part of the wider workforce. Indeed, some of these professions may be considered be practitioners in public health, however for the purpose of this report are included in the wider workforce. These early adopters in the wider workforce include the **fire services, health trainers, midwives, pharmacists, allied health professions and parts of the social housing and voluntary sectors**

including unpaid carers. While these are certainly not the only groups making a significant contribution to health and wellbeing, these diverse groups may be a good place to start to develop the wider workforce.

Additionally there are some key factors that appear to have facilitated the wider workforce's engagement with public health. In some cases, good practice has started with individuals recognising their potential to contribute to health and wellbeing, for example, allied health professionals and pharmacists. Other occupational groups have evolved through strategic leadership that has encouraged the expansion of services to increase the contribution to health and wellbeing.

What this process has identified is just the beginning of the conversation about those who makes up the wider workforce. With such diverse occupations, ranging in potential influence, abilities and scope, the requirements for coordination, training, and support are varied. However, what has become clear is that there is an appetite and enthusiasm in the workforce for acknowledgement of the contribution they make to health and wellbeing. There is also a strong desire for national leadership to help translate local level individual projects and programmes into wider learning and opportunities across the workforce.

6.2 Suggestions for next steps

The CfWI, the RSPH and PHE recognise that the scale of the wider workforce means that development will need to be staged. Our suggestions for the way forward cover three key areas:

- **System leadership** – to champion this disparate workforce
- **Development and training interventions** – to support quality
- **Ongoing research and evidence-gathering** – to demonstrate the value of the workforce and the impact it is making.

6.2.1 Leadership of the wider workforce system

The project partners recognise that significant creativity and contribution is made at a local and occupation level, and that system leadership of the wider workforce needs to support the wider workforce to continue to innovate to improve health and wellbeing.

This is because the wider workforce is fragmented and highly diverse, encompassing a large proportion of the working age population. System level leadership and engagement will help to draw out synergies and opportunities in the wider workforce to drive the radical upgrade in prevention and public health. PHE and the RSPH are already well positioned to take on this leadership and support role for the wider workforce. However our suggestions are addressed more broadly to policy makers, commissioners and the core public health workforce.

We are suggesting that system leadership takes the following approaches:

- **Provision of opportunities to share best practice in the wider workforce.** The potential of the wider workforce to influence wellbeing is hugely diverse. Opportunities to learn from the experience, success and challenges in the wider workforce may encourage good practice. This could be in the form of an online tool, such as a portal, or the extension of the ***What Works Centre for Wellbeing*** website (http://whatworkswellbeing.org/), launched in October 2014. Local or national networks may also help with sharing learning and support across the wider workforce. An award system to acknowledge innovators and leaders in the wider workforce may be an effective way to highlight best practice and the contributions made to health and wellbeing.

- **Incorporate public health objectives into the policy and leadership of *active* and *interested* wider occupations.** This should facilitate recognition of the contribution made by the wider workforce, especially if it is able to link to public health service commissioning objectives. The RSPH and PHE should seek to encourage commissioners to recognise the social value (and inherent return on investment) of better public health and (accepting that the evidence base for public health is not always available) to take more risks when commissioning services. Directors of Public Health may also have a role to play to stimulate action and engagement at a local level.

This can be further supported by the following:

- **The introduction of a tiered approach to workforce engagement and development.** Engagement with the wider workforce should start with the occupations that have proactively demonstrated their commitment to public health, and are seeking to extend existing programmes and policies. Examples of key occupations identified through this project are health training, community pharmacy, public and social housing, allied health professions and fire services. Another tier may be public facing occupations where there is opportunity for wider implementation of the MECC programme. The wider workforce has demonstrated a high degree of innovation and creativity in improving health and wellbeing, and in the development of new models of care, consideration should be given to the capacity and willingness of the wider workforce to participate in public health.
- **Access to education and training on health-related conversations and wellbeing.** Managerial and strategic occupations will require a different approach to the MECC, one that focuses on health inequalities, health protection or a more theoretical understanding of the drivers of wellbeing. This project identified a number of occupations that are either actively involved in the delivery of public health, or who may be interested in engaging with the public health system to increase their contribution to improving wellbeing.

Note that the suitability of scaling up projects and programmes will need to be assessed on individual appropriateness, with an assessment of population needs, occupational relevance and organisational capacity.

6.2.2 Development of the wider workforce

The development of the wider workforce needs to address the current workforce (particularly those at lower levels not fully recognised by existing schemes) and professional education and training. We recognise that these suggestions are easiest to implement for the paid workforce, however there are around 5 million unpaid carers in England, and these should not be forgotten.

- **Public health competency framework.** A competency framework for the wider workforce is required to provide guidance on the expectations for practices that support evidence based public health delivery. It would help individuals to demonstrate their contribution to wellbeing, and illustrate the potential for progression into public health from the wider workforce, for instance as a public health practitioner. There may be an opportunity for the Public Health Skills and Knowledge Framework to fulfil this function, as part of its current review. For those members of the wider workforce who are interested in pursuing a career in public health, it will highlight the opportunities for career development, and incorporate expectations for professional standards.
- **HEE, PHE and higher education providers should look for opportunities to incorporate core prevention and public health knowledge and skills in pre- and post-registration education across the health and social care system as and where appropriate.** A large proportion of the wider workforce is in the health and social care sector. Incorporating elements of public health theory and practice into pre-registration

training, and post-registration professional development would support the delivery of a radical upgrade in prevention and public health called for in the *Five Year Forward View* (NHS England, 2014).

6.2.3 Tracking the progress of the wider workforce

Research and evidence-gathering to demonstrate the value of the workforce should include:

- **Ongoing evaluation and innovation.** Ongoing evaluation of the public health contribution of the wider workforce, will provide evidence on whether to invest in developing public health skills and competencies outside the core public health workforce. Building evaluation in to programme design, may help the wider workforce to evidence the impact they're making in public health, potentially enhancing the sustainability of these programmes. In the first instance, this may be limited to a small, prioritised section of the wider workforce, for example early adopters such as the fire services, health trainers, allied health professions, community pharmacy and public housing sectors. These have all demonstrated an enthusiasm to demonstrate their contribution to public health but may need financial support to complete robust research projects and quantify benefits arising. The *What Works for Wellbeing* website, or another wider workforce portal may assist in facilitating evaluation and innovation. Additionally, the NICE *Return on Investment Tools* (NICE, 2014) may assist the wider workforce and commissioners to evaluate the contribution of their service delivery.
- **In-depth review of part of the wider workforce.** An exemplar project that considers the numbers and future drivers of the workforce, incorporating horizon scanning and modelling, could demonstrate the impact a higher profile for public health could have on a specific workforce or the workforce around a target group. The project should consider the expected outcomes of greater utilisation of these segments of the wider workforce on health at the population level. An in-depth review of this nature would highlight the contribution of the wider workforce and their development needs. It would inform training and recruitment requirements.
- **Pursue a project that takes a 10 year view of a local workforce for public health service delivery.** Recent changes to public health service delivery models, including the decentralisation of many public health responsibilities, will likely have a significant impact on the shape of the public health workforce over the coming years. The CfWI and the RSPH anticipate that the wider workforce will play an increasing role in public health service delivery. A future project may examine the local context, population needs and the type of services required over the coming 10 years, and map that back to the local workforce. A project of this kind could incorporate both paid and unpaid workforces, and issues based scenarios for workforce modelling. Realistically, this would need to focus on a single authority or sub-region to keep the data manageable but could help other local authorities and public health policy makers to plan future services.

With the reorganisation of the public health workforce in England, and the presence of public health in local government there is a unique opportunity to encourage the people working outside the traditional public health system to have a greater role in improving the public's health. The scale, diversity and reach of the wider workforce means that it has great potential to make a significant contribution to health and wellbeing across England. Our experience in engaging with sections of the wider workforce for this project has identified that there is a lot of goodwill in the community, and that there are many individuals and organisations already proactively engaging with their communities to positively influence health risk factors, health inequalities and the wider determinants of health.

We hope that this report is able to act as a catalyst for further conversation and engagement with the wider workforce.

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Annex A: Source data

The tables below shows the ONS Labour Force Survey EMP04, August 2014, data including Standard Occupation Classification, and the UK Total in employment 2010. Further columns indicate our weighted estimate of the number in Employment in England, and further coding undertaken as part of this project, including whether each occupation related to public health, level of engagement, the employment group, and the public interactions. All occupations that are shaded have been included in the initial wider workforce headcount estimate found in Section 4.2.

