

Untapped Resources:

**Accredited Registers in
the Wider Workforce**



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Foreword from Harry Cayton and Shirley Cramer

The public health challenges facing the UK today are deep-seated and varied. If we are to continue to make progress on such health priorities as obesity and smoking, we must embrace all opportunities to improve and protect the public's health, and embed healthy lifestyles within communities. With thousands of interactions with members of the public every day, the accredited registers practitioners represent a section of the health workforce we can ill afford to ignore.

The accredited registers workforce, currently nearing 80,000 strong nationwide, comprises a wide variety of healthcare practices, the majority of which share the common feature of being based on a trusted relationship between client and practitioner. Thanks to this, in combination with the regular, extended contact hours that accredited registers practitioners typically offer, they are ideally placed to raise lifestyle health issues with their clients, and ultimately enable them to lead healthier lives.

There are many examples throughout the accredited registers workforce where practitioners are already supporting the public's health, but they can always be supported to do more. It is a vital network through which we can support behaviour change and ultimately improve the public's health: whether it is signposting people to smoking cessation services or offering brief lifestyle advice on healthy eating, accredited registers practitioners are undoubtedly an unsung and instrumental part of the wider public health workforce.



Shirley Cramer CBE
Chief Executive
Royal Society for Public Health



Harry Cayton CBE
Chief Executive,
Professional Standards Authority

Executive Summary

There are nearly 80,000 healthcare professionals on accredited registers in the UK, representing a huge workforce with potential to make a significant contribution to promoting and protecting the public's health. In order to better understand their role in this regard, the Royal Society for Public Health (RSPH) and the Professional Standards Authority (the Authority) have undertaken a joint project to uncover the ways that accredited registers (AR) occupations are already supporting the public's health, and explore the factors that may be hampering their further utilisation.

The project included a survey completed by over 4,500 members of accredited registers, along with a series of focus groups and one-to-one interviews to explore the views and experiences of the workforce in more detail. A public opinion poll with a nationally representative 2,000-strong sample investigated how members of the public interact with and perceive the AR workforce.

Because AR practitioners typically focus on holistic health, build trusted relationships with their patients, and have comparatively long treatment sessions, they are ideally placed to deliver brief interventions and effective signposting. A positive finding was that many practitioners on accredited registers are already engaging in a variety of public-health-promoting practices, with nine in 10 (89%) considering "promoting the public's health" to be at least "somewhat part of [their] role". Despite this, three quarters of AR practitioners feel that they are under-utilised in promoting the public's health. While it is encouraging that around half of survey respondents expressed an interest in having a greater role in promoting the public's health, they also identified several ways in which their capacity to do so is being hindered, for example:

- **Difficulty in staying up to date with the full range of services to which they can signpost their patients.**
- **Concerns about how to initiate healthy conversations without making the patient feel uncomfortable, and jeopardising their opportunity to treat effectively.**
- **Public's capacity to access the AR workforce being limited in several ways. This was perceived to be driven by two main factors: a lack of awareness of the AR workforce among other healthcare professionals, and the financial obstacle many people face to privately funding their own healthcare.**

Over the course of the focus groups, interviews, and survey, a number of different solutions were proposed by AR practitioners, as ways of working towards overcoming some of the barriers.

These include:

- **Creating a regularly updated list of services bringing all local signposting information together, maintained and disseminated to AR practitioners through public health teams.**
- **Introducing a standardised health assessment tool to be introduced in appropriate occupations. This could help identify unaddressed lifestyle health issues, and provide an opportunity to raise matters sensitively.**
- **Employers to put in place benefit schemes for their staff, either subsidising access to the services of an AR occupation, or providing in-house specialists, such as counsellors.**
- **AR practitioners to have more authority to make direct NHS referrals, in appropriate cases, thereby reducing the administrative burden on GP surgeries.**

1: Introduction

Background: the hidden wider public health workforce

The public health challenges our nation faces today remain deep rooted and severe. Over six in 10 adults in the UK are overweight or obese¹ and, though smoking rates are in decline, we still expect around 96,000 tobacco-related deaths every year.² Moreover, many of our most persistent health problems, obesity and smoking included, exemplify the stark health inequalities that characterise modern Britain. In the most deprived areas of the UK, people can now expect to live 20 fewer years of their lives in “good health”, compared with the least deprived areas.³

Improving the public’s health is going to be critical in reducing the burden on our welfare and healthcare system, and the importance of this is rightly recognised in the NHS Five Year Forward View.⁴ A key part of how we will achieve this is to embed healthy lifestyles throughout communities, making public health ‘everybody’s business’.

Research from the Centre for Workforce Intelligence estimated that in England around 40,000 people are part of the core public health workforce, but that is less than 0.07% of the population. It would be a mistake to think that this workforce by itself can tackle the deeply embedded public health challenges facing our nation.

In *Rethinking the Public Health Workforce*, RSPH described the contribution that wider health and care professionals can make to tackling these public health challenges.⁵ There is now increasing recognition of such a “wider public health workforce”, whose primary role is not public health focused, but nevertheless can champion and support the public’s health and wellbeing through their day to day contact with the public.

The accredited registers (AR) workforce, numbering almost 80,000 nationwide, is ideally placed to play an integral role in this wider workforce, thanks to the thousands of interactions they have with members of the public every day. This report shows how AR practitioners are contributing to many public health priorities, uncovers some of the barriers which exist around the workforce doing more to support the public health, and provides some suggested recommendations aimed at unleashing their full potential.¹

About the accredited registers (AR) workforce:

Practitioners on accredited registers span a diverse range of occupations, including in public, mental, and physical health. They include nutritional therapists, play therapists, sports rehabilitators, counsellors and psychotherapists, foot health practitioners, acupuncturists, and a variety of complementary therapists.

They are registered to professional organisations that are not regulated by law, but are independently assessed by the Professional Standards Authority instead. AR practitioners are not obliged to go on an accredited register, but having done so they benefit from a quality mark signifying their commitment to high standards, and being part of a professional community.

¹ In this context, the UK Public Health Register (UKPHR) is an anomalous case. Its registrants are members of the core public health workforce, and therefore cannot be considered as part of the wider workforce.

In total, there are 79,585 practitioners on accredited registers across the UK, working in the following areas:

AR practitioners tend to see their patients and clients regularly, and typically for extended sessions of at least 40 minutes. Their services are predominantly accessed privately, funded by the patient, representing an access problem to those with lower incomes. Nevertheless, with approximately one in four of the general UK population accessing the services of AR practitioners at some point, this workforce has huge potential to support the public's health at a significant scale.

Talking therapies	49,549
Complementary therapies	20,680
Healthcare science	3,034
Play therapies	2,106
Foot health	1,622
Public health	885
Sports rehabilitation	731
Nonsurgical cosmetic interventions	666
Healthcare chaplaincy	312

