Evidence for transforming community services

Wellbeing and health inequalities
Transforming community services will lead to more empowered, engaged and enlivened people. The NHS aims to support people to keep themselves well and ensure that everyone has access to the right care in the right place at the right time. We share the lessons from more than 1000 studies focused on improving wellbeing and reducing health inequalities in community services.

The information in this document is drawn from a rapid evidence review. We searched 10 reference databases for systematic reviews, randomised trials and observational studies available as of January 2009. Studies were screened for relevance and validity and key themes were identified. This document provides a summary of only those interventions which are not widespread in the NHS and which have the potential to transform community services. It is not an exhaustive overview of all literature identified.
Top transformations

Ten important issues identified by the research evidence that may improve wellbeing and health inequalities are:

- providing time and funds to test innovative approaches
- undertaking an analysis of people’s needs to target services appropriately
- asking people what services will meet their needs
- proactively encouraging physical activity
- setting up joint initiatives with education, social care and other services
- taking services into the community using health buses, shops and local venues
- training all staff in cultural and social sensitivity and health promotion
- considering service users as care providers for themselves and others
- using text messages, websites and technology to deliver care and share data
- using campaigning and health promotion approaches to raise awareness

There is evidence that focusing on each of these issues may transform community services, but many other initiatives may also be worthwhile.
The NHS is striving to improve the overall health of the population and tackle health inequalities. This is both a high level policy goal, and the backbone of practical services delivered day to day. Transforming community services to further promote wellbeing and reduce health inequalities may involve a myriad of changes. Many thousands of studies have focused on specific interventions. Rather than summarising every one, we concentrate on drawing out the key themes that span many service redevelopments. Success factors for transforming services in the community are divided into who, what and where to target.

**Who: targeting services**

Needs assessments help target community services

Evidence suggests that it is important to develop mechanisms to understand the health needs of local populations and profile the causes of poor health such as socio-economic status, age and ethnicity. Many innovative methods of needs analysis and modelling have been developed, including visual representations of determinants of health, mapping and online questionnaires.

There is evidence that systematically examining health needs and the determinants of poor health can improve community services. In Australia a small rural health service undertook a rigorous evidence based needs assessment to plan transformations. The needs assessment combined a socio-demographic, epidemiological and community consultative approach. Evidence of best practice was identified and the recommendations were used to develop new services such as advocacy, care pathways, care coordination, standardised multidisciplinary assessment and outcome based care plans.
Numerous similar studies from around the world have documented changes in services as a result of needs analysis. An implication for the NHS is the importance of systematic and standardised methods of addressing community needs, with a focus on exploring the determinants of health. Work has been done in some local areas, but there is no consistent approach across the NHS, nor easy to use tools, definitions or frameworks.

The NHS wants to ensure that health services are accessible to all and meet the diverse social, cultural and health needs of the population. There are specific targets for people from black and ethnic minority groups, but research in the UK and internationally suggests that many other less advantaged groups require special attention. In particular, services for homeless people, people with learning disabilities, people with mental health needs, people who speak languages other than English, travellers, offenders and young people have been highlighted for attention.\textsuperscript{6,7}

We reviewed studies from around the world and found that while numerous interventions have been implemented to target and support different groups, there is no ‘magic formula’ for enhancing access to care or reducing health inequalities.
Three principles are common across the most successful approaches:

- targeting populations thought to be vulnerable for additional support without waiting for requests
- working with members of the targeted communities to develop programmes and approaches that they feel are appropriate and sensitive to their particular needs
- asking people about their needs and desires and developing services and systems to address these

For example, a UK study with people with learning disabilities found that the top three things they wanted from health services were time to talk, opportunities to see healthcare professionals other than GPs, and explanations of health information in an informal setting with no appointments.8

Another study in the UK found that dental services are particularly inaccessible for minority ethnic groups from less advantaged socio-economic groups. The key barriers were thought to be the structure of primary dental care, cost and anxiety about accessing services. Importantly, there was little evidence of differences in barriers to access based on ethnicity alone. Social class was a contributing factor. Suggested ways to increase access to dental care included outreach activities, developing communication skills within primary dental care practices and integration with other community health services.