Standard Occupational Classification (SOC 2010):	UK Total in employment (000's)	England weighted (000's)	Public health	Engagement	Employment	Public Interactions
1. MANAGERS, DIRECTORS AND SENIOR OFFICIALS						
111 Chief Executives and Senior Officials						
1115 Chief executives and senior officials	**69.96**	**58.77**	**Yes**	**Interested**	**Admin & mgmt**	**No**
1116 Elected officers and representatives	**5.40**	**4.53**	**Yes**	**Interested**	**Admin & mgmt**	**Repeat**
112 Production Managers and Directors						
1121 Production managers and directors in manufacturing	**273.06**	**229.37**	**Yes**	**Interested**	**Admin & mgmt**	**No**
1122 Production managers and directors in construction	**173.16**	**145.46**	**Yes**	**Interested**	**Admin & mgmt**	**No**
1123 Production managers and directors in mining and energy	**12.37**	**10.39**	**Yes**	**Interested**	**Admin & mgmt**	**No**
113 Functional Managers and Directors						
1131 Financial managers and directors	**205.86**	**172.92**	**No**			
1132 Marketing and sales directors	**162.72**	**136.69**	**No**			
1133 Purchasing managers and directors	**58.72**	**49.32**	**No**			
1134 Advertising and public relations directors	**22.45**	**18.86**	**No**			
1135 Human resource managers and directors						
1136 Information technology and telecommunications directors	**77.70**	**65.27**	**No**			
1139 Functional managers and directors n.e.c[4].	**113.46**	**95.30**	**No**			
115 Financial Institution Managers and Directors						
1150 Financial institution managers and directors	**79.19**	**66.52**	**No**			
116 Managers and Directors in Transport and Logistics						
1161 Managers and directors in transport and distribution	**69.54**	**58.41**	**Yes**	**Unengaged**	**Admin & mgmt**	**No**
1162 Managers and directors in storage and warehousing	**85.00**	**71.40**	**No**			
117 Senior Officers in Protective Services						

[4] not elsewhere classified (n.e.c.)

Standard Occupational Classification (SOC 2010):	UK Total in employment (000's)	England weighted (000's)	Public health	Engagement	Employment	Public Interactions
1171 Officers in armed forces	**22.87**	**19.21**	**No**			
1172 Senior police officers	**16.14**	**13.56**	**Yes**	**Active**	**Protection services**	**Yes**
1173 Senior officers in fire, ambulance, prison and related services	**11.19**	**9.40**	**Yes**	**Active**	**Protection services**	**Yes**
118 Health and Social Services Managers and Directors						
1181 Health services and public health managers and directors	**52.13**	**43.79**	**No**			
1184 Social services managers and directors	**52.28**	**43.91**	**Yes**	**Active**	**Welfare**	**No**
119 Managers and Directors in Retail and Wholesale						
1190 Managers and directors in retail and wholesale	**333.34**	**280.00**	**No**			
121 Managers and Proprietors in Agriculture Related Services						
1211 Managers and proprietors in agriculture and horticulture	**32.10**	**26.97**	**No**			
1213 Managers and proprietors in forestry, fishing and related services	**7.80**	**6.55**	**No**			
122 Managers and Proprietors in Hospitality and Leisure Services						
1221 Hotel and accommodation managers and proprietors	**56.53**	**47.48**	**Yes**	**Interested**	**Hospitality**	**Yes**
1223 Restaurant and catering establishment managers and proprietors	**125.40**	**105.34**	**Yes**	**Interested**	**Hospitality**	**No**
1224 Publicans and managers of licensed premises	**45.71**	**38.39**	**Yes**	**Interested**	**Hospitality**	**Repeat**
1225 Leisure and sports managers	**50.81**	**42.68**	**Yes**	**Interested**	**Sports & fitness**	**Repeat**
1226 Travel agency managers and proprietors	**10.17**	**8.54**	**No**			
124 Managers and Proprietors in Health and Care Services						
1241 Health care practice managers	**19.25**	**16.17**	**Yes**	**Active**	**Health professionals**	**Repeat**
1242 Residential, day and domiciliary care managers and proprietors	**57.31**	**48.14**	**Yes**	**Active**	**Welfare**	**Repeat**
125 Managers and Proprietors in Other Services						
1251 Property, housing and estate managers	**182.49**	**153.29**	**Yes**	**Interested**	**Welfare**	**Repeat**
1252 Garage managers and proprietors	**34.30**	**28.81**	**Yes**	**Interested**	**Retail trades**	**Yes**
1253 Hairdressing and beauty salon managers and proprietors	**35.34**	**29.68**	**Yes**	**Interested**	**Retail trades**	**Repeat**
1254 Shopkeepers and proprietors – wholesale and retail	**141.45**	**118.82**	**Yes**	**Interested**	**Retail trades**	**Yes**
1255 Waste disposal and environmental services managers	**13.17**	**11.06**	**Yes**	**Interested**	**Environment**	**Yes**
1259 Managers and proprietors in other services n.e.c.	**206.14**	**173.16**	**Yes**	**Interested**	**Retail trades**	**Yes**
2 PROFESSIONAL OCCUPATIONS						
211 Natural and Social Science Professionals						
2111 Chemical scientists	**29.07**	**24.42**	**Yes**	**Unengaged**	**Scientists & engineers**	**No**
2112 Biological scientists and biochemists	**101.46**	**85.22**	**Yes**	**Unengaged**	**Scientists & engineers**	**No**

Standard Occupational Classification (SOC 2010):	UK Total in employment (000's)	England weighted (000's)	Public health	Engagement	Employment	Public Interactions
2113 Physical scientists	**25.80**	**21.67**	**Yes**	**Unengaged**	**Scientists & engineers**	**No**
2114 Social and humanities scientists	**9.85**	**8.27**	**No**			
2119 Natural and social science professionals n.e.c.	**40.46**	**33.98**	**No**			
212 Engineering Professionals						
2121 Civil engineers	**85.82**	**72.09**	**Yes**	**Unengaged**	**Scientists & engineers**	**No**
2122 Mechanical engineers	**75.16**	**63.14**	**No**			
2123 Electrical engineers	**43.50**	**36.54**	**No**			
2124 Electronics engineers	**28.23**	**23.71**	**No**			
2126 Design and development engineers	**67.10**	**56.37**	**Yes**	**Unengaged**	**Scientists & engineers**	**No**
2127 Production and process engineers	**65.82**	**55.29**	**Yes**	**Unengaged**	**Scientists & engineers**	**No**
2129 Engineering professionals n.e.c.	**93.57**	**78.59**	**No**			
213 Information Technology and Telecommunications Professionals						
2133 IT specialist managers	**181.51**	**152.46**	**No**			
2134 IT project and programme managers	**68.07**	**57.18**	**No**			
2135 IT business analysts, architects and systems designers	**102.04**	**85.71**	**No**			
2136 Programmers and software development professionals	**274.16**	**230.29**	**No**			
2137 Web design and development professionals	**70.23**	**58.99**	**No**			
2139 Information technology and telecommunications professionals n.e.c.	**151.18**	**126.99**	**No**			
214 Conservation and Environment Professionals						
2141 Conservation professionals	**13.01**	**10.93**	**Yes**	**Unengaged**	**Environment**	**No**
2142 Environment professionals	**32.14**	**27.00**	**Yes**	**Unengaged**	**Environment**	**No**
215 Research and Development Managers						
2150 Research and development managers	**35.48**	**29.80**	**No**			
221 Health Professionals						
2211 Medical practitioners	**247.40**	**207.81**	**Yes**	**Active**	**Health professionals**	**Repeat**
2212 Psychologists	**39.24**	**32.96**	**Yes**	**Active**	**Health professionals**	**Repeat**
2213 Pharmacists	**59.68**	**50.13**	**Yes**	**Active**	**Health professionals**	**Repeat**
2214 Ophthalmic opticians	**21.92**	**18.41**	**Yes**	**Active**	**Health professionals**	**Repeat**
2215 Dental practitioners	**51.30**	**43.09**	**Yes**	**Active**	**Health professionals**	**Repeat**
2216 Veterinarians	**20.28**	**17.03**	**Yes**	**Active**	**Environment**	**Repeat**
2217 Medical radiographers	**23.20**	**19.49**	**Yes**	**Active**	**Health professionals**	**Yes**
2218 Podiatrists	**16.32**	**13.70**	**Yes**	**Active**	**Health professionals**	**Repeat**
2219 Health professionals n.e.c.	**47.69**	**40.06**	**Yes**	**Active**	**Health professionals**	**Repeat**

