Community Learning and Health 'How To' Guide

1. Introduction

This guide sets out to help providers of Adult Education understand the strategic and operational opportunities for working in partnership that are now available following the transfer of some Public Health functions from the NHS into Local Authorities on the 1st April 2013.

It starts by defining Public Health and its key drivers, the socioeconomic determinants of health. It then explains the policy and operational context of both Public Health and Adult Education. The key health improvement and education priorities are provided to show where there are opportunities for partnership working. In essence the key Public Health driver that adult learning practitioners should consider engaging with is the health inequalities agenda. Potential synergies and the implications for Adult Education delivery are explored below.

There are a number of steps that need to be taken for Adult Education to engage with Public Health and a checklist has been provided to assist with this process.

2. Definition of Public Health

The emphasis of Public Health is the prevention of ill health rather than the treatment of it. Therefore Public Health is about understanding the social and economic factors that affect people's ability to lead a healthy life and finding ways to improve them.

One definition of Public Health is:

"Public health refers to all organised measures (whether public or private) to prevent disease, promote health, and prolong life among the population as a whole. Its activities aim to provide conditions in which people can be healthy and focus on entire populations, not on individual patients or diseases. Thus, public health is concerned with the total system and not only the eradication of a particular disease. The three main public health functions are:

- the assessment and monitoring of the health of communities and populations at risk to identify health problems and priorities;
- the formulation of public policies designed to solve identified local and national health problems and priorities;
- to assure that all populations have access to appropriate and cost-effective care, including health promotion and disease prevention services.

Public Health professionals monitor and diagnose the health concerns of entire communities and promote healthy practices and behaviours to ensure that populations stay healthy. The following list of public health campaigns illustrate its breadth:

- vaccination and control of infectious diseases
- motor-vehicle safety
- safer workplaces
- safer and healthier foods
- safe drinking water
- healthier mothers and babies and access to family planning
- decline in deaths from coronary heart disease and stroke
- recognition of tobacco use as a “health hazard”.

(www.who.int/trade/glossary/story076/en/)

Underpinning this definition is the idea of Health Improvement, which is nowadays used to refer to health promotion. Health Improvement practitioners have long acknowledged that education is both a key socio-economic determinant of health and a vital tool in delivering Health Improvement programmes. It is with these practitioners that Adult Learning professionals may well have the greatest opportunity to forge strategic and operational partnerships.

3. Social Determinants of Health

What is the Socio-economic Model of Health?

Proponents of a socio-economic model acknowledge that there are multiple factors that determine people’s health such as where they live, education, health behaviour, income and the environment. Thus the socio-economic determinants of health include:

- the social and economic environment,
- the physical environment, and
- the person’s individual characteristics and behaviours.

These factors affect people’s health and in essence mean that people who experience poorer living and economic conditions and who do not adopt healthier behaviours are likely to have more adverse health outcomes compared to their more affluent counterparts. This is what is meant by health inequalities. According to the Marmot Report of 2010, many people cannot control the socio-economic factors that affect their health and it is therefore Government and Public Health practitioners who have a key role in addressing these factors, thus reducing the inequalities of health that are prevalent today.

In essence Health Inequalities mean that individuals from less affluent communities tend to die younger of preventable illnesses than their more affluent counterparts. In addition, they generally tend to have more illness (sometimes called co-morbidity), which can have a significant impact on quality of life. Local health inequality information can be found in Health Profiles, which cover a particular local authority area and often contain ward level information.

In general, health in the UK is improving, but over the last 10 years health inequalities between the social classes have widened – the gap has increased by 4% amongst men, and 11% amongst women.

This means that:
When comparing, at age 33, those who were disengaged at school and had no GCSE level equivalents with those who did, the odds of:

- smoking are 4.7 times higher for women and 3.5 times higher for men;
- drinking heavily at age 33 are 1.5 times higher;
- taking exercise less than once a week 1.5 times higher;
- having depression 2.4 times higher for women and 2.0 times higher for men;
- having back pain 1.3 times higher in men;
- having migraines 1.3 times higher for women.

(Report by the Centre for the Study of the Wider Benefits of Learning 2006)

From the point of view of practitioners from other disciplines who wish to engage with Health Improvement practitioners, it is important to remember that tackling health inequalities is highly likely to be their lead priority.

Despite a plethora of health improvement initiatives to cut the health inequalities gap between the richest and the poorest, there are still disparities between different social groups as shown by the following key points outlined in the 2011 Census.