These examples highlight that many of the changes suggested by service users are feasible and relatively small scale, but others would require transformation of the broader system of care.
A great deal of research has examined ways to get service users more involved in their care. People who are encouraged to participate actively in their healthcare tend to have more favourable health outcomes than those who do not.\textsuperscript{9}

Merely providing information leaflets may not be satisfactory. One randomised trial in the UK found that such leaflets might improve satisfaction, but also increase unnecessary use of health services. In this study, leaflets were mailed to 636 patients from five primary care practices encouraging them to raise concerns and to discuss symptoms or other health issues in primary care consultations. The leaflet increased patient satisfaction with care. There was no change in prescribing or referral, but people who received the leaflet had more investigations during the consultation. Most extra investigations were thought to be unnecessary by the doctor and by the patient.

But leaflets signposting people to available services and posted reminders to attend wellness checkups have been found to be beneficial. For example, in Australia, a randomised trial of reminders to visit community services found that children with asthma had increased wellbeing and fewer emergency visits to hospital.\textsuperscript{10}

The NHS is focused on involved people in their care, but asking for input into how to redevelop community services has staff and time implications. Research suggests that appropriate staff training and infrastructure is needed to involve service users effectively. One review found that effective involvement methods require appropriate skills, resources, and time to develop and follow good working practices.\textsuperscript{11} Studies suggest that community health professionals might find needs assessment, asking service users for their opinions and true engagement ‘hard work’ and may not have the skills to listen effectively or deal appropriately with feedback.\textsuperscript{12,13} Yet little work has outlined the practical steps that community services could take to address this. It is an area in need of further consideration.
What: service delivery

Use campaign approaches to raise awareness

Public health teams in the NHS and internationally have long recognised the value of health promotion strategies for enhancing population wellbeing. These may involve media advertising, leaflets, displays in health centres and shops, stickers, talks in schools and ‘shock advertisements’ which show potential negative health impacts. These strategies have been used to good effect in smoking cessation, nutrition, drink driving, bullying and benefit fraud.

Campaigning approaches may have value for other components of public health and, perhaps more innovatively, for directly addressing discrimination and visible health inequalities. The factors common to successful campaigns include a consistent message used in all media, bright and clear branding, an active message, a focus on potential benefits or risks to individuals and encouragement to be proactive.

Proactively encourage physical activity

Of all the studies we reviewed, some of the most successful for improving health and wellbeing focused on physical activity. These may involve supervised exercise programmes in health centres or community venues, partnership approaches with leisure facilities, group activities and programmes which include weekly or monthly programme checks. Unsupervised programmes and those which did not include charted progress over time were least likely to be effective for long term gains in physical fitness and weight loss.

In contrast to the positive research about proactive physical activity programmes, reviews of healthy eating programmes or motivational interviewing for overweight people found that these can have mixed effects. To optimise the benefits, there is a need for more focus on new immigrants to developed countries who may not be used to the diet, young children and men.
Where: location

Use technology to deliver health messages

Research into the most appropriate location for delivering services to promote wellbeing and reduce health inequalities often focuses on physical locations. Over the past decade however, some of the most transformational approaches have examined using technology to promote public health, as well as monitoring and treating specific conditions.\(^{18}\)

There are numerous systematic reviews about the potential pros and cons of delivering services for people with particular conditions using telecare, but far less research is available about telecare for health promotion. One promising approach involves using text messages and emails to provide health promotion messages, remind people about appointments, encourage healthy behaviours such as nutrition and exercise and send positive messages to improve mental attitudes. Text messages have been found to be useful for young people, pregnant mothers and people with long term conditions, although research is in the early stages.\(^{19}\)

In the US, the YMCA set up a ‘Youth Institute’ to improve mental wellbeing and help train young people. The innovative programme uses learning about technology itself as a mechanism for promoting positive youth development while enhancing the academic and career readiness of low-income, culturally diverse, urban high school students.\(^{20}\)

Another trial evaluated an online initiative designed to alleviate body image and eating problems in adolescent girls. Six 90 minute weekly small group sessions were facilitated online by a therapist. Compared to a control group, girls who used the system had improved health and wellbeing that lasted over time. They were enthusiastic about using the internet to access the programme and this also allowed the initiative to reach girls from many different locations simultaneously, including rural areas.\(^{21}\)
Using technology to improve health and wellbeing is not without limitations however. A health web portal aimed at promoting health and wellbeing in Harlem, US found that some community members were distrustful of health organisations and wanted much more community-specific content than the developers had in mind. The software was therefore customised to foster connections and collaborations between community members and a diverse range of health organisations. Despite this, the system received limited use. A lesson for the NHS, which is reinforced by countless other literature, is that use of technology merely to provide information is unlikely to transform the delivery of care or have tangible benefits for health and wellbeing.