Standard Occupational Classification (SOC 2010):	UK Total in employment (000's)	England weighted (000's)	Public health	Engagement	Employment	Public Interactions
222 Therapy Professionals						
2221 Physiotherapists	**52.21**	**43.86**	**Yes**	**Active**	**Health professionals**	**Repeat**
2222 Occupational therapists	**41.74**	**35.06**	**Yes**	**Active**	**Health professionals**	**Repeat**
2223 Speech and language therapists	**11.02**	**9.26**	**Yes**	**Active**	**Health professionals**	**Repeat**
2229 Therapy professionals n.e.c.	**42.85**	**35.99**	**Yes**	**Active**	**Health professionals**	**Repeat**
223 Nursing and Midwifery Professionals						
2231 Nurses	**590.20**	**495.77**	**Yes**	**Active**	**Health professionals**	**Repeat**
2232 Midwives	**40.54**	**34.05**	**Yes**	**Active**	**Health professionals**	**Repeat**
231 Teaching and Educational Professionals						
2311 Higher education teaching professionals	**154.57**	**129.84**	**Yes**	**Active**	**Education**	**Repeat**
2312 Further education teaching professionals	**106.51**	**89.47**	**Yes**	**Active**	**Education**	**Repeat**
2314 Secondary education teaching professionals	**410.83**	**345.10**	**Yes**	**Active**	**Education**	**Repeat**
2315 Primary and nursery education teaching professionals	**431.30**	**362.29**	**Yes**	**Active**	**Education**	**Repeat**
2316 Special needs education teaching professionals	**78.85**	**66.24**	**Yes**	**Active**	**Education**	**Repeat**
2317 Senior professionals of educational establishments	**100.06**	**84.05**	**Yes**	**Active**	**Education**	**Repeat**
2318 Education advisers and school inspectors	**34.75**	**29.19**	**Yes**	**Active**	**Education**	**No**
2319 Teaching and other educational professionals n.e.c.	**217.36**	**182.58**	**Yes**	**Active**	**Education**	**Repeat**
241 Legal Professionals						
2412 Barristers and judges	**30.87**	**25.93**	**Yes**	**Unengaged**	**Other professions**	**Repeat**
2413 Solicitors	**110.91**	**93.17**	**Yes**	**Unengaged**	**Other professions**	**Repeat**
2419 Legal professionals n.e.c.	**50.30**	**42.25**	**Yes**	**Unengaged**	**Other professions**	**Yes**
242 Business, Research and Administrative Professionals						
2421 Chartered and certified accountants	**203.07**	**170.58**	**No**			
2423 Management consultants and business analysts	**188.08**	**157.99**	**No**			
2424 Business and financial project management professionals	**205.90**	**172.96**	**No**			
2425 Actuaries, economists and statisticians	**33.58**	**28.21**	**No**			
2426 Business and related research professionals	**40.19**	**33.76**	**No**			
2429 Business, research and administrative professionals n.e.c.	**45.72**	**38.40**	**No**			
243 Architects, Town Planners and Surveyors						
2431 Architects	**52.41**	**44.02**	**Yes**	**Active**	**Environment**	**No**
2432 Town planning officers	**23.77**	**19.97**	**Yes**	**Active**	**Environment**	**No**
2433 Quantity surveyors	**36.97**	**31.06**	**Yes**	**Interested**	**Environment**	**No**
2434 Chartered surveyors	**53.93**	**45.30**	**Yes**	**Interested**	**Environment**	**No**
2435 Chartered architectural technologists			**No**			

Standard Occupational Classification (SOC 2010):	UK Total in employment (000's)	England weighted (000's)	Public health	Engagement	Employment	Public Interactions
2436 Construction project managers and related professionals	**60.64**	**50.94**	**Yes**	**Interested**	**Environment**	**No**
244 Welfare Professionals						
2442 Social workers	**95.75**	**80.43**	**Yes**	**Active**	**Welfare**	**Repeat**
2443 Probation officers	**12.76**	**10.72**	**Yes**	**Active**	**Protection services**	**Repeat**
2444 Clergy	**58.45**	**49.10**	**Yes**	**Active**	**Welfare**	**Repeat**
2449 Welfare professionals n.e.c.	**20.72**	**17.40**	**Yes**	**Active**	**Welfare**	**Repeat**
245 Librarians and Related Professionals						
2451 Librarians	**23.99**	**20.15**	**Yes**	**Interested**	**Other professions**	**Repeat**
2452 Archivists and curators	**11.87**	**9.97**	**Yes**	**Interested**	**Other professions**	**No**
246 Quality and Regulatory Professionals						
2461 Quality control and planning engineers	**31.44**	**26.41**	**Yes**	**Interested**	**Scientists & engineers**	**No**
2462 Quality assurance and regulatory professionals	**71.42**	**59.99**	**Yes**	**Interested**	**Scientists & engineers**	**No**
2463 Environmental health professionals	**13.57**	**11.40**	**No**			
247 Media Professionals						
2471 Journalists, newspaper and periodical editors	**60.26**	**50.61**	**Yes**	**Interested**	**Arts & media**	**Yes**
2472 Public relations professionals	**44.69**	**37.54**	**No**			
2473 Advertising accounts managers and creative directors	**32.80**	**27.55**	**No**			
3 ASSOCIATE PROFESSIONAL AND TECHNICAL OCCUPATIONS						
311 Science, Engineering and Production Technicians						
3111 Laboratory technicians	**84.92**	**71.33**	**No**			
3112 Electrical and electronics technicians	**29.05**	**24.40**	**No**			
3113 Engineering technicians	**75.25**	**63.21**	**No**			
3114 Building and civil engineering technicians	**12.60**	**10.58**	**No**			
3115 Quality assurance technicians	**18.45**	**15.50**	**Yes**	**Unengaged**	**Scientists & engineers**	**No**
3116 Planning, process and production technicians	**27.29**	**22.93**	**No**			
3119 Science, engineering and production technicians n.e.c.	**43.71**	**36.71**	**No**			
312 Draughtspersons and Related Architectural Technicians						
3121 Architectural and town planning technicians	**19.52**	**16.39**	**Yes**	**Interested**	**Environment**	**No**
3122 Draughtspersons	**38.64**	**32.45**	**Yes**	**Interested**	**Other professions**	**No**
313 Information Technology Technicians						
3131 IT operations technicians	**99.67**	**83.72**	**No**			
3132 IT user support technicians	**86.74**	**72.86**	**No**			
321 Health Associate Professionals						

Standard Occupational Classification (SOC 2010):	UK Total in employment (000's)	England weighted (000's)	Public health	Engagement	Employment	Public Interactions
3213 Paramedics	22.03	18.51	Yes	Active	Health professionals	Yes
3216 Dispensing opticians	6.23	5.23	Yes	Active	Health professionals	Repeat
3217 Pharmaceutical technicians	24.96	20.96	Yes	Active	Health professionals	Yes
3218 Medical and dental technicians	45.99	38.63	Yes	Active	Health professionals	Yes
3219 Health associate professionals n.e.c.	52.31	43.94	Yes	Active	Health professionals	Repeat
323 Welfare and Housing Associate Professionals						
3231 Youth and community workers	78.73	66.13	Yes	Active	Welfare	Repeat
3233 Child and early years officers	27.60	23.19	Yes	Active	Welfare	Repeat
3234 Housing officers	43.83	36.81	Yes	Active	Welfare	Repeat
3235 Counsellors	27.49	23.09	Yes	Active	Welfare	Repeat
3239 Welfare and housing associate professionals n.e.c.	111.91	94.00	Yes	Active	Welfare	Repeat
331 Protective Service Occupations						
3311 NCOs and other ranks	44.05	37.01	Yes	Active	Protection services	No
3312 Police officers (sergeant and below)	165.62	139.12	Yes	Active	Protection services	Repeat
3313 Fire service officers (watch manager and below)	39.49	33.17	Yes	Active	Protection services	Yes
3314 Prison service officers (below principal officer)	38.28	32.16	Yes	Active	Protection services	Repeat
3315 Police community support officers	13.62	11.44	Yes	Active	Protection services	Repeat
3319 Protective service associate professionals n.e.c.	46.18	38.79	Yes	Active	Protection services	Yes
341 Artistic, Literary and Media Occupations						
3411 Artists	47.49	39.89	Yes	Interested	Arts & media	No
3412 Authors, writers and translators	87.78	73.74	Yes	Interested	Arts & media	Yes
3413 Actors, entertainers and presenters	46.68	39.21	Yes	Interested	Arts & media	Yes
3414 Dancers and choreographers	13.45	11.29	Yes	Interested	Arts & media	Yes
3415 Musicians	40.68	34.17	Yes	Interested	Arts & media	Yes
3416 Arts officers, producers and directors	62.10	52.16	Yes	Interested	Arts & media	No
3417 Photographers, audio-visual and broadcasting equipment operators	84.00	70.56	Yes	Interested	Arts & media	Yes
342 Design Occupations						
3421 Graphic designers	82.52	69.32	No			
3422 Product, clothing and related designers	57.08	47.95	No			
344 Sports and Fitness Occupations						
3441 Sports players	18.57	15.60	Yes	Active	Sports & fitness	Yes
3442 Sports coaches, instructors and officials	89.57	75.24	Yes	Active	Sports & fitness	Repeat
3443 Fitness instructors	50.43	42.36	Yes	Active	Sports & fitness	Repeat