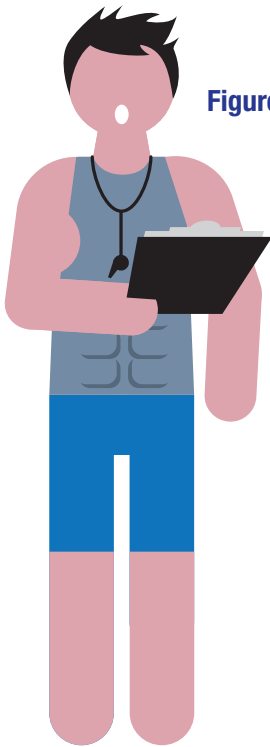
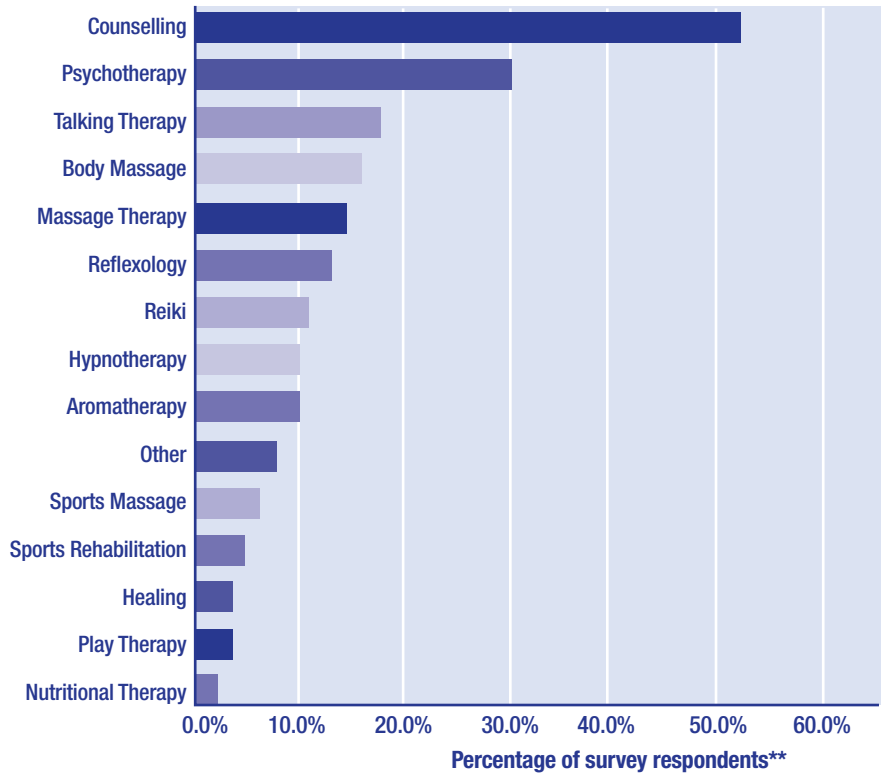


Figure 1: The 15 most common occupations among respondents to accredited registers workforce survey*

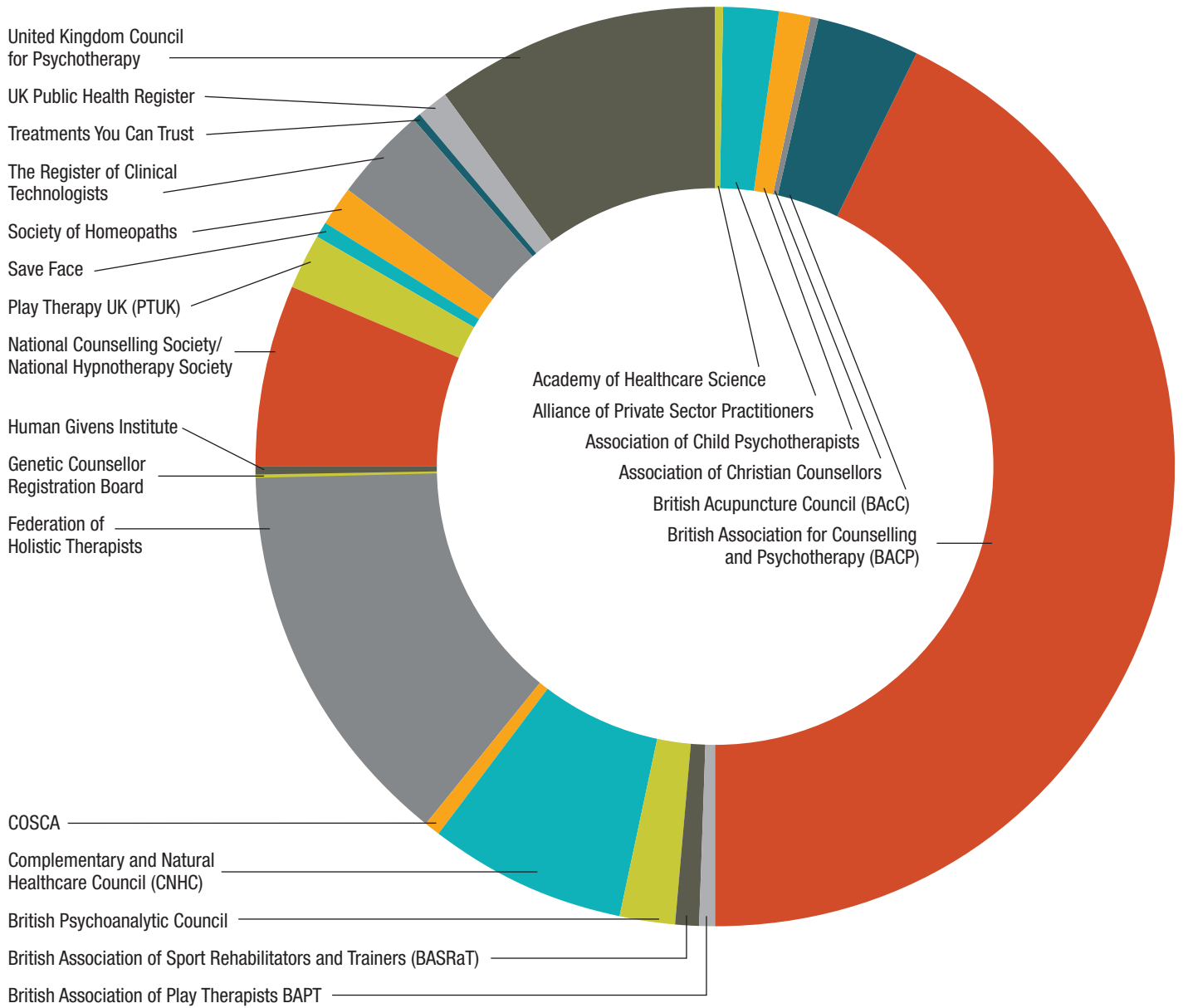


*RSPH survey data n=4,508

**Practitioners may have more than one occupational area



Figure 2: Accredited Registers Workforce by register



* There are 79,585 practitioners in total; sector sizes on the chart are proportionate to the number in each register.

2: How can practitioners on accredited registers support the public's health?

In the Authority's 2015 report on the Accredited Registers, improving public health and preventing illness was cited as a key way in which the AR workforce can contribute to health policy objectives.⁶ Some of the disciplines practised within the AR workforce directly engage with key public health priorities, such as the role of nutritional therapists in addressing obesity in the UK. However, this report is primarily concerned with the wider ways in which health can be promoted by AR practitioners.

The AR workforce is in contact with members of the public thousands of times every day, and on each occasion there is scope to pick up on possible signs of lifestyle health issues, taking steps to support their associated health needs. These interactions may include a very brief intervention, such as a 'healthy conversation' between an AR practitioner and their client or patient. This occurs during a typical appointment, but may be entirely separate from the main treatment for which the client has chosen to use their service.

Some of the AR occupations are already undertaking work in this area in the form of 'healthy conversations', health check tests and signposting; through this project we will seek to explore the opportunities and barriers to further utilisation.

What is a healthy conversation?

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



“Practitioners registered with CNHC support public health by encouraging their clients to make a range of lifestyle changes. These include improvements to diet and nutrition, support with giving up smoking and losing weight, support with reducing stress, improving sleep, managing pain and other symptoms, as well as overall enhancements to wellbeing. All CNHC registrants are committed to enhancing the UK public's health and wellbeing.”