There is good evidence that providing care at home can improve satisfaction, but perhaps increase costs. For health promotion work this approach may not be feasible, but alternatives have been tried. For example in Canada a ‘health bus’ has been used to take health education and treatment services into local communities, including supermarkets, community centres and sports grounds. This approach was found to be particularly beneficial for reaching marginalised populations who may not visit community health services and for reducing health inequalities.

Another approach involved taking sexual health education to sites such as bars, streets, bus stops, shopping centres and other public venues. A community health worker visited locations, spoke to members of the public, and handed out leaflets. A random trial found that this approach appeared to work well to raise awareness and reduce the risk of dangerous sexual behaviour.

Taking healthcare into workplaces has also been explored. One randomised trial found that a short course run at a bus company reduced back injuries and days off work. The result remained after two years. Simple outreach may be worth considering by the NHS.
In order to transform community services, rather than merely implement new services, research suggests that a great deal rests on the development and training of teams. NHS staff at every level need to be fully educated and aware of the reasons for promoting good health, differences between groups of people and strategies for empowerment. Promoting health and wellbeing and reducing health inequalities could be part of the job description of every team member, and is something that would need to be a priority for every member of staff in order to fully transform community services.

In some parts of the US, students studying to become health professionals or social workers complete mandatory courses on cultural sensitivity. Competencies have been developed relating to knowledge, values and skills in caring for older people from ethnic minority groups. Following training students and staff say they feel more confident working with people from different ethnic groups and more sensitive to their needs. Models of cultural competency have also been developed in the UK, but are applied in practice to a varying extent.

There is conflicting research about the value of recruiting people from diverse groups to provide health services. While there are undoubted benefits from ensuring that the healthcare workforce is diverse and reflects the broad community it serves, such recruitment practices do not necessarily translate into improved health outcomes. Also, studies have pointed out that sometimes particular equalities issues are prioritised over others. For instance, a study in north west England found that South Asian women who attempted suicide or self-harm can be marginalised due to a focus on ethnicity rather than gender. In this instance, the study found that the recruitment of staff of the same ethnic group as service users was problematic rather than beneficial.

The value of training in health promotion is illustrated by studies of NHS smoking cessation services. Although these services have varying levels of success, the best performing programmes targeted at pregnant women all had in common systematic and detailed training of midwives in how to refer pregnant smokers. Other key success factors in these programmes included offering flexible home visits and providing intensive multi-session treatment delivered by a small number of dedicated staff – but good training in health promotion and specific smoking cessation practices underpinned success.
Often when considering the health and social care workforce, planners and policy makers focus on practitioners and managerial staff. Yet, service users and members of the public are a valuable resource in promoting wellbeing and reducing health inequalities. Strategies such as peer education, buddy-ing, mentoring programmes and peer-led services have been found to improve satisfaction with care and cultural appropriateness. Peer-led services in public health and mental health have been found to have equal clinical outcomes to those led by professionals in many cases, although systematic reviews have found mixed evidence of the success of using lay workers.

Promoting self care and self management is now a mainstay of health policy in the NHS, but it is innovative to take this one step further and view service users not only as active participants in their care but also the leaders of their care – for themselves and potentially for others. For example in the US, peer educators have provided sexual health information and support to homeless women. Peer educators were equally likely to improve health outcomes as nurses.