Standard Occupational Classification (SOC 2010):	UK Total in employment (000's)	England weighted (000's)	Public health	Engagement	Employment	Public Interactions
351 Transport Associate Professionals						
3511 Air traffic controllers	**8.34**	**7.00**	**No**			
3512 Aircraft pilots and flight engineers	**24.18**	**20.31**	**No**			
3513 Ship and hovercraft officers	**17.29**	**14.53**	**No**			
352 Legal Associate Professionals						
3520 Legal associate professionals	**54.04**	**45.39**	**No**			
353 Business, Finance and Related Associate Professionals						
3531 Estimators, valuers and assessors	**76.07**	**63.90**	**No**			
3532 Brokers	**57.78**	**48.54**	**No**			
3533 Insurance underwriters	**20.36**	**17.10**	**No**			
3534 Finance and investment analysts and advisers	**183.42**	**154.08**	**No**			
3535 Taxation experts	**34.39**	**28.89**	**No**			
3536 Importers and exporters	**14.27**	**11.98**	**No**			
3537 Financial and accounting technicians	**20.38**	**17.12**	**No**			
3538 Financial accounts managers	**140.37**	**117.91**	**No**			
3539 Business and related associate professionals n.e.c.	**139.39**	**117.09**	**No**			
354 Sales, Marketing and Related Associate Professionals						
3541 Buyers and procurement officers	**67.61**	**56.79**	**No**			
3542 Business sales executives	**138.69**	**116.50**	**No**			
3543 Marketing associate professionals	**161.31**	**135.50**	**No**			
3544 Estate agents and auctioneers	**54.64**	**45.90**	**No**			
3545 Sales accounts and business development managers	**443.13**	**372.23**	**No**			
3546 Conference and exhibition managers and organisers	**60.44**	**50.77**	**No**			
355 Conservation and Environmental associate professionals						
3550 Conservation and environmental associate professionals	**8.00**	**6.72**	**Yes**	**Active**	**Environment**	**Yes**
356 Public Services and Other Associate Professionals						
3561 Public services associate professionals	**104.52**	**87.79**	**Yes**	**Interested**	**Other professions**	**No**
3562 Human resources and industrial relations officers	**149.68**	**125.73**	**Yes**	**Interested**	**Other professions**	**No**
3563 Vocational and industrial trainers and instructors	**154.05**	**129.40**	**Yes**	**Interested**	**Education**	**Repeat**
3564 Careers advisers and vocational guidance specialists	**37.53**	**31.53**	**Yes**	**Interested**	**Welfare**	**Repeat**
3565 Inspectors of standards and regulations	**51.13**	**42.95**	**Yes**	**Interested**	**Other professions**	**No**
3567 Health and safety officers	**40.83**	**34.30**	**Yes**	**Interested**	**Other professions**	**Repeat**

4 ADMINISTRATIVE AND SECRETARIAL OCCUPATIONS

Standard Occupational Classification (SOC 2010):	UK Total in employment (000's)	England weighted (000's)	Public health	Engagement	Employment	Public Interactions
411 Administrative Occupations: Government and Related Organisations						
4112 National government administrative occupations	**222.75**	**187.11**	**Yes**	**Active**	**Admin & mgmt**	**No**
4113 Local government administrative occupations	**138.07**	**115.98**	**Yes**	**Active**	**Admin & mgmt**	**No**
4114 Officers of non-governmental organisations	**52.67**	**44.24**	**Yes**	**Active**	**Admin & mgmt**	**No**
412 Administrative Occupations: Finance						
4121 Credit controllers	**36.92**	**31.01**	**No**			
4122 Book-keepers, payroll managers and wages clerks	**426.55**	**358.31**	**No**			
4123 Bank and post office clerks	**124.06**	**104.21**	**No**			
4124 Finance officers	**41.27**	**34.67**	**No**			
4129 Financial administrative occupations n.e.c.	**163.56**	**137.39**	**No**			
413 Administrative Occupations: Records						
4131 Records clerks and assistants	**125.47**	**105.40**	**No**			
4132 Pensions and insurance clerks and assistants	**76.01**	**63.85**	**No**			
4133 Stock control clerks and assistants	**94.72**	**79.57**	**No**			
4134 Transport and distribution clerks and assistants	**62.43**	**52.44**	**No**			
4135 Library clerks and assistants	**26.65**	**22.38**	**Yes**	**Interested**	**Other professions**	**No**
4138 Human resources administrative occupations	**45.62**	**38.32**	**No**			
415 Other Administrative Occupations						
4151 Sales administrators	**65.33**	**54.87**	**No**			
4159 Other administrative occupations n.e.c.	**618.15**	**519.25**	**No**			
416 Administrative Occupations: Office Managers and Supervisors						
4161 Office managers	**153.54**	**128.98**	**Yes**	**Unengaged**	**Admin & mgmt**	**No**
4162 Office supervisors	**38.69**	**32.50**	**No**			
421 Secretarial and Related Occupations						
4211 Medical secretaries	**63.43**	**53.28**	**Yes**	**Interested**	**Health professionals**	**Repeat**
4212 Legal secretaries	**43.51**	**36.55**	**Yes**	**Interested**	**Other professions**	**Repeat**
4213 School secretaries	**62.49**	**52.49**	**Yes**	**Interested**	**Education**	**Repeat**
4214 Company secretaries	**43.18**	**36.27**	**Yes**	**Interested**	**Admin & mgmt**	**No**
4215 Personal assistants and other secretaries	**226.11**	**189.93**	**Yes**	**Interested**	**Admin & mgmt**	**No**
4216 Receptionists	**234.85**	**197.28**	**Yes**	**Interested**	**Admin & mgmt**	**Repeat**
4217 Typists and related keyboard occupations	**52.58**	**44.17**	**No**			
5 SKILLED TRADES OCCUPATIONS						
511 Agricultural and Related Trades						