The Complementary and Natural
Healthcare Council (CNHC)

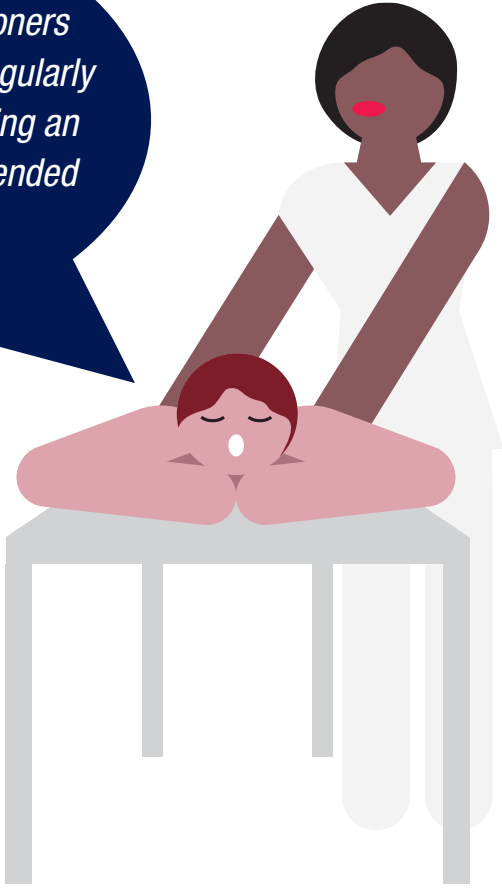
Healthy conversations between patients and clinicians have several elements to them:

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

Making Every Contact Count (MECC) is a widely recognised training programme and approach for increasing healthy conversations within health and care services. The MECC premise was based on the need to recognise the huge potential of the wider workforce to promote healthier lifestyles, instead of relying on public health professionals. The aim is for every interaction healthcare services have with the public to be taken as an opportunity to promote healthy lifestyle choices and signpost to relevant healthcare services. The informality and flexibility of MECC was seen as its strength, and is based on the principle of ‘support from next door’ rather than ‘advice from on high’.

A key feature of AR practitioners is that they typically see patients and clients on multiple and regular occasions, and often for relatively long sessions of 40 minutes or more. According to MECC guidance, this provides excellent opportunities for an ‘extended brief intervention’.

“A key feature of AR practitioners is that they see their clients regularly and for long sessions, providing an excellent opportunity for ‘extended brief interventions’.”



3: Methodology

In order to better understand the role of the AR workforce in supporting the public's health, RSPH and the Authority have undertaken a joint project to uncover the ways that AR occupations are already contributing to this aim, and explore the factors that may be hampering their further utilisation. We wanted to obtain the views of as many AR practitioners as possible, from across the range of AR occupations, as well as getting a perspective from members of the public.

Our methodology was a pragmatic approach, rather than a rigorous scientific study, to obtain a snapshot of the current perspectives within and towards the AR workforce. There were three strands to this research: a survey of AR practitioners, focus groups and interviews involving AR practitioners, and a public poll.

Survey

An online survey was promoted to all AR practitioners between 1 September 2016 - 17 October 2016, and was circulated through RSPH and the Authority's distribution channels, as well as through the accredited registers. The survey asked questions aimed at understanding the types of health promotion work that AR practitioners are already undertaking, as well as looking for potential areas for further development, and any challenges being faced in achieving this. It asked about the range of different lifestyle issues as well as what factors may assist these practitioners in undertaking healthy conversations with patients. This resulted in 4,508 responses, giving a sample that accounted for 6% of the entire AR workforce, and is representative of the wide range of occupations. A breakdown of the responses by occupation, both in the sample and in the population, is given in the appendix.

Focus groups and one to one interviews

Survey respondents were asked whether they would be happy to participate in focus groups at the end of the survey. Those who agreed were contacted and invited to register for one of our focus groups. Three focus groups of between five and eight participants each were held by teleconference to ensure access from AR practitioners across the country. The focus groups were intended to glean more detail on the views of the AR workforce on the following areas which were highlighted as important in the survey:

- **Relationship an AR practitioner has with their patients**
- **Relationships with and perceptions from other parts of the health service**
- **Signposting**
- **Training needs**

Three interviews were also held with members of accredited registers, to ensure the views of the broad range of occupations were captured, and to provide short case studies exemplifying some of the issues already raised in the survey and focus groups.

Notes were taken during the focus groups and interviews, and from these the key themes and concerns were consolidated. The number of focus groups and interviews was determined by data saturation point, plus a coverage of sufficient occupations to obtain a broad overview of the AR workforce, not limited to most common occupations only.

Public polling

To complement this work, a national online public poll was commissioned from Populus. This was conducted between 21-24 April 2017 and had 2,062 respondents (the survey was conducted across the UK and the results have been weighted to the profile of all adults). Respondents were asked about the following and given a range of response options. Full questions are included in the appendix.

- **If you've not accessed the services of an AR healthcare practitioner before, what are the main reasons for this?**
- **If an AR healthcare practitioner spoke to you about a lifestyle health issue relevant to your wellbeing (e.g. smoking, alcohol, exercise, diet), how would you respond?**
- **What, if anything, would make you more positive about having a conversation about lifestyle health advice with an AR healthcare practitioner?**

Limitations

Though the survey attracted a large number of responses from all the accredited registers, it may be that many of these are from the AR practitioners with the keenest interest in furthering the role of their occupation in supporting the public's health. The results therefore need to be treated with caution. Nevertheless, we believe this report gives a useful and much needed insight into the role of the AR workforce, and highlights both the opportunities and challenges for them to become more widely utilised.

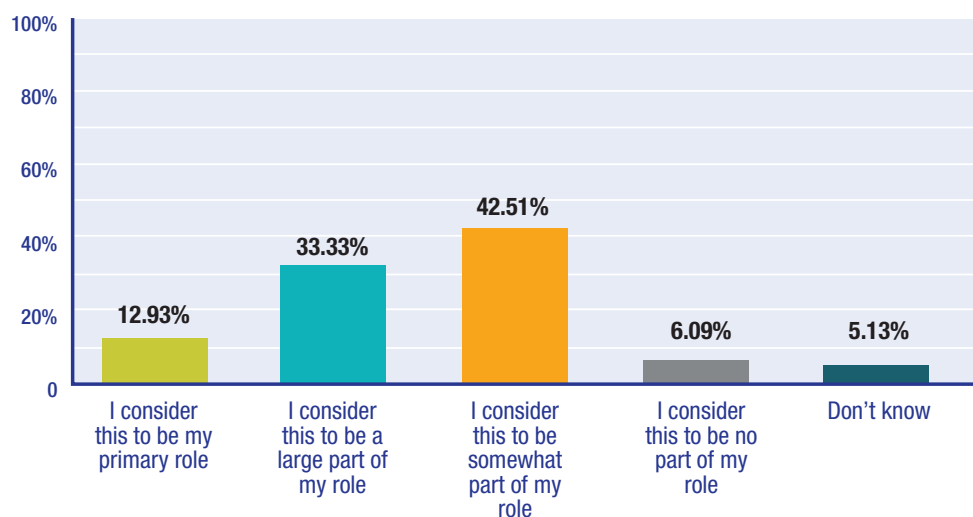


4: Results

A key feature of the findings was that many practitioners on accredited registers already do engage in practice that promotes the public's health. This was reflected at all stages of the research including the survey, which showed that nine in 10 (89%) consider "promoting the public's health" to be at least "somewhat part of [their] role".

Figure 3: To what extent, do you consider 'promoting the public's health' to be part of your role?

n=4,152



4.1: A natural fit

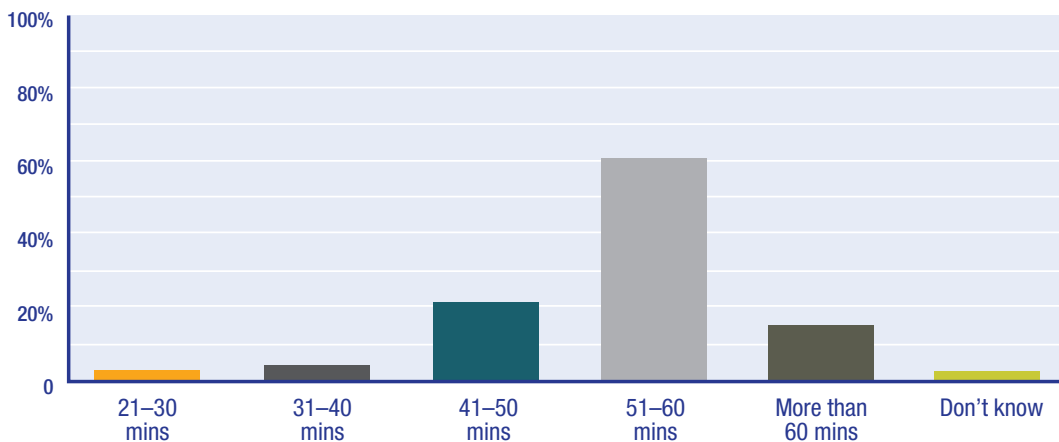
Though the AR workforce is highly diverse, it became clear throughout the focus groups and interviews that many occupations share some characteristics, which make them generally well placed to support the public's health.