Drawing on the expertise of service users to help lead and manage care would have a range of implications for the NHS. Firstly, there would need to be appropriate training for service users so they felt comfortable within the system. Secondly, there would need to be extensive staff development, so teams accepted the value of service users as care providers without feeling threatened and so staff were able to provide appropriate levels of support. There would need to be more focus on administrative support, so that service users could concentrate on their key role rather than being caught up in paperwork or bureaucracy. Sensitive monitoring strategies would need to be developed to ensure quality at the same time as valuing diversity and difference in terms of how lay people may offer services.
Transforming systems

There is evidence that the way healthcare is funded and incentivised has a significant impact on accessibility, the emphasis placed on public health and reducing health inequalities. Some healthcare systems have undergone large scale redesign in order to reduce health inequalities. For example, in New Zealand minorities experience significant health disparities related to both ethnicity and deprivation. The average life expectancy for indigenous New Zealanders is nine years less than for other New Zealanders. The government recently introduced a set of primary care reforms aimed at improving health and reducing disparities by reducing co-payments, moving from fee-for-service to capitation, promoting population health management and developing a not for profit infrastructure with community involvement to deliver primary care.\textsuperscript{42} Such widespread transformation to payment structures, contracts and commissioning may not be planned for the NHS, but there are other aspects of system redesign (rather than reform or total transformation) that can be learned from other countries.

Research from around the world suggests that innovative transformation to promote wellbeing and reduce inequality requires partnership throughout the health system and collaborative working with other sectors.\textsuperscript{43} In particular, there is a need to plan strategically and work on a day to day basis with housing, social services, education, benefits services, employment services, the voluntary sector, the police and offender rehabilitation services.\textsuperscript{44} The education sector has a special role to play in helping to educate children and parents about healthy eating and physical activity from an early age. Joint health and education sector programmes on nutrition, exercise and sexual activity have been found to be beneficial. Key success factors in school based programmes include school organisation, a detailed curriculum on the topic area, staff development, using peer resources, including parent education, and school-community linkages.\textsuperscript{45}
Example of partnerships with voluntary groups

In Australia, the ‘Listening to Ethnic Communities about Diabetes’ programme has developed culturally appropriate health promotion and healthcare services for minority ethnic groups. One of the critical success factors was that while the project was grounded in a health promotion framework, the lead agency did not have a great deal of health expertise. Instead, the lead agency was experienced in building relationships with ethnic communities. This allowed for a shift in traditional power structures as the communities were given a real voice and decision-making powers. Health service providers brought clinical knowledge to the table, but it was the involvement of minority group organisations and ethnic community representatives that enabled the project to develop services that were relevant and accessible to the target community. The project used strategies that reflect the cultural practices and preferences of the target communities because these communities were partners in building the programme. This has implications for the NHS, suggesting that there is much to learn from the voluntary sector and from partnership work with other agencies.
Studies have also highlighted the positive impact of improved housing conditions on health. In England, a number of partnerships between voluntary sector home improvement agencies, local authorities and the health sector have already been implemented. The most successful programmes to date include schemes providing information and training for health and social care sector staff, joint approaches to falls prevention, hospital discharge services and initiatives to address cold, damp housing.

Partnerships within the health sector are important too. There have been studies of how dental care can be used to support improved general health. For instance, two publicly funded dental clinics in the US took part in a comparative study. In one clinic practitioners were trained to conduct a tobacco-use assessment and provide a brief cessation intervention for all smokers. In the other clinic, everyone received usual dental care. Most patients were from low income households and minority ethnic groups. People who received cessation advice from their dentist were more likely to quit and remain tobacco-free after one year. The study demonstrated that short simple interventions, delivered in alternative settings such as dental surgeries, can have an impact. In England, some dentists already take part in local enhanced services for smoking cessation programmes. Such partnerships may be worth investigating further.

There are also examples of partnerships with the private sector. Birmingham OwnHealth is a partnership between a PCT (the commissioner), a private sector provider (Pfizer Health Solutions), and NHS Direct (subcontracted by the private sector). The programme uses NHS Direct nurses and call centre facilities to proactively support people with long term conditions with the aim of increasing self management and reducing unnecessary use of health services, especially unplanned admissions. People with conditions such as diabetes and heart disease are sourced from GP lists and invited to enrol in the telephone care management programme. Participants receive regular telephone calls which involve checks on symptoms, motivational interviewing and information to support self management. This programme is about improving wellbeing rather than treating conditions. The programme reported measurable improvements in motivation to change, healthy behaviour and dietary change and a trend towards reduced use of hospital services.