Standard Occupational Classification (SOC 2010):	UK Total in employment (000's)	England weighted (000's)	Public health	Engagement	Employment	Public Interactions
5111 Farmers	**166.67**	**140.00**	**Yes**	**Interested**	**Environment**	**No**
5112 Horticultural trades	**14.85**	**12.47**	**Yes**	**Interested**	**Environment**	**No**
5113 Gardeners and landscape gardeners	**157.83**	**132.58**	**Yes**	**Interested**	**Environment**	**No**
5114 Groundsmen and greenkeepers	**25.91**	**21.76**	**Yes**	**Interested**	**Environment**	**No**
5119 Agricultural and fishing trades n.e.c.	**22.66**	**19.04**	**Yes**	**Interested**	**Environment**	**No**
521 Metal Forming, Welding and Related Trades						
5211 Smiths and forge workers	**6.36**	**5.34**	**No**			
5212 Moulders, core makers and die casters	**0.00**		**No**			
5213 Sheet metal workers	**12.99**	**10.91**	**No**			
5214 Metal plate workers, and riveters	**11.26**	**9.46**	**No**			
5215 Welding trades	**85.83**	**72.10**	**No**			
5216 Pipe fitters	**9.21**	**7.74**	**No**			
522 Metal Machining, Fitting and Instrument Making Trades						
5221 Metal machining setters and setter-operators	**49.86**	**41.88**	**No**			
5222 Tool makers, tool fitters and markers-out	**12.17**	**10.22**	**No**			
5223 Metal working production and maintenance fitters	**195.88**	**164.54**	**No**			
5224 Precision instrument makers and repairers	**23.03**	**19.35**	**No**			
5225 Air-conditioning and refrigeration engineers	**12.35**	**10.37**	**No**			
523 Vehicle Trades						
5231 Vehicle technicians, mechanics and electricians	**186.61**	**156.75**	**Yes**	**Unengaged**	**Retail trades**	**Repeat**
5232 Vehicle body builders and repairers	**31.51**	**26.47**	**No**			
5234 Vehicle paint technicians	**17.10**	**14.36**	**No**			
5235 Aircraft maintenance and related trades	**23.67**	**19.89**	**No**			
5236 Boat and ship builders and repairers	**11.60**	**9.74**	**No**			
5237 Rail and rolling stock builders and repairers	**12.04**	**10.12**	**No**			
524 Electrical and Electronic Trades						
5241 Electricians and electrical fitters	**248.50**	**208.74**	**Yes**	**Unengaged**	**Scientists & engineers**	**Yes**
5242 Telecommunications engineers	**53.65**	**45.07**	**Yes**	**Unengaged**	**Scientists & engineers**	**Yes**
5244 TV, video and audio engineers	**5.97**	**5.01**	**Yes**	**Unengaged**	**Scientists & engineers**	**Yes**
5245 IT engineers	**48.07**	**40.38**	**Yes**	**Unengaged**	**Scientists & engineers**	**No**
5249 Electrical and electronic trades n.e.c.	**78.11**	**65.61**	**Yes**	**Unengaged**	**Scientists & engineers**	**Yes**
525 Skilled Metal, Electrical and Electronic Trades Supervisors						
5250 Skilled metal, electrical and electronic trades supervisors	**38.22**	**32.11**	**No**			
531 Construction and Building Trades						

Standard Occupational Classification (SOC 2010):	UK Total in employment (000's)	England weighted (000's)	Public health	Engagement	Employment	Public Interactions
5311 Steel erectors	**13.96**	**11.72**	**No**			
5312 Bricklayers and masons	**68.85**	**57.83**	**No**			
5313 Roofers, roof tilers and slaters	**44.81**	**37.64**	**No**			
5314 Plumbers and heating and ventilating engineers	**178.12**	**149.62**	**No**			
5315 Carpenters and joiners	**244.30**	**205.21**	**No**			
5316 Glaziers, window fabricators and fitters	**41.02**	**34.46**	**No**			
5319 Construction and building trades n.e.c.	**240.49**	**202.01**	**No**			
532 Building Finishing Trades						
5321 Plasterers	**57.26**	**48.10**	**No**			
5322 Floorers and wall tilers	**24.96**	**20.97**	**No**			
5323 Painters and decorators	**126.05**	**105.88**	**No**			
533 Construction and Building Trades Supervisors						
5330 Construction and building trades supervisors	**59.68**	**50.13**	**No**			
541 Textiles and Garments Trades						
5411 Weavers and knitters	**4.96**	**4.17**	**No**			
5412 Upholsterers	**15.91**	**13.36**	**No**			
5413 Footwear and leather working trades	**7.53**	**6.32**	**No**			
5414 Tailors and dressmakers	**17.70**	**14.87**	**No**			
5419 Textiles, garments and related trades n.e.c.	**8.66**	**7.27**	**No**			
542 Printing Trades						
5421 Pre-press technicians	**10.52**	**8.84**	**No**			
5422 Printers	**30.19**	**25.36**	**No**			
5423 Print finishing and binding workers	**17.60**	**14.79**	**No**			
543 Food Preparation and Hospitality Trades						
5431 Butchers	**25.09**	**21.07**	**Yes**	**Active**	**Retail trades**	**Yes**
5432 Bakers and flour confectioners	**39.66**	**33.31**	**Yes**	**Active**	**Retail trades**	**Yes**
5433 Fishmongers and poultry dressers	**11.18**	**9.39**	**Yes**	**Active**	**Retail trades**	**Yes**
5434 Chefs	**228.87**	**192.25**	**Yes**	**Active**	**Hospitality**	**No**
5435 Cooks	**101.25**	**85.05**	**Yes**	**Active**	**Hospitality**	**No**
5436 Catering and bar managers	**59.27**	**49.79**	**Yes**	**Active**	**Hospitality**	**Yes**
544 Other Skilled Trades						
5441 Glass and ceramics makers, decorators and finishers	**11.49**	**9.65**	**No**			
5442 Furniture makers and other craft woodworkers	**30.85**	**25.91**	**No**			
5443 Florists	**9.01**	**7.57**	**No**			

Standard Occupational Classification (SOC 2010):	UK Total in employment (000's)	England weighted (000's)	Public health	Engagement	Employment	Public Interactions
5449 Other skilled trades n.e.c.	**48.09**	**40.39**	**No**			
6 CARING, LEISURE AND OTHER SERVICE OCCUPATIONS						
612 Childcare and Related Personal Services						
6121 Nursery nurses and assistants	**174.02**	**146.18**	**Yes**	**Active**	**Health professionals**	**Repeat**
6122 Childminders and related occupations	**128.73**	**108.13**	**Yes**	**Active**	**Welfare**	**Repeat**
6123 Play workers	**34.19**	**28.72**	**Yes**	**Active**	**Welfare**	**Repeat**
6125 Teaching assistants	**355.78**	**298.86**	**Yes**	**Active**	**Education**	**Repeat**
6126 Educational support assistants	**135.89**	**114.14**	**Yes**	**Active**	**Education**	**Repeat**
613 Animal Care and Control Services						
6131 Veterinary nurses	**15.20**	**12.77**	**Yes**	**Interested**	**Environment**	**Repeat**
6132 Pest control officers	**8.08**	**6.79**	**Yes**	**Interested**	**Environment**	**Yes**
6139 Animal care services occupations n.e.c.	**63.94**	**53.71**	**Yes**	**Interested**	**Environment**	**Repeat**
614 Caring Personal Services						
6141 Nursing auxiliaries and assistants	**300.20**	**252.17**	**Yes**	**Active**	**Health professionals**	**Repeat**
6142 Ambulance staff (excluding paramedics)	**20.61**	**17.31**	**Yes**	**Active**	**Health professionals**	**Yes**
6143 Dental nurses	**52.89**	**44.43**	**Yes**	**Active**	**Health professionals**	**Repeat**
6144 Houseparents and residential wardens	**39.93**	**33.54**	**Yes**	**Active**	**Welfare**	**Repeat**
6145 Care workers and home carers	**792.00**	**665.28**	**Yes**	**Active**	**Welfare**	**Repeat**
6146 Senior care workers	**71.86**	**60.36**	**Yes**	**Active**	**Welfare**	**Repeat**
6147 Care escorts	**16.32**	**13.71**	**Yes**	**Active**	**Welfare**	**Repeat**
6148 Undertakers, mortuary and crematorium assistants	**15.34**	**12.88**	**No**			
621 Leisure and Travel Services						
6211 Sports and leisure assistants	**57.96**	**48.69**	**Yes**	**Interested**	**Sports & fitness**	**Repeat**
6212 Travel agents	**32.33**	**27.16**	**No**			
6214 Air travel assistants	**39.88**	**33.50**	**Yes**	**Interested**	**Transport**	**Yes**
6215 Rail travel assistants	**12.91**	**10.84**	**Yes**	**Interested**	**Transport**	**Yes**
6219 Leisure and travel service occupations n.e.c.	**33.12**	**27.82**	**Yes**	**Interested**	**Retail trades**	**Yes**
622 Hairdressers and Related Services						
6221 Hairdressers and barbers	**170.96**	**143.60**	**Yes**	**Interested**	**Retail trades**	**Repeat**
6222 Beauticians and related occupations	**93.13**	**78.23**	**Yes**	**Interested**	**Retail trades**	**Repeat**
623 Housekeeping and Related Services						
6231 Housekeepers and related occupations	**42.12**	**35.38**	**Yes**	**Interested**	**Retail trades**	**Repeat**
6232 Caretakers	**60.22**	**50.58**	**Yes**	**Interested**	**Hospitality**	**No**