Firstly, a common feature among participants was that AR practitioners will often look at a whole host of health problems, and not just the ones directly related to the issue which the individual has come to discuss. There was consensus among all focus groups that because of this focus on holistic health, AR practitioners are naturally well placed for effective signposting. This is consistent with the findings of a 2015 RSPH and PHE report (Healthy Conversations and the Allied Health Professionals), in which healthcare professionals who reported feeling more confident at conducting healthy conversations were the same ones who were more practised at taking a holistic view of an individual's health.⁷

Another benefit highlighted was that in much of the AR workforce, comparatively long sessions are typical, with 94% of practitioners averaging over 40 minutes per appointment. The engagement that AR practitioners enjoy means they can offer breadth and depth of health support over a period of time. Individuals are made to feel they have an ‘open door’ to come back, and indeed many AR practitioners will typically have a series of successive appointments with their patients, instead of a one-off. Because of this, they are able to develop an intimate and private setting, in which nothing is off limits. As a result of this environment – where patients can talk about the issues they perhaps aren’t happy to discuss elsewhere – there are opportunities to identify lifestyle health issues that would otherwise stay hidden. The public reinforced this, with almost one in three (32%) stating they would feel more positive having a conversation about lifestyle health issues if they had privacy in the appointment. Focus group participants agreed that this was an important reason why appointments with AR practitioners are such suitable settings for brief interventions.

Figure 4: On average, how long are your appointments with a client/patient?

n=4,187



“There’s a degree of anxiety for someone coming into the room for the first time and I have to help them to feel relaxed and comfortable straight away. This candid conversation creates a perfect opportunity for the individual to talk freely about any behaviours or thoughts that are creating barriers to their health and wellbeing. Another major benefit of providing complementary therapy in a private setting is that I am far less restricted by time than NHS healthcare providers, which gives me the space to help them to think about their self-care in new and empowering ways.”

Angela Beasor, Naturopath

Figure 6 gives some illustrative examples of the ways in which some of the key AR occupations can and already do have healthy conversations, further promoting the wellbeing of their patients through signposts or referrals to appropriate services.

Figure 5 shows a number of brief interventions and healthy conversations that AR practitioners undertake, and what proportion of the workforce are currently doing so. In the majority of cases, AR practitioners are not being commissioned to provide these services.

Figure 5: Which of the following activities do you currently undertake with your clients/patients?

n=4,074

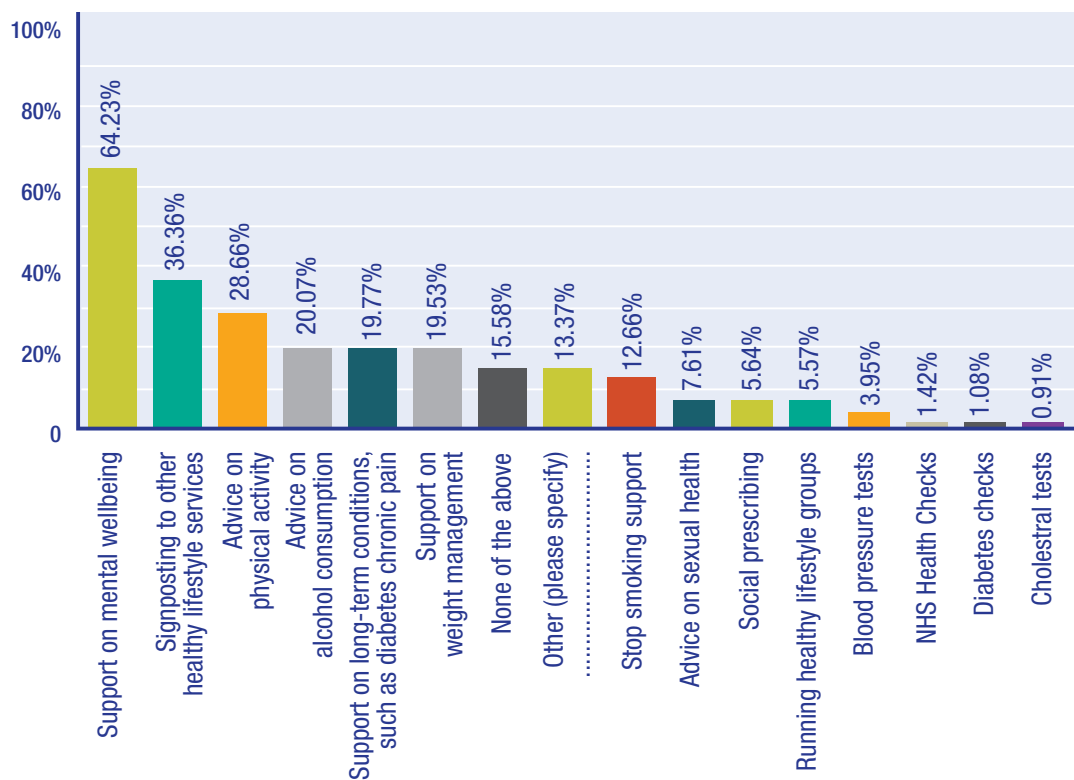
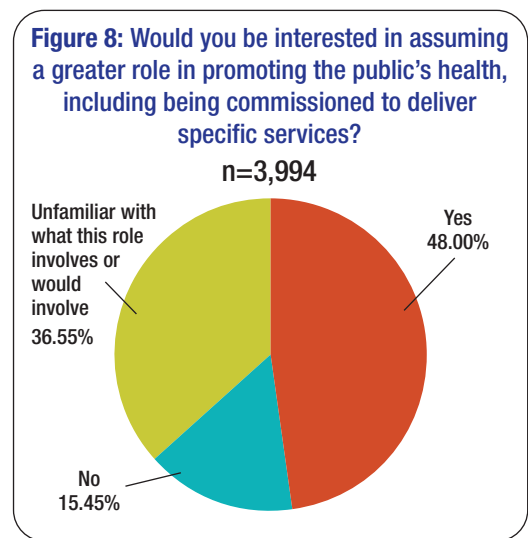
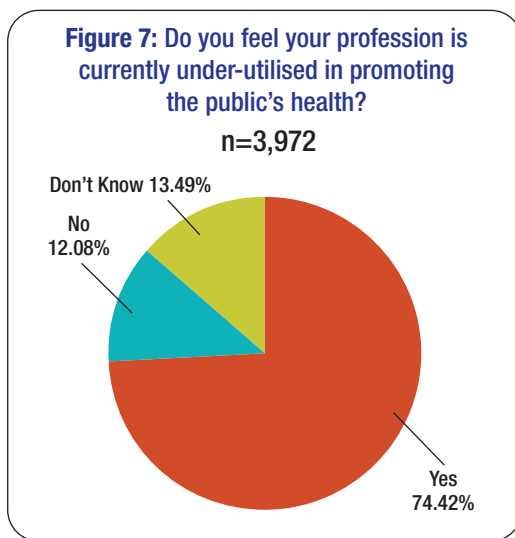


Figure 6:

AR OCCUPATION	HEALTH ISSUE	SIGNPOST/ REFERRAL
Counsellor/other talking therapist	<i>Clients seeking help for bereavement may be at increased risk of falls</i>	Falls prevention
	<i>For those suffering with depression, healthy exercise and diet may be factors in aiding recovery</i>	Social media – running groups/ group communities based on health/ leisure centre outdoor gym
	<i>The practitioner may become aware that a client is using alcohol or drugs to cope with their mental health issue</i>	Alcohol/ substance abuse treatment services
	<i>Where a client seeks help with an eating disorder, information on healthy eating and diet may be useful</i>	Nutritional therapists, nutritionists, and dietitians.
Nutritional therapist	<i>Smoking can lead to type 2 diabetes, which may lead many to seek help of nutritional therapists</i>	Stop smoking services
Foot health practitioner/ reflexologist	<i>Smoking can lead to Peripheral Arterial Disease (PAD), or other foot health issues</i>	Stop smoking services
	<i>Foot health issues can lead to medical, complications such as diabetic ulcers</i>	Podiatrists
	<i>Seeing an elderly client on a regular basis the practitioner may become aware that the client has developed dementia</i>	Dementia care services
Play therapist	<i>Some children undertaking play therapy may be doing so because they have speech and language difficulties</i>	Speech and language therapist
Sports rehabilitator	<i>Service users seeking help for a knee injury may also be overweight</i>	Weight loss programmes /group communities based on health/leisure centre/outdoor gym
Non-surgical cosmetic practitioner	<i>May see clients who are smokers wishing to have lip fillers. Smoking can cause the lines around the mouth to be more pronounced</i>	Stop smoking services
Massage therapist	<i>During treatment the therapist may notice an injury which is causing mobility issues</i>	Physiotherapist, sports rehabilitator

Notwithstanding the range of activities already undertaken by members of the AR workforce, as many as three quarters feel that they are under-utilised in promoting the public's health, as shown in figure 7. This should be cause for concern, given the breadth and depth of skills that exist within the AR workforce. Encouragingly, however, there is much appetite among the occupations for actions to be taken which would allow them to contribute more, with one in two interested in having a greater role in promoting the public's health (figure 8). This report looks to set out and clarify the ways in which AR practitioners can assume this greater role, as well as exploring the barriers to doing so.



4.2: Barriers experienced by accredited registers practitioners

Though there is much enthusiasm among the AR workforce to do more to support the public's health, they also identified several challenges to doing this in practice.

Across the different research stages, these concerns could be grouped into three themes:

ACCESS

There are several factors limiting the extent to which members of the public are able or likely to interact with AR practitioners.

SIGNPOSTING

AR practitioners do not always have access to accurate, up to date information about local services that would be available to their clients.

CONTEXT

How comfortable the AR practitioner feels initiating healthy conversations, especially about issues not directly related to the reason for seeing the client.

Here we explore these obstacles, and in section 5 suggest some solutions.

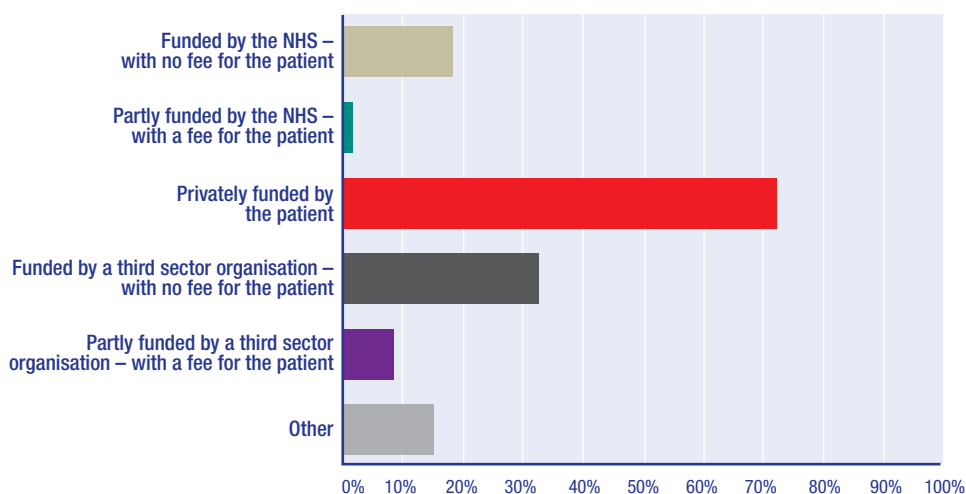
ACCESS

Public Access

When asked what factors contribute to the under-utilisation of their occupation in promoting the public's health, the most commonly stated reason – given by 72% of participants – was a lack of public funding available for the types of services available from the AR workforce.

Figure 9: Choosing from the options below, how are the costs of your services covered?

n=4,331



Since public funding for AR occupations is very limited, much of the workforce is funded on a private basis, with 72% of respondents indicating their services are paid for by their clients. This figure is as high as 97% for practitioners registered to the Complementary & Natural Healthcare Council (CNHC, one of the larger registers), according to their survey data.⁸ As such, many people on lower incomes are effectively excluded from the services offered by the AR workforce, along with any of the associated health and wellbeing benefits: an example of the income-based health inequality that exists in the UK.

Public polling revealed the extent of the access problem at hand, with only one in ten believing they have ever accessed the services of an AR practitioner. Of those who have not done so, many either were unaware of the available services (38%) or haven't had health problems which would benefit from their services (36%). After these, the most common reason for not seeing AR practitioners was a reluctance or inability to privately fund healthcare (23%).

Awareness across the healthcare system

Another reason for this access problem, cited by 68% of survey participants, is a lack of awareness and understanding amongst other healthcare professionals. Many felt that this is the root factor in explaining why more pharmacists, for example, are not signposting to AR practitioners, and why they face such difficulties in securing referrals from GPs.

The AR workforce can support their clients both through the direct professional service they provide, but also indirectly each practitioner enjoys a relationship with their patient/client which could be capitalised on. Nutritional therapists, for example, support an individual's lifestyle health with advice about diet and through the ordinary practice of their discipline. In addition, they can initiate healthy conversations and other brief interventions with their patients/clients. Given that 80% of NHS spending on diabetes goes to managing avoidable complications, the public health case for greater prevalence of these practices is strong.⁹

“Too often Nutritional Therapists are the last port of call for members of the public, when they could be the first. Whilst doctors are becoming aware of the growing evidence base that supports nutritional therapy, they lack the knowledge of how the actual ‘process’ works, and without formal backing by their governing bodies, the NHS and CCGs, they are not inclined to go out on a limb and offer it as an optional, adjunctive therapy.”

Eleanor Strang, Nutritional Therapist

“Local GPs in my area who would like to refer Musculoskeletal patients to me due to my experience and knowledge state they cannot, as they are guided to send patients to the overcrowded and stretched NHS Physiotherapy Departments. This means I can only receive private clients who can afford to pay, meaning those from lower socio-economic backgrounds may never receive the health benefits from my services.”

Mike Murphy, Graduate of Sports Rehabilitation



Given the large number of people with an interest in seeing practitioners who are not statutorily regulated health professionals, it is clearly beneficial to ensure that as many as possible are directed to those practitioners who are on accredited registers (and are therefore assured for safety and quality of care). These registers are individually assessed by the Authority, the organisation that also oversees the statutory professional health and social care regulators. It is therefore a positive step that GMC Delegation and referral guidance¹⁰ now states that GPs can refer to any practitioner on an accredited register.ⁱⁱ However, many in the AR workforce report that this is not widely understood by GPs, representing a further barrier to the ability of AR practitioners to play a role in supporting the public's health.

SIGNPOSTING

The AR workforce regularly signpost their clients and patients to a number of other services depending on their needs. This includes such wide ranging services as GPs, local drug and alcohol treatment services, social services, domestic abuse charities, or even groups on social media that could be helpful. However, one recurring theme that emerged through the focus groups and interviews was that AR practitioners are not always aware of all the services to which they could signpost.

Many AR practitioners reported that keeping up to date with an ever changing environment, as well as the latest lifestyle health advice, can be challenging. Locally relevant healthy lifestyle services will differ from area to area, and in quality of service, but such information is not readily available to most AR practitioners. As such, AR practitioners are sometimes unable to effectively signpost, as they either cannot be confident of doing so in the right direction, or simply haven't been made aware of the service which would be appropriate for their patient.