Partners need to be carefully chosen however. Studies in Australia found that partnerships with supermarkets to promote healthy eating were not always successful because supermarkets had competing priorities: financial gains from ‘junk food’ were more attractive than long term gains in population health.
Developing infrastructure to support partnership working and share information is important for providing seamless care. Studies from the UK and abroad have highlighted the necessity for strong information systems to support preventive community services, but there is mixed evidence of success in practice.

Some systems use web based tools to share information about innovation and improved services. For instance, the US Agency for Healthcare Research and Quality (AHRQ) has set up the ‘Healthcare Innovations Exchange’ website (www.innovations.ahrq.gov). This is designed to be a national electronic learning hub for sharing health service innovations and bringing innovators and adopters together. The database contains thousands of case studies, spanning community services and secondary care. The database is well used, especially for networking purposes. Something similar could be set up on a regional or national scale for health and social care in the UK, building on the other formal knowledge transfer networks already available.

Other systems focus on storing information about service users and linking this to good practice guidelines. In Australia, one study examined the development and dissemination of best practice guidelines supported by an electronic client register, recall and reminder systems, staff training and audit and feedback. The aim was to improve health and wellbeing among minority ethnic groups in rural locations. Three year monitoring showed that these initiatives were associated with initial improvements in the quality of care, but this was not sustained over time. Many thousands of studies from around the world have similar findings.

It appears that electronic information systems, training and reminder systems alone are not sufficient to improve wellbeing and reduce health inequalities. What may be missing is a culture of continual innovation, staff motivation to acknowledge and celebrate difference, and an integrated system-wide approach. An electronic client record and reminder system may be of limited benefit if that information cannot be shared with other sectors and used to support a person holistically.
Cash incentives are probably not the answer

It is uncertain whether providing additional funds directly to socially or economically disadvantaged families improves health and wellbeing. A systematic review of nine trials with more than 25,000 participants found that providing money directly to disadvantaged families with the aim of improving children’s health had mixed results. Although some studies suggested that financial support could have some impacts on wellbeing, the review concluded that providing money to families generally did not improve health and wellbeing overall. Such schemes are also fraught with practical difficulties including setting criteria for participation, determining eligibility and monitoring appropriate use of funds. It would seem that this may not be a useful initiative to try in the NHS at this time, although the review has significant implications for policies such as individually held health and social care budgets. The difference between the reviewed studies and individual budgets is that in the case of this research families were given cash to spend as they wished, rather than allocated a budget from within which health and social care organisations could arrange services.

Allow time to build innovative services

One of the key lessons learned from programmes around the world is that transformation requires innovation and improvement. This cannot be forced or mandated; it must be nurtured and protected. There have been critiques of past of initiatives which aim to promote wellbeing and reduce inequalities, but which are too ‘rule driven’:

“First, the Department of Health guidelines for smoking cessation provide quite prescriptive directions as to the nature of service implementation, restricting the ability of services to develop service models to meet the needs of disadvantaged groups. Second, although supposedly intended to promote locally innovative solutions to tackle health problems such as smoking, the imposition of government controls in HAZ programmes has militated against such innovation. As a result … there is little scope for experimentation in this area and a clear opportunity is being missed.”
There are several evidence-based approaches that the NHS can undertake to adopt and spread innovation:

1. Build on previous NHS experience of what has and hasn’t worked and try quality improvement collaboratives and professional networks.
2. Engage frontline staff to mobilise commitment to change.
3. Adopt a campaigning approach to support action on key priorities, such as the US IHI 100,000 lives campaign on patient safety.
4. Support leaders and innovators through training and by creating time to concentrate on creating and developing new ideas.
5. Make it easy to find and share knowledge about innovations. Like many large and complex organisations, the NHS is weak in sharing information and helping staff find out what has been tried elsewhere and whether it works.
6. Learn from organisations that have a track record of innovation such as the US Veterans’ Health Administration which focused on organisational turnaround using leadership from the top, structured communication through internal newsletters, emails and meetings, using collaboratives, a formal framework of spread and using a checklist to rate improvement and innovation potential.
7. Value and celebrate innovation and innovators, including local and regional innovation awards and tolerating the ‘maverick’ ways of working that people in these roles often exhibit, rather than seeking to ensure conformity with a corporate culture.
8. Foster links with private sector organisations.
9. Recognise and nurture innovation brokers or change champions.
10. Use competition and incentives to drive innovation.