Standard Occupational Classification (SOC 2010):	UK Total in employment (000's)	England weighted (000's)	Public health	Engagement	Employment	Public Interactions
624 Cleaning and Housekeeping Managers and Supervisors						
6240 Cleaning and housekeeping managers and supervisors	**64.48**	**54.17**	**Yes**	**Interested**	**Hospitality**	**No**
7 SALES AND CUSTOMER SERVICE OCCUPATIONS						
711 Sales Assistants and Retail Cashiers						
7111 Sales and retail assistants	**1,102.49**	**926.09**	**Yes**	**Unengaged**	**Retail trades**	**Yes**
7112 Retail cashiers and check-out operators	**223.28**	**187.56**	**Yes**	**Unengaged**	**Retail trades**	**Yes**
7113 Telephone salespersons	**36.34**	**30.53**	**No**			
7114 Pharmacy and other dispensing assistants	**65.91**	**55.37**	**Yes**	**Unengaged**	**Health professionals**	**Repeat**
7115 Vehicle and parts salespersons and advisers	**32.63**	**27.41**	**No**			
712 Sales Related Occupations						
7121 Collector salespersons and credit agents	**23.98**	**20.14**	**No**			
7122 Debt, rent and other cash collectors	**20.17**	**16.94**	**No**			
7123 Roundspersons and van salespersons	**14.03**	**11.79**	**No**			
7124 Market and street traders and assistants	**23.24**	**19.52**	**Yes**	**Interested**	**Retail trades**	**Yes**
7125 Merchandisers and window dressers	**27.01**	**22.69**	**No**			
7129 Sales related occupations n.e.c.	**68.40**	**57.45**	**No**			
713 Sales Supervisors						
7130 Sales supervisors	**194.16**	**163.09**	**No**			
721 Customer Service Occupations						
7211 Call and contact centre occupations	**113.57**	**95.39**	**Yes**	**Unengaged**	**Retail trades**	**Yes**
7213 Telephonists	**16.15**	**13.57**	**No**			
7214 Communication operators	**30.26**	**25.42**	**No**			
7215 Market research interviewers	**15.54**	**13.05**	**No**			
7219 Customer service occupations n.e.c.	**229.78**	**193.01**	**Yes**	**Unengaged**	**Retail trades**	**Yes**
722 Customer Service Managers and Supervisors						
7220 Customer service managers and supervisors	**131.07**	**110.10**	**Yes**	**Unengaged**	**Retail trades**	**Yes**
8 PROCESS, PLANT AND MACHINE OPERATIVES						
811 Process Operatives						
8111 Food, drink and tobacco process operatives	**134.80**	**113.23**	**No**			
8112 Glass and ceramics process operatives	**10.89**	**9.15**	**No**			
8113 Textile process operatives	**12.24**	**10.28**	**No**			
8114 Chemical and related process operatives	**38.15**	**32.05**	**No**			

Standard Occupational Classification (SOC 2010):	UK Total in employment (000's)	England weighted (000's)	Public health	Engagement	Employment	Public Interactions
8115 Rubber process operatives	**4.95**	**4.16**	**No**			
8116 Plastics process operatives	**32.29**	**27.12**	**No**			
8117 Metal making and treating process operatives	**12.10**	**10.16**	**No**			
8118 Electroplaters	**0.00**		**No**			
8119 Process operatives n.e.c.	**20.64**	**17.34**	**No**			
812 Plant and Machine Operatives						
8121 Paper and wood machine operatives	**29.39**	**24.68**	**No**			
8122 Coal mine operatives	**0.00**		**No**			
8123 Quarry workers and related operatives	**9.32**	**7.83**	**No**			
8124 Energy plant operatives	**9.65**	**8.11**	**No**			
8125 Metal working machine operatives	**47.21**	**39.65**	**No**			
8126 Water and sewerage plant operatives	**7.57**	**6.36**	**No**			
8127 Printing machine assistants	**11.87**	**9.97**	**No**			
8129 Plant and machine operatives n.e.c.	**39.29**	**33.00**	**No**			
813 Assemblers and Routine Operatives						
8131 Assemblers (electrical and electronic products)	**28.31**	**23.78**	**No**			
8132 Assemblers (vehicles and metal goods)	**44.19**	**37.12**	**No**			
8133 Routine inspectors and testers	**78.53**	**65.97**	**No**			
8134 Weighers, graders and sorters	**18.98**	**15.94**	**No**			
8135 Tyre, exhaust and windscreen fitters	**17.93**	**15.06**	**Yes**	**Unengaged**	**Retail trades**	**Yes**
8137 Sewing machinists	**31.98**	**26.87**	**No**			
8139 Assemblers and routine operatives n.e.c.	**40.65**	**34.14**	**No**			
814 Construction Operatives						
8141 Scaffolders, stagers and riggers	**31.86**	**26.76**	**No**			
8142 Road construction operatives	**23.38**	**19.64**	**No**			
8143 Rail construction and maintenance operatives	**9.06**	**7.61**	**No**			
8149 Construction operatives n.e.c.	**89.92**	**75.53**	**No**			
821 Road Transport Drivers						
8211 Large goods vehicle drivers	**285.33**	**239.67**	**No**			
8212 Van drivers	**200.73**	**168.61**	**No**			
8213 Bus and coach drivers	**99.50**	**83.58**	**Yes**	**Interested**	**Transport**	**Yes**
8214 Taxi and cab drivers and chauffeurs	**199.45**	**167.54**	**Yes**	**Interested**	**Transport**	**Yes**
8215 Driving instructors	**42.12**	**35.38**	**Yes**	**Interested**	**Transport**	**Repeat**
822 Mobile Machine Drivers and Operatives						

Standard Occupational Classification (SOC 2010):	UK Total in employment (000's)	England weighted (000's)	Public health	Engagement	Employment	Public Interactions
8221 Crane drivers	**8.01**	**6.73**	**No**			
8222 Fork-lift truck drivers	**104.51**	**87.79**	**No**			
8223 Agricultural machinery drivers	**7.95**	**6.68**	**No**			
8229 Mobile machine drivers and operatives n.e.c.	**50.76**	**42.64**	**No**			
823 Other Drivers and Transport Operatives						
8231 Train and tram drivers	**18.01**	**15.13**	**No**			
8232 Marine and waterways transport operatives	**6.79**	**5.71**	**No**			
8233 Air transport operatives	**16.95**	**14.24**	**No**			
8234 Rail transport operatives	**15.39**	**12.92**	**No**			
8239 Other drivers and transport operatives n.e.c.	**20.92**	**17.58**	**No**			
9 ELEMENTARY OCCUPATIONS						
911 Elementary Agricultural Occupations						
9111 Farm workers	**68.16**	**57.26**	**No**			
9112 Forestry workers	**10.18**	**8.55**	**No**			
9119 Fishing and other elementary agriculture occupations n.e.c.	**26.59**	**22.33**	**No**			
912 Elementary Construction Occupations						
9120 Elementary construction occupations	**168.26**	**141.34**	**No**			
913 Elementary Process Plant Occupations						
9132 Industrial cleaning process occupations	**36.22**	**30.42**	**No**			
9134 Packers, bottlers, canners and fillers	**152.24**	**127.88**	**No**			
9139 Elementary process plant occupations n.e.c.	**80.30**	**67.45**	**No**			
921 Elementary Administration Occupations						
9211 Postal workers, mail sorters, messengers and couriers	**172.70**	**145.07**	**Yes**	**Unengaged**	**Other professions**	**Yes**
9219 Elementary administration occupations n.e.c.	**42.35**	**35.58**	**Yes**	**Unengaged**	**Admin & mgmt**	**No**
923 Elementary Cleaning Occupations						
9231 Window cleaners	**47.30**	**39.73**	**Yes**	**Interested**	**Environment**	**No**
9232 Street cleaners	**12.14**	**10.20**	**Yes**	**Interested**	**Environment**	**No**
9233 Cleaners and domestics	**600.46**	**504.39**	**Yes**	**Interested**	**Environment**	**Repeat**
9234 Launderers, dry cleaners and pressers	**31.05**	**26.08**	**Yes**	**Interested**	**Retail trades**	**Yes**
9235 Refuse and salvage occupations	**33.68**	**28.29**	**Yes**	**Interested**	**Environment**	**No**
9236 Vehicle valeters and cleaners	**27.17**	**22.82**	**Yes**	**Interested**	**Retail trades**	**No**
9239 Elementary cleaning occupations n.e.c.	**8.64**	**7.26**	**Yes**	**Interested**	**Environment**	**No**
924 Elementary Security Occupations						