This represents a host of missed opportunities for individuals who access AR practitioners' services to improve their health and wellbeing. There is therefore a need for AR practitioners to have systematic ways of keeping abreast of lifestyle health services that are available to their patients at the local level.



ⁱⁱ GMC Delegation and referral guidance now states that GPs should use accredited registers to assure the safety and quality of care provided when referring to non-statutorily regulated healthcare professionals.

CONTEXT

Many AR practitioners voiced concern about how they might approach raising a lifestyle health issue in a conversation with their patient or client, and how to avoid patients feeling probed. They stressed that it is important for such brief interventions to be client-led, and not to become artificial interactions.

As part of a patient-led approach, the conversation topics raised should be relevant and sensitive to the needs of the individual, and this will depend on the type of therapy the individual is receiving. Play therapists, for example, often work with troubled children, some of whom may have mental health issues, and it may be detrimental to raise certain issues which aren't directly related to the issue at hand. In cases like these, it may be better to avoid the risk of jeopardising an important relationship that has been established with the individual. The importance of keeping conversations relevant to the patient was backed up by the public polling. When the public were asked what factors would make them feel more positive about receiving lifestyle health advice in this way, 30% said "if it was related to a condition [they] had come to see the AR practitioner about".

The public polling further underlined the importance of the AR practitioner's role in making the patient or client feel comfortable having conversations about lifestyle health issues. The most popular reasons given by the public for feeling positive about having a healthy conversation were if the healthcare professional has a non-judgmental approach (41%), and if they are relaxed and not rushing the consultation (40%).

"Before I can work with my clients I need to develop a therapeutic relationship that works towards helping the young person to value, love and respect themselves so that they want to take responsibility and better care of themselves. My experience is that 'pushing any agenda' that is not the client's own usually results in resistance and at worst non-attendance."

Debbie Chapel, Play Therapist



The polling also provided reassurance that large parts of the AR workforce are well placed to provide such brief interventions. For example, when the public were asked how they would respond to counsellors and psychotherapists raising a lifestyle health issue with them, the two most common responses were that they would welcome the conversation (29%), and would trust the advice given to them (29%). Significantly, almost one in four (23%) stated that the conversation would prompt them to either take or consider taking action.



Nevertheless, it is clear that given the complex and individual needs of each patient, and the diverse range of AR disciplines, the practitioner's ability to make a judgement call as to when and how to raise a particular subject is fundamental.



5: Supporting Accredited Registers Practitioners to further promote the public's health

Over the course of the focus groups, interviews, and survey, a number of different solutions were proposed by AR practitioners, as ways of working towards overcoming some of the barriers explored in the previous section.

5.1: Mitigating access barriers

Employers to consider ways of easing employees' financial barriers to accessing the AR workforce

Many of the challenges identified by AR practitioners were, at root, problems of ensuring the accessibility of their services to the public. One important aspect of this was overcoming the financial barrier, since in the majority of cases AR practitioners are only able to receive clients privately, meaning the public are less likely to use their services, with those from lower socio-economic groups at a particular disadvantage.

Although this will likely remain a challenge, one way of addressing it could involve employers helping to make it easier for their employees to access the services of AR practitioners, as part of their health and wellbeing strategy. Many employers already incorporate such health promoting aspects in their employee benefit schemes: the cycle-to-work scheme, for example, is now highly popular and successful across the country. Many workplaces provide subsidised gym memberships to their employees, and others provide subsidised or even in-house counselling services. While schemes like these are beneficial for the health of many, there are also many employees who could greatly benefit from increased access to the services of AR practitioners. If employers were to, through their employee benefit schemes, remove or reduce some of the financial barriers to accessing the AR workforce, it could pave the way for more employees to access services which they would otherwise not have the opportunity to receive.

Nevertheless, such schemes cannot provide a complete solution, not least because many of those who stand to benefit from the services of AR practitioners may, for a variety of reasons, not be in employment. The AR workforce are generally very aware of this issue, and there are many examples of groups of practitioners setting up enterprising schemes which increase access to their services among low income groups, either through means-testing their services or sometimes even offering them pro-bono. One example is the All Wales Play Therapy Support Group, a group of practitioners registered with the British Association of Play Therapists, who have looked at a number of ways to help families who need financial support to access play therapy.¹¹ These include setting up a not-for-profit which funds therapy, and signposting families to charities who are already funding therapy. Overall, practitioners are acutely aware of how UK health inequalities are compounded by problems with the accessibility of the AR workforce, and are very open to entering discussions around how to make their services more available to all.

AR practitioners to be able to refer directly to NHS healthcare professionals

Another important way to improve the public's access to the healthcare they need is through extending the referral options available to AR practitioners. By providing a referral pathway from AR practitioners to other healthcare professionals, patients would no longer be forced to make time-consuming GP visits just to secure the referrals they need.

For example, a foot health practitioner may see a patient who has a risk of developing diabetic ulcers, and could therefore be referred to a podiatrist. However, foot health practitioners are at present unable to write NHS referrals directly to podiatrists. They can write a private referral, but if the patient's podiatry treatment is to be NHS funded the AR practitioner must signpost the patient to their GP, who then makes the referral. For many referral cases this extra step in the process unnecessarily increases the administrative and financial burden on GP services, and could be short-circuited. If instead AR practitioners could bypass the GP, and directly refer to other relevant healthcare professionals, it would give their patients a simpler route to accessing the NHS funded services they require, at the same time as reducing the strain on GP services.

5.2: Health screening

Registers to consider introducing a health assessment tool

A key theme that emerged from the research was that across the AR workforce there is a great deal of variation in the extent to which individuals are screened for current health issues in their first appointment. Many AR practitioners reported that they undertake quite an in-depth health check, whereas others stated they did minimal or no health screening. Notably, this inconsistency was identifiable within occupation groups, as well as between them. It was suggested that a standardised health assessment questionnaire could be a positive step in some occupations.

When the public were asked what would make them feel more positive about receiving lifestyle health advice from an AR practitioner, one in four said "if [they] had completed a health assessment questionnaire at the beginning of the appointment".

Some AR practitioners said they felt a health assessment form may prove too invasive an intervention, and could risk undermining the trust that they need to build with their patients. To this end, some felt that they would not always be comfortable asking patients to complete such a form, and emphasised the need to respect patients' desire for privacy with regards to their health issues. Nevertheless, participants generally agreed that the idea of a health screening sheet, developed as a standard tool to be used by all practitioners on a particular accredited register, is one that could be developed. The health screening process should be broadly standardised across the workforce; however, given the large variety of constraints faced by practitioners in different occupations, it would be beneficial for the different registers to build in elements that are specific to the needs of their discipline as well.



Another area for improvement identified by the AR practitioners in our research was the two-way relationship between primary care and the AR workforce. Many felt they faced great difficulty in securing referrals from GPs toward their services, and that this was therefore contributing to their under-utilisation as a public health promoting workforce.

In May 2016, the Authority launched the "Let's Work Together" campaign, intended to work towards better collaboration between registers and those working in primary care settings. This involves recognising the great resource available in the AR workforce, and the need to find new ways to relieve the pressure on NHS services. Accredited Registers offer a way for GPs to provide patients with a more holistic service, either by referral or signposting patients toward them – a point made by the General Medical Council (GMC) in their Delegation and referral guide on Good Medical Practice.¹⁰

This practice could prove beneficial in two ways. First, many AR practitioners expressed that they would sometimes feel uncomfortable raising a lifestyle health issue with a patient, especially when that issue is not directly related to the primary reason for the session. If the patient has completed a brief, non-obligatory health assessment questionnaire, their answers could provide the rationale for a healthy conversation on the relevant topic in a natural fashion. This is supported by the views of the public, of whom one in four say they would feel more positive receiving lifestyle health advice with an AR practitioner if they had completed a health assessment questionnaire at the beginning of the appointment. The questionnaire could give the AR practitioner the opportunity to raise the issue without fear of sounding insensitive, or appearing to probe for details against the patients' wishes. This is the role of a "cue" in a healthy conversation – a hook which makes it easier for the practitioner to raise a subject. If as a result healthcare practitioners are able to identify issues that would not otherwise be picked up, they can then offer brief advice, make referrals, or signpost to other appropriate services.