- Men and women (aged 40 to 44) living in the most deprived areas are around four times more likely to have 'Not Good' health compared to their equivalent in the least deprived areas.
- Inequalities in health remain large, even at older ages; in the least deprived areas people aged 80 to 84 reported better rates of health than those 20 years their junior in the most deprived areas.
- The inequality in health between the most and least deprived areas peaks at ages 55 to 59 for women and 60 to 64 for men.
- Future fitness to enjoy retirement is likely to be more favourable for the least deprived population than the most deprived; at ages 60 to 64 disabling health problems are much less common among the least deprived.
- The disability prevalence divide between the most and least deprived areas is large across the working ages of 30 to 64, where adults are expected to participate in the labour market.
- The fact that both men and women in the least deprived areas aged 65 to 69 have similar percentages disabled as those aged 40 to 44 in the most deprived areas suggests fitness to extend working careers post the traditional state pension age for men (65) is more likely among the least deprived area residents.

(http://www.ons.gov.uk/ons/rel/census/2011-census-analysis/inequality-in-general-health-and-activity-limiting-health-problems-and-disabilities-by-imd-2010-area-deprivation--england-2011/rpt-health-inequality.html).

Why Learning is a Determinant of Health

It is now acknowledged that people with the worst health outcomes are also generally those people with lower levels of language literacy and numeracy skills. The reason for this is the levels of educational attainment and its influence on other determinants of health such as employment and income, which in turn have an impact on housing, transport and lifestyle.

4. Evidence of the impact learning has on health – what we know already

Evaluations of the Community Learning Innovation Fund (CLIF) and Skilled for Health (SfH) show that learning does have an impact on health both in terms of changes in health behaviours as well as wellbeing outcomes such as feeling more positive. Additionally, learning can provide people with the skills that enable them to make informed decisions about their own and their family's health and wellbeing and build resilience when they are coping with illness.

The Community Learning Impact Fund (CLIF), which was managed by NIACE for the Skills Funding Agency, consisted of almost 100 projects (predominantly partnerships led by the voluntary and community sector) engaged over 15,000 learners in around 1,500 learning programmes.

These consisted of adults from a range of diverse backgrounds. They included residents of deprived localities and adults who were marginalised, excluded or struggling in life due to their personal circumstances. The learning they have undertaken as part of the CLIF projects has helped a diverse group of people who have poor mental or physical health, disability, vulnerable housing, a history of offending or being offended against, substance or alcohol misuse, or those in poverty or who are isolated. These are the very people who also face the poorest health outcomes.

The key findings of the CLIF Health Impact Project Evaluation are as follows:

Community learning supports current health improvement policy and practice. Evidence confirms that community learning brings a wide range of health benefits, including supporting people to feel more positive about life, increasing their understanding of a health condition, and assisting them to eat more healthily.

Community learning can:

- enable adults to take part in shared care decision-making
- develop informed adults who can take part in shaping health policy
- assist in tackling the growing health inequalities gap
- enhance mental health and wellbeing
- supports the maintenance of good physical health

(Jan Novitzky, Community Health and Learning, Niace CLIF report 2014)

5. Health Literacy

Adult learning also plays a key role in addressing the Health Literacy challenges faced by people in navigating health systems, making informed

choices and managing their health. According to recent (2012) research by London SBU, 43% of adults aged 18-65 do not routinely understand health information – a figure which rises to 61% when an element of numeracy is involved.

Health Literacy is defined by WHO as 'the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health. Health literacy means more than just being able to read pamphlets and successfully make appointments. By improving people's access to health information and their capacity to use it effectively, health literacy is critical to empowerment'. If people lack basic skills it is problematic to imagine them developing higher levels of health literacy and not difficult to see how adult learning can play a part in addressing this. Indeed, it was this recognition, which led to the development of Skilled for Health, the national Health Literacy course in England.

Funded by the Department of Health and The Department for Business Innovation and Skills and managed by the CHLF's predecessor body, ContinYou, the project developed and trialed health related learning resources that embed Language, Literacy, Numeracy and ESOL within them. The resources, which became Skilled for Health, were trialed in 157 interventions across 17 sites involving 3,500 participants.

The key health impacts from the evaluation are as follows.

- Learners showed a substantial increase in knowledge on health after having participated in a Skilled for Health course, particularly in the areas of healthy eating, exercising, smoking and drinking or looking after their mental health. Indeed, Skilled for Health courses seem to have produced wider changes in learner behaviour by helping them to take up healthier options in terms of fruit and vegetable consumption and more frequent exercise.