Standard Occupational Classification (SOC 2010):	UK Total in employment (000's)	England weighted (000's)	Public health	Engagement	Employment	Public Interactions
9241 Security guards and related occupations	**174.24**	**146.36**	**No**			
9242 Parking and civil enforcement occupations	**21.58**	**18.13**	**Yes**	**Interested**	**Other professions**	**Yes**
9244 School midday and crossing patrol occupations	**87.59**	**73.57**	**Yes**	**Interested**	**Education**	**Repeat**
9249 Elementary security occupations n.e.c.	**27.42**	**23.03**	**No**			
925 Elementary Sales Occupations						
9251 Shelf fillers	**79.11**	**66.45**	**No**			
9259 Elementary sales occupations n.e.c.	**22.96**	**19.28**	**No**			
926 Elementary Storage Occupations						
9260 Elementary storage occupations	**417.87**	**351.01**	**No**			
927 Other Elementary Services Occupations						
9271 Hospital porters	**24.89**	**20.91**	**Yes**	**Interested**	**Health professionals**	**Yes**
9272 Kitchen and catering assistants	**449.08**	**377.23**	**Yes**	**Interested**	**Hospitality**	**No**
9273 Waiters and waitresses	**249.42**	**209.51**	**Yes**	**Interested**	**Hospitality**	**Yes**
9274 Bar staff	**204.74**	**171.98**	**Yes**	**Interested**	**Hospitality**	**Yes**
9275 Leisure and theme park attendants	**28.20**	**23.69**	**Yes**	**Interested**	**Hospitality**	**Yes**
9279 Other elementary services occupations n.e.c.	**35,292.00**	**29,645.28**	**No**			

Source: CfWI / PSPH / PHE analysis of ONS LFS 2010

Annex B: Case studies

The table below summarises the case study material received from the call for evidence, where it can be analysed against the column headers shown. The CfWI and RSPH would like to thank all those who contributed.

Organisation(s)	Project	Drivers for change	PHOF/Marmot/NHS targets	Proposed/actual impact	Training/development needs
Community-based projects					
Redbridge Council for Voluntary Services (commissioned by Redbridge Council)	Fit for Fun - community-based physical activity project.	Active people survey found that a large proportion of the population in Redbridge were leading sedentary lifestyles.	Percentage of physically active/inactive adults, rates of obesity/overweight, life/healthy life expectancy, preventable mortality.	Evaluation has shown increased activity levels in participants. The success of the project has led to funding being secured for the roll out of the project in a neighbouring London borough.	Training around programme governance, such as equality and diversity and safeguarding.
Bury Council, funded through Sport England (National Lottery)	I Will If You Will - movement designed to increase activity levels of women and girls in Bury by overcoming the many physical and emotional barriers to exercise	Data highlighted low activity levels amongst the local female population.	Percentage of physically active/inactive adults, rates of obesity/overweight, life/healthy life expectancy, preventable mortality.	Increased awareness of the programme (in Sept 2014, 68% of borough were aware of IWIYW) and increased activity levels of participants (number of females taking part in regular activity increased by 2500).	Training around how to recruit/retain people

Organisation(s)	Project	Drivers for change	PHOF/Marmot/NHS targets	Proposed/actual impact	Training/development needs
Medway Council Public Health	A Better Medway Champions - a programme and network of health champions providing brief advice and signposting.	Recognised that awareness of local services was not sufficient amongst the wider workforce	Life expectancy/gap in life expectancy, smoking prevalence, preventable mortality rates, percentage of physically active/inactive adults, overweight/obesity rates among others	Evaluation has found increased understanding of health improvement and increased signposting.	Need for training to increase general understanding of health improvement.
Coventry City Council	Coventry on the Move - supporting people in community settings to introduce initiatives to encourage more active lifestyles amongst the public	Physical activity was recognised as a major issue for Coventry.	Percentage of physically active/inactive adults, rates of obesity/overweight, life/healthy life expectancy, preventable mortality.	Robust evaluation yet to be carried out.	Understanding of social mobilisation techniques
Employment and/or housing service providers					
Ipswich Borough Council, in partnership with Suffolk County Council	Engaging vulnerable groups and deprived communities - development and delivery of a training and support package for frontline advisors in employment and housing services.	Recognition of the connection between health and securing and retaining employment and sustainable tenancy. Local data highlighting that they are reaching many people with mental health issues, but housing/employment services have little contact with mental health services.	Percentage of people with mental health issues in stable accommodation and employment. Suicide rate statistics.	Thus far there has been a high level of enthusiasm and commitment, with continued growth of integrated working.	Training to increase knowledge around health issues and linking these back to the work of employment/housing and the situation in Ipswich.

Organisation(s)	Project	Drivers for change	PHOF/Marmot/NHS targets	Proposed/actual impact	Training/development needs
Kemble Housing (KH), part of WM Housing	Kemble Health Hub - support offered to all residents across Hertfordshire through, for example, group/ community activities, one-to-one sessions or group taster sessions.	Recognition of the connection between housing and health. Alongside this, a recognition that KH has the potential to positively impact public health as KH is in contact with those most in need and often has built a trusting relationship with its clients	Life expectancy/gap in life expectancy, smoking prevalence, preventable mortality rates, percentage of physically active/inactive adults, overweight/obesity rates, social isolation statistics among others	The project so far has engaged with the most deprived groups, who suffer disproportionately from poor health outcomes.	Training to increase understanding of the issues and connection to housing
Sandwell Metropolitan Borough Council	Health Wellbeing and Housing Group – set up to support the ongoing process of integrating public health back into the council by bringing together services and agencies.	This group was set up to support the transition of public health back to the local authority and realise the clear opportunities for integration.	Life expectancy/gap in life expectancy, preventable mortality rates among others	Emerging sense of shared ownership and initiatives that would not previously have happened.	Need to increase understanding of health as everybody's business - awareness around social determinants and potential for other services to impact health
Environmental Health, London Borough of Tower Hamlets	Private rented sector housing conditions project – develop a referral system to environmental health and raise awareness of the issues amongst both professionals and tenants.	Recognition of connection between health and housing	Percentage of people with mental health issues or disabilities living in appropriate housing, life expectancy/gap in life expectancy, preventable mortality rates among others	Project is ongoing – yet to be evaluated.	Identified gap in how to refer and understanding of what services are available

Organisation(s)	Project	Drivers for change	PHOF/Marmot/NHS targets	Proposed/actual impact	Training/development needs
Emergency services					
Greater Manchester Fire and Rescue Service (GMFRS)	Salford Integrated Prevention Service - partnership between GMFRS, Greater Manchester Police and Salford City Council. Each hub will provide a range of integrated multi-agency intervention addressing the complex needs of the most vulnerable people in Salford.	A lack of cooperation recognised between the local agencies working with 11-25 year olds and their families in the 'complex dependency' cohort.	Number of those not in employment, education or training (NEETs), number of first time entrants to the criminal justice system, reoffending rates among others	Anticipated impact includes: • Reduced demand on fire, justice and police services • Improved interoperability of emergency and youth services • Better outcomes for young people, their families	Training gap analysis yet to be completed.
GMFRS working in partnership with Pennine Care NHS Foundation Trust (PCFT)	Mental Health and Substance Use - partnership involving the creation of a steering group, reciprocal training and reciprocal referral pathways.	Recognition of the importance of working together to more effectively meet the aims of both organisations. Those at greatest risk of fire are more likely to be service users known to the Pennine Care NHS Foundation Trust.	Number of preventable deaths	Not yet properly evaluated, but so far there has been the development of referral pathways and increased understanding and awareness of the issues. Over the longer term, intended outcomes include - increased referrals and reduction in fire injuries and deaths in PCFT premises.	Training needed to increase understanding of the connection between these two areas of work.