A secondary benefit would be that if there were a standardised procedure of recording interactions across one AR occupation, they would be able to produce records of the public health impact of their service. They could then better position the occupation as an important part of the public health workforce, both in the eyes of commissioners and the wider health service.

Measuring Public Health Impact – *Everyday Interactions*

The findings in this report clearly highlight that many AR healthcare practitioners are already working to improve the health of individuals beyond that which would be expected from their primary work role. However, being able to record this practice, and the impact it is having on public health, is useful on many levels. For the AR practitioners themselves, it highlights the worth of the work they are doing and provides encouragement to continue to invest time and energy in public health. It is also a clear way to demonstrate to commissioners the public health value of services. In *Everyday Interactions*,¹² a recent report in partnership with PHE, RSPH have set out a toolkit which seeks to provide a quick, straightforward and easy way for healthcare professionals (HCPs) to record and measure their public health impact in a uniform and comparable way. Though the toolkit was developed with certain HCPs in mind (allied health professionals, dentists, nurses & midwives, and pharmacists), much of it is also applicable to those working in AR occupations.

The toolkit involves ten different 'impact pathways', all focusing on measuring an HCP's impact on a different public health priority, such as obesity, dementia, alcohol, and smoking. The key benefit of this toolkit to AR practitioners is that it provides a framework for ensuring all opportunities to improve the health of patients and clients are taken. Furthermore, following this framework provides the basis for the AR workforce to evidence the hard work they put in, and their success in promoting the public's health.

5.3: Improvements to signposting

Public health teams to maintain and disseminate a regularly updated list of services bringing all local signposting information together

One of the areas of concern put forward by many of the AR practitioners was that they are not always fully aware of the range of services available to which they could signpost their patients or clients. Keeping up to date with ever-changing types of organisations they can signpost to was flagged as a challenge for participants, especially given the local variation of such services, and the need to provide for clients from different areas.

A regularly updated list of local services was suggested as one way of bringing all local signposting information together, so that AR practitioners can use it as a resource to make the process as streamlined and effective as possible for their clients. This could work through Directors of Public Health and their public health teams maintaining the list, ensuring that all services were of a high standard, and overseeing its effective dissemination to healthcare professionals across the area. Such resources could be hosted on the websites for the local public health teams, with responsibility for maintaining the list lying with the Directors of Public Health.

It was reported that resources of this type have been available in some localities before, and there may be current examples as well. However, in order to maximise impact, there should be systems in place to make sure the resource is rolled out to all localities, so that the benefits extend to all AR practitioners and members of the public.

“In Oxfordshire, it used to be the responsibility of Locality Coordinators to keep all child practitioners up-to-date regarding the local services available for children and families. This led to the really useful development of a county wide database service directory that we could all access. Practically, in the consulting room I would use the directory to inform students and signpost them to services outside of the school that could help them. At the time this made for an effective signposting system, but a database is only useful if the data is up-to-date and relevant.”

Debbie Chapel, Play Therapist

5.4: Training

Training was identified by participants as a means of equipping AR practitioners with a better understanding of undertaking a brief intervention or healthy conversation in a non-judgmental, non-clinical, patient-centred, and relevant way. Over 50% of survey participants stated they were willing to undertake further training to be part of the wider public health workforce, including the RSPH level 2 award in Understanding Health Improvement. Although it is clear that many AR practitioners are already well-equipped to perform their role as part of the wider public health workforce, it is encouraging that there is appetite to contribute more.

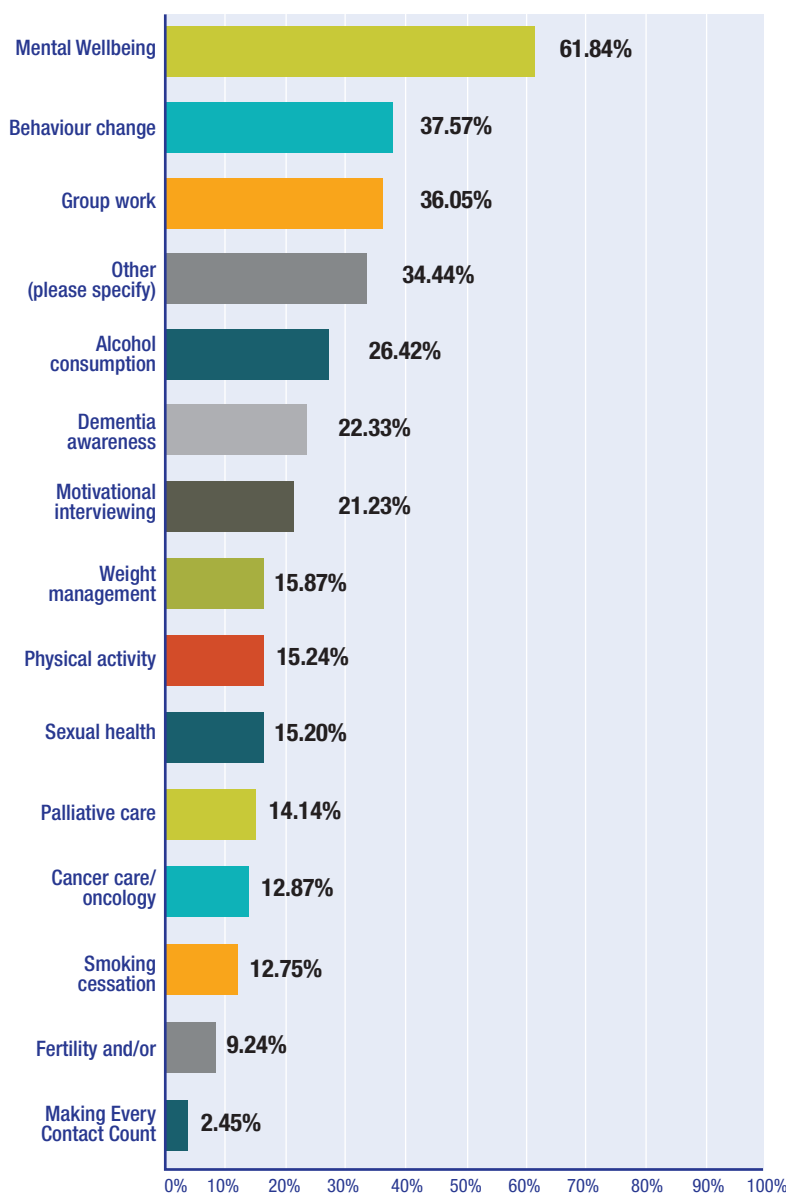
There is a broad range of CPD training available for AR practitioners, including NHS and local authority training, and the RSPH Level 2 Award in Improving the Public's Health. With regards to training styles and formats, many survey participants were positive about receiving training through e-learning (70%), as well as through traditional face-to-face training (77%), while other formats such as video (29%) and webinar (39%) were less popular.

This finding was echoed in the focus groups: participants generally agreed that e-learning was a highly effective means of information transferral, but acknowledged the need for an experiential element in training, and therefore that face-to-face training was vital as well. It was pointed out that since these training styles have independent merits, the usefulness of either will depend greatly on the professional occupation for whom the training is taking place.

Findings from the survey also indicated that many AR practitioners are widely skilled, having undertaken training in a large number of areas other than the training needed to qualify in their own profession. This is demonstrated in figure 10, and illustrates just how well positioned the AR workforce is to provide holistic care to patients.