- Although changes to smoking and drinking behaviour are far less pronounced and in both cases, around three quarters of phase two learners reported they had not changed their behaviour. However, the most significant outcome here is that learners understood the negative consequences of these habits even though they are not always ready to change them during their attendance on the course.

- Mental health is another agreed area of outcome for individuals in a number of projects. Learners reported some 'better than usual' responses to concentration, enjoying day-to-day activities and feeling reasonably happy. The social side of the courses may also be an outcome that contributes to these changes.

- The skills and knowledge in healthy eating developed during courses can also be said to have secondary outcomes, with learners making improvements to family health and cascading their new knowledge back into the community.

(The Tavistock Institute and Shared Intelligence (2009), The Evaluation of the

Second Phase of Skilled for Health).

6. The Policy Context

A Brief history of health promotion

Promoting good health has been around for a long time and in the 19th Century was mainly concerned with the environment mainly focused on sanitation. The late 19th Century, early 20th Century Public Health focused on preventative medicines with the notion of health being more about the absence of disease. The 1940s and 50s introduced the idea of social sciences and the risk factors of individual behaviours such as smoking and diet. However, the idea of Health Promotion (now often called Health Improvement) did not really develop until the 1980s as evidence began to emerge from the end of the 19th Century that the decline in mortality rates was less due to medical intervention and more the result of improvements in living standards and better nutrition.

This resulted, in the 1970s and 1980s in a series of initiatives stressing the importance of promoting good health as well as tackling ill health. The most important of these was the Ottowa Charter, which set out the concept of health promotion and identified 5 key areas of action.

1. Building healthy public policy.
2. Creating supportive environments
3. Strengthening community action
4. Developing personal skills
5. Reorienting health services

This document shifted the focus of public health from disease prevention to ‘capacity building for health’ and the wider determinants of health. This approach still guides the practice of many Health Improvement specialists working in Public Health today.

More recently health promotion has been defined by the WHO (2005) as the process of enabling people to increase control over their health and its determinants, and thereby improve their health" The primary means of health promotion occur through developing health public policy that addresses the prerequisites of health such as income, housing, food security, employment, and quality working conditions.

Health and Education Priorities

The priorities of Public Health and Adult Education are outlined below. It is clear to see that Adult Education has a role to play in supporting Public Health to achieve their priorities, particularly in the areas of family learning, older people, adults with disabilities and people in work.

Public Health England Priorities

“We will focus our energies on five high-level enduring priorities:
1. Helping people to live longer and more healthy lives by reducing

preventable deaths and the burden of ill health associated with smoking, high blood pressure, obesity, poor diet, poor mental health, insufficient exercise, and alcohol
2. Reducing the burden of disease and disability in life by focusing on preventing and recovering from the conditions with the greatest impact, including dementia, anxiety, depression and drug dependency
3. Protecting the country from infectious diseases and environmental hazards, including the growing problem of infections that resist treatment with antibiotics
4. Supporting families to give children and young people the best start in life, through working with health visiting and school nursing, family nurse partnerships and the Troubled Families programme
5. Improving health in the workplace by encouraging employers to support their staff, and those moving into and out of the workforce, to lead healthier lives."

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192676/Our_priorities_final.pdf

Adult Education Priorities

The Adult Education priorities were set out in the New Challenges, New Chances, Further Education and Skills Reform Plan: Building a World Class System (BIS, December 2011). These priorities are to:

- widen participation and transform people's destinies by supporting learning and progression in the broadest sense for adults, especially those who are most disadvantaged and least likely to participate in learning;

- promote social renewal and develop stronger communities with more self-sufficient, connected and pro-active citizens;

- maximise the benefit and impact of community learning on the social and economic well-being of individuals, families and communities;

- include effective strategies to ensure that the work and its impact can be sustained when project funding comes to an end;

- align with the work of emerging Community Learning Trusts – a distinct but complementary initiative.

National Accountability

The Department of Health provides Public Health leadership, policy development and funding. NHS England oversees and fund CCGs, improve outcomes and quality of care, commission primary care and specialist services and ensure health inequalities are tackled, while Public Health England lead and co-ordinates the public health workforce, build an evidence base for effective practice and support initiatives at a local and national level which enable healthier choices.

The Operating Context

Until 1974 all Health Promotion services were a local government responsibility. Between 1974 and 2013 they were located in the NHS and then were transferred back into local authorities, where of course Adult Learning also sits. This now offers an opportunity for potential new partnerships and ways of working. However, this will be complex and will require significant shared mutual understanding.