Organisation(s)	Project	Drivers for change	PHOF/Marmot/NHS targets	Proposed/actual impact	Training/development needs
GMFRS	Fire and Falls Prevention - through joint working, fire crews and falls teams are able to identify those at risk of falls and/or fire and refer them to the appropriate services.	Data showing prevalence of falls and the value of prevention. Recognition of the potential for the fire service to have a real impact in this area due to their visits to homes of the elderly.	Injuries due to falls, preventable mortality rates	Significant increase in referrals from the fire service to falls service. Between September 2014 and January 2015, GMFRS delivered 602 home safety checks, 37% of which were identified as at risk of falls and 52% of these had their details passed to the falls prevention service.	The fire and falls prevention programme is now being rolled out to the ten boroughs of Greater Manchester.
GMFRS in partnership with North West Ambulance Service, Greater Manchester Police and Greater Manchester Local Authorities	Community Risk Intervention Teams - reducing the demand for emergency services by providing a holistic risk reduction service in areas such as fire, falls, and carbon monoxide among others in the homes of those most at risk.	Driven by a desire to improve quality of life outcomes, whilst reducing impact on services and realising financial benefits for all partners.	Number of first time entrants to the criminal justice system, reoffending rates among others, injuries due to falls, preventable mortality rates	A number of indicators of success, including - reduction in the impact of falls on services, improved referral pathways and information sharing.	Not yet identified
Royal Berkshire Fire & Rescue Service	Making Every Contact Count pilot - firefighters trained to deliver the '3 As' (ask, advise, assist) as part of routine home fire safety checks to vulnerable older people in their homes	Prevention is a key priority and it was recognised that the service can contribute to other areas such as public health through their routine work	Smoking prevalence, premature mortality rates	Increased knowledge and small increase in confidence to deliver the '3 As'	Training to increase understanding of public health issues and local context - needed to not create extra work

Organisation(s)	Project	Drivers for change	PHOF/Marmot/NHS targets	Proposed/actual impact	Training/development needs
West Midlands Fire Service	Aurora youth development programme - 10 to 12 month programme with ongoing support provided throughout.	Part of wider Birmingham Agreement with all key partners organisations to work together to support an improvement in social inclusion and disadvantage in targeted communities and neighbourhoods in the city	Reoffending rates, first time entrants to the criminal justice system, number of NEETs among others	Positive outcomes for those who attended - all students who completed the course ceased offending, 4 attended full time sixth form and 4 attended mainstream school full time.	Continuing professional development is vital
Local authority whole-system approach					
Wigan Council	Transition of PH team from NHS	Agreed that following the transition of public health to local authority the new model should be based on the Marmot vision with public health at the heart of system-wide transformation	Life/healthy life expectancy, premature mortality	Improvements in public health outcomes in Wigan have accelerated since the transition - partly attributed to the whole-system approach.	Bespoke training needed to help make public health messages real for individuals and organisations.
Portsmouth City Council	Building a Healthy City series of seminars	Recognition of the importance of taking a whole-system approach.	Life/healthy life expectancy, premature mortality	Increased understanding between departments of each other's agendas, improved relationships and information sharing.	To ensure appropriate knowledge, greater opportunities could be provided for, for example, work shadowing and cross directorate health impact assessments.

Organisation(s)	Project	Drivers for change	PHOF/Marmot/NHS targets	Proposed/actual impact	Training/development needs
Schooling/Education					
Medway Council Public Health Directorate	PSHE secondary schools project - providing training and support to school staff to improve the quality of PSHE provision in secondary schools across Medway.	Cuts in funding/support for teenage pregnancy services. Consequently, public health had to look at cost-effective alternatives, enabling a universal approach and utilising the wider workforce.	Under 18 conceptions, statistics in other health issues such as smoking prevalence in 15 year olds	This has not yet been properly evaluated, but so far there is better understanding of the issues. Also, this approach has reached a wider audience than previously and in a more cost-effective manner.	General understanding of public health issues/ services available, emerging issues for young people and also building confidence
Talking Mats (a social enterprise whose vision is to improve the lives of people with communication difficulties)	Talking Mats and WHO International classification of functional disability and health - children & youth version. A framework to help adolescents to set individual education plan targets	Wanted young people to be more involved in making decisions that affect their lives		Pupils reflected positively on being involved and were motivated to achieve their goals	Training needed in the following areas; understanding the holistic model, principles in consulting children/young people, communication style and using wellbeing model to focus on outcomes.
University of Southampton	Initial teacher education health and wellbeing curriculum for trainee teachers	Teachers were identified as a key influence on students' health and wellbeing, but a survey found large gaps in health and wellbeing training.	Statistics on various health issues, such as smoking prevalence in 15 year olds, overweight and obesity rates, physical activity rates	Raised awareness and increased knowledge	Developing the knowledge, skills and confidence to teach topics such as sex and relationships, drugs and alcohol education.

Organisation(s)	Project	Drivers for change	PHOF/Marmot/NHS targets	Proposed/actual impact	Training/development needs
Stoke on Trent City Council in partnership with Staffordshire and Stoke-on-Trent Partnership NHS Trust	Stoke Speaks Out - multi agency preventative approach to tackling high incidence of speech and language difficulties faced by children in Stoke on Trent	Local research identified high levels of children entering school with delayed speech and language.	School readiness data	By 2010 the incidence of SLCN on entry in school had reduced by 39%. Since the reduction in funding this has slightly increased but the numbers are still 20% improved since 2002.	Lack of confidence and skills in attachment and communication knowledge.
Acute care settings					
Heart of England NHS Foundation Trust	Eat...Drink...Move...! - Development of a mobility bundle to promote increased mobilisation in acute hospital setting.	Recognition of the link between greater mobility and recovery	Preventable mortality rates	Academic study found that for two wards using the intervention patients had increased mobility, halved incidence of pneumonia and were more likely to have a hospital stay in the shortest quartile.	On the job training is important for hospital staff who cannot leave their wards
Barts Health NHS Trust	Cancer Transitions - 6 week programme for people who have finished their acute cancer treatment and are in remission.	Recognised gap in service provision		The programme received positive feedback from participants and the evaluation found that it promoted changes in lifestyle, particularly around physical activity and dietary habits	Need for training around motivational interviewing, exercise prescription and health coaching.

Organisation(s)	Project	Drivers for change	PHOF/Marmot/NHS targets	Proposed/actual impact	Training/development needs
Integration of health and social care					
Health Education Wessex and South Eastern Hants CCG	Action on Community Education and Training – collaborative project between health and social care commissioners, providers and local higher education institutes.	Driven by the aim to better meet the needs of patients through integrated care systems	Preventable mortality rates	Evaluation is ongoing.	To build awareness of frailty and long term conditions in the carer population, of services available and of knowledge of political context/integrated care agendas
Environmental influences on health					
Sandwell Metropolitan Borough Council	Improving air quality in Sandwell	Recognised issue with high pollution - whole borough declared an Air Quality Management Area in 2005	Fraction of mortality attributable to particulate air pollution	Has drawn attention to the issues and provided robust evidence to shape any planned interventions	Practical issues such as use of IT programmes and understanding outputs.
College of Occupational Therapists	Living well through activity in care homes: the toolkit	Evidence of benefits of increased occupation in care homes		Widely recognised and endorsed by partner organisations.	Training required around helping staff to fully understand their role and responsibilities in enabling residents to engage in daily activities.

Organisation(s)	Project	Drivers for change	PHOF/Marmot/NHS targets	Proposed/actual impact	Training/development needs
Community Pharmacy					
Thames Valley Local Pharmaceutical Committee Network	Health Education in Local Pharmacies	Recognition of potential of pharmacists to positively impact public health in areas such as dementia, raising awareness of the issues faced by carers and improving patient outcomes.	Premature mortality, life/healthy life expectancy, smoking prevalence, obesity/ overweight rate	Good numbers have attended training - for example, 205 members of staff have gained the health champion qualification and 304 pharmacists have attended leadership training/consultation skills or medicine optimisation training.	Leadership skills for team leaders and confidence/ communication skills/technical knowledge for team members.
Workplace					
County Sports Partnership Network	Workplace Challenge	Recognition that the workplace offers a unique opportunity to reach inactive people		Increased participation in sport and activity levels. Aims of the project include having 2000 workplaces take part in the workplace challenge and 5000 previously inactive employees achieving 1 x 30 min per week participation in sport.	Training in promotion of workplace health, business engagement and behaviour change

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The CfWI produces quality intelligence to inform better workforce planning that improves people's lives

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