Figure 10: Other than the qualifications and training undertaken to qualify in your profession in which of the following areas have you undertaken additional training?

n=2,369



Many participants in the focus groups raised the possibility of further education and training for *other healthcare professions*, as well as Clinical Commissioning Groups. This was suggested for pharmacists and for GPs in particular, who it was thought could do a better job of directing people to AR practitioners when appropriate.

It was emphasised how important it was for these groups to become more aware of the benefits that the AR workforce can offer, and how they can be referred to, as part of the strategy to address public health priorities. Participants argued this is important because in many cases members of the public are not aware of what they could gain by seeing an AR practitioner, and this can be addressed by first increasing awareness within the wider medical professions.

6: Conclusion

Practitioners on accredited registers make a large contribution to promoting the public's health, and this report has drawn out some of the many ways they encourage and promote healthy behaviour and lifestyles in the UK. It is a key principle of the wider public health workforce that every contact between a professional and a member of the public can and should be capitalised upon in any number of ways to support their health and wellbeing. Despite this, it is clear that the large majority of AR practitioners consider themselves to be under-utilised in promoting the public's health.

Meeting the challenges outlined in this report will require the best practice in brief interventions, such as healthy conversations and accurate signposting advice, to be embedded more systematically in the AR workforce. Combined with the significant appetite among accredited registers to play a larger role in supporting the public's health, the impact of these interventions can be extended as much as possible. With 80,000 practitioners now on accredited registers, many of whom naturally engage their clients in lifestyle discussions as part of their work already, this workforce should be recognised as an untapped resource, that has both the opportunity and ability to positively impact the public's health.

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8: Acknowledgements

We would like to thank all the accredited registers bodies who supported the research through promoting the survey to their members, as well as the practitioners who gave their time to take part in interviews, focus groups, and surveys.

9: Appendix

Breakdown of survey response, by profession

Question:

Choosing from the list below, please select your occupation or areas of practice (Select all that apply)

Occupation/ area of practice	Percentage of respondents	Response Count
Counselling	51.5%	2321
Psychotherapy	29.9%	1348
Talking Therapy	16.5%	744
Body Massage	15.9%	719
Massage Therapy	15.4%	693
Reflexology	13.0%	588
Reiki	10.4%	469
Aromatherapy	9.8%	443
Hypnotherapy	9.8%	442
Other	8.5%	385
Sports Massage	7.9%	358
Sports Rehabilitation	5.5%	249
Healing	4.8%	217
Play Therapy	4.5%	205
Nutritional Therapy	3.9%	178
Sports Therapy	3.7%	168
Children's Health	3.0%	136
Public Health	2.6%	119
Acupuncture	2.0%	88
Bowen Therapy	1.4%	63
Healthcare Science	1.4%	62
Genetic Counselling	1.4%	61
Yoga Therapy	1.3%	57
Foot Health	1.1%	50
Kinesiology	0.8%	37
Naturopathy	0.7%	30
Craniosacral Therapy	0.6%	26
Shiatsu	0.5%	24
Clinical Science	0.4%	20
Life Sciences	0.4%	18
Alexander Technique	0.4%	16
Physiological Sciences	0.3%	15
Homeopathy	0.3%	14
Non-surgical Cosmetic Practice	0.3%	13
Physical Sciences	0.3%	13
Microsystems Acupuncture	0.3%	12
Health Informatics	0.2%	11
Biomedical Science	0.2%	10
Clinical Terminology	0.2%	8
Biomechanical Engineering	0.2%	7
Haematology	0.2%	7
Rehabilitation Engineering	0.2%	7
Nuclear Medicine	0.1%	5
Audiology	0.1%	3
Bioinformatics	0.1%	3
Radiation Physics	0.1%	3
Radiotherapy Physics	0.1%	3
Renal Technology	0.1%	3
Microbiology	0.0%	1
Radiation Engineering	0.0%	1
Medical Engineering	0.0%	0
Total:	232.3%	10473

(Since respondents indicated all professional areas that applied, the total response count is greater than total number)

AR workforce by membership of accredited registers – population breakdown vs estimates from RSPH survey



Public Polling Questions

The “accredited registers workforce” includes a range of different healthcare professionals, including nutritionists, play therapists, sports rehabilitators, counsellors and psychotherapists, foot health practitioners, acupuncturists, massage therapists, reflexologists, and a variety of other complementary therapists. They are not regulated by law, but are regulated by the professional bodies they are registered to.

1. If you've not accessed the services of an AR healthcare professional before, what are the main reasons for this?

- a. I'm not aware of the services that are available
- b. I am reluctant or unable to fund my healthcare privately
- c. I haven't had health problems which would benefit from their services
- d. I don't trust that they will provide high quality health care
- e. The services I would access aren't available in my local area
- f. I have accessed the services of an Accredited Registers healthcare professional
- g. OTHER

Accredited Registers (AR) healthcare professionals often use their appointments with patients to raise lifestyle health issues relevant to their wellbeing (e.g. their smoking habits, alcohol intake, exercise, or diet) and “signpost” the patient to other local health services that could help them (e.g. a stop smoking service).

2. If an Accredited Registers healthcare professional spoke to you about a lifestyle health issue relevant to your wellbeing (e.g. smoking, alcohol, exercise, diet), which of the below options would describe how you would respond?

- a. It would make me feel embarrassed
- b. I would welcome the conversation
- c. I would feel that it was none of their business
- d. It would make me feel that they cared about my health and wellbeing
- e. I would trust the advice given to me
- f. I would listen politely to what they said but ignore it
- g. It would have no effect
- h. It would prompt me to consider taking action or take action
- i. OTHER

	Counsellors and psychotherapists	Acupuncturist	Hypnotherapist	Foot health therapist	Nutritionist	Massage therapist	Sports therapist
a. It would make me feel embarrassed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. I would welcome the conversation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. I would feel that it was none of their business	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. It would make me feel that they cared about my health and wellbeing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. I would trust the advice given to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. I would listen politely to what they said but ignore it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. It would have no effect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. It would prompt me to consider taking action or take action	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. OTHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Which of the below, if any, would make you more positive about having a conversation about lifestyle health advice with an Accredited Registers healthcare professional?
- a. If the healthcare professional was to wear a badge stating that “You can ask me about your health and lifestyle”
 - b. Prompt cards available in the healthcare professional’s premises which you can complete and hand to the healthcare professional stating that you would like to discuss your weight, smoking, drinking etc today
 - c. If the healthcare professional had a non-judgemental approach
 - d. If the healthcare professional was relaxed and not rushing the consultation
 - e. If the signposting advice given to you was based on a regularly updated list of high quality local services, maintained by the council or local authority
 - f. If you had the privacy to raise an issue
 - g. If It was related to a condition you were already speaking to the AR health professional about
 - h. If you had completed a health assessment questionnaire at the beginning of the appointment
 - i. Something else
 - j. Nothing would encourage you to have a conversation about lifestyle health advice with an AR professional [EXCLUSIVE]

10: Editor's Note



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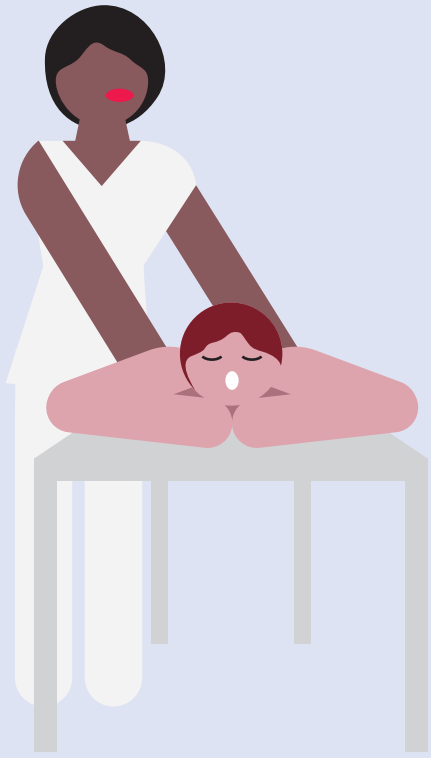
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