In addition the establishment of Community Learning Trusts also offers an opportunity for greater collaboration. This is because they allow for more innovative and flexible delivery to meet local needs. Again, this will be complex and will require significant shared mutual understanding.

7. Policy Into Practice

There are a number of steps that the Adult Learning Sector can take to achieve this. They are found in the Checklist below. However, it is not the intention of this Guide to in any way imply that this is one-way traffic. Adult learning has a lot to offer to the Health Improvement agenda and we firmly believe that Public Health also has a role in developing this relationship.

Adult Education Practitioners are now in an ideal position however to be proactive in contacting Health Improvement Practitioners in their local area by contacting the Public Health department and finding out who has the lead role for Health Improvement. Theoretically, this should be much simpler now both departments are now in the same Authority. However, it is difficult to provide precise guidance as to how to do this because every area will have slightly different arrangements and may also use slightly different terminology to describe their Health Improvement Specialists. Nevertheless, everyone working in Public Health will understand who carries out the health improvement role in their department.

Relationship Development Checklist:

I. Find out who the Health Improvement Lead is in your area
II. Find out what the local health priorities are in your area. This information can be found on local Health Observatory websites and in the Joint Strategic Needs Assessment.
III. Examine if the work you are doing already contributes to those key priorities and document it. For this you could use evidence from the CLIF report and the SfH evaluation as well as any local evidenced provision
IV. Understand how Public Health commissioning works in your area by becoming familiar with how the Local Authorities Health and Wellbeing Boards operate and prioritise.
V. Talk informally to Health Improvement specialists in your area to assist their understanding of how adult learning contributes to Health Improvement and how you might need to describe your outcomes in “health improvement” as well as “learning outcomes” terms

Joint Activity Checklist:

I. Set up a series of formal joint meetings with key personnel from both Departments to explore joint working
II. Develop a joint health and learning strategy and delivery plan
III. Look at developing a joint evaluation framework to capture health and learning outcomes concomitantly
IV. Undertake a joint pilot
V. Consider secondments
VI. Learn to speak “Public Health” or in other words start to think about how learning outcomes can also address the Health Improvement/ Health Inequalities agenda.

8. Good practice in Health and Education

The move of Public Health into Local Authorities is fairly recent but there are signs of early adopters of a new approach to collaboration and partnership working. For instance, Northamptonshire County Council are in the process of creating a new directorate, entitled, Public Health and Wellbeing (PHAW), composed of a number of divisions, each led by an Assistant Director.

It is anticipated that the following services will be included in the new directorate: Public Health, Libraries, Archives and Heritage, County Sports Partnership, Marketing and Communications, Countryside Services, Arts and Culture, Registrations and Coroners, Knuston Hall Residential Learning Centre, Outdoor Learning Centres, Voluntary and Community Sector Liaison, Community Safety and Adult Learning Services.

The directorate has 2 goals for residents, communities and businesses:

- Increase the wellbeing of communities
- Help people to take charge of their lives

A proposed working definition of wellbeing is to ‘increase wellbeing by helping people to improve how they feel and how they function, both on a personal and social level and how they evaluate their lives as a whole’.

9. Conclusion

The move of Public Health back into Local Authority provides a great opportunity for Public Health and Adult Education Providers to work in partnership to achieve shared aims and outcomes.

In order to ‘make the case’ to Public Health Commissioners, Adult Education Providers will need to understand who their local Health Improvement Lead is, what the local health improvement priorities are and use the wealth of evidence that is now available to show that education, a social and economic determinant of health, can improve people’s health. However, in order to engage public health any evidence provided will need to be expressed in the priority health improvement outcomes rather than learning.

10. Bibliography

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Community Learning Trusts Pilot Evaluation Report- Set Up Stage; Department for Business Innovation and Skills (2013)

Skills Funding Statement 2012 -2015; Department for Business Innovation and Skills (2012)

The Marmot Review – Strategic Review of Health Inequalities in England post 2010 (2010)

Resources

- Skilled for Health File 1; Health and Wellbeing, File 2; Services and Self Care: www.chlfoundation.org.uk/resources
- Public Health Observatories: www.apho.org.uk
- Public Health Topics: https://www.gov.uk/government/topics/public-health
- Health Profiles: http://www.healthprofiles.info
- Community Learning Resource: www.niace.org.uk/community-learning/

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