



## Original Research

## Investigating the delivery of health improvement interventions through professional football club community trusts-strengths and challenges

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## ABSTRACT

**Objectives:** This study audits health improvement provision delivered in/by English professional Football Club Community Trusts and reports the strengths and challenges around the implementation of interventions.

**Study design:** Multi-methods design: Data were collected through (i) a review of trust websites (n = 72), (ii) an online survey (n = 34/47.2%) and (iii) semi-structured interviews (n = 11/32.3%) with a sub-sample of trust managers.

**Results:** The review of websites confirms all trusts provided physical activity-led interventions. The