In order to ‘transform’ community services innovation is required. Some of the commonly documented characteristics of innovative organisations involve:

- Strong, clearly expressed shared values
- A strong, clearly communicated sense of history
- Intense customer focus
- Cultures that encourage openness and playfulness
- Celebrate successes constantly
- Clear focus on trends, even those that do not seem to directly affect current businesses
- Cross functional teams
- An appreciation of the individuals working with them and everything they can bring to the organisation

But more than anything, innovation requires time, space and a commitment to testing new ideas. Managers and practitioners need to have time ‘off the treadmill’ of day to day work to think about ways of doing things differently.
An example of putting new ideas into practice is the The Humboldt-Del Norte Independent Practice Association in the US. Similar to a practice based commissioning group, it was formed to give clinicians more ‘clout’ when negotiating contracts and services. The Practice Association wanted to spread the use of a registry for people with diabetes in the community, to improve quality of care and ensure that people’s symptoms were controlled. Registries were not common among primary practitioners so the Association took a ‘big bang’ approach – installing the concept into as many practices as possible. The Association leaders called a meeting attended by all practices and outlined how the registry might work, with a focus on the benefits to practices and patients. The registry was rolled out to as many practices as possible simultaneously. It was designed to be easy for practices to use, with data automatically loaded from practice records. Medical assistants at each practice were taught to use the registry and the Association funded web access and computers if necessary.

The messages used to promote the registry were tailored to meet the concerns of different groups of practices and GPs. For example some were focused on saving money or being paid more under pay-for-performance schemes, others were concerned with making their own work life easier and others were eager to improve patient satisfaction or improve the quality of care.

The learning point is that innovation in community services can take place within practice based commissioning groups and other localised networks as long as there is leadership, adequate resourcing, and ongoing support. This group relied on the passion of a champion to identify an innovation and spread the idea. What is interesting for the NHS is how key stakeholders were targeted and the value of thinking about the incentives and motivating factors for different audience groups – and spreading appropriate messages to those groups.

Work in the NHS has found that innovations in service delivery can rarely if ever be copied. Instead, they must be adapted and customised to fit differences in organisational contexts and variations in receptiveness to new ways of working. A number of factors influence the uptake of innovations in service delivery, including leadership by chief executives and senior managers, clinical engagement and ownership of new ways of working, training and development to support changes in practice, the time and resources available to implement innovations, and alignment with performance management and incentive systems. The complexity of organisational change in healthcare means there are no magic bullets or shortcuts in improving community services, but allowing managers and practitioners the time and space to develop and test new ideas is key.
This overview has briefly outlined lessons from research into improving health and wellbeing and reducing health inequalities in community services. More than 1000 studies were screened so we have included just a small number of illustrative examples of key points. We focused not on examining individual services or models of care, but rather potential high impact changes that cut across all pathways.

We have summarised some of the potential priorities for further consideration in the table.

Priorities for further consideration are based on an assessment of the amount of evidence available, the quality of evidence, the effect of interventions and the extent to which initiatives are already being implemented in the NHS or might be a significant change or transformation. It is important to emphasise that not all possible interventions are listed here. Also, in many cases there is not a strong evidence base. This does not mean that an intervention does not work well; only that it has not been well researched. For this reason, the Department of Health used the evidence as just one of the components considered when developing high impact changes. Expert opinion, consensus workshops and other methods were used to form a well rounded picture, underpinned by this rapid evidence review.

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<th>Intervention</th>
<th>Evidence quality</th>
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<td>Provide time and funds to test innovation</td>
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<td>Focus on proactive physical activity programmes</td>
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<td>Collect data for needs analysis</td>
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<td>Target support to groups with specific needs</td>
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<td>Use campaigns to promote wellbeing and public health</td>
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<td>Support self care</td>
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<td>Support service users as providers of care</td>
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<td>Develop information sharing systems</td>
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<td>Focus on dietary programmes</td>
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<td>Use websites for health info</td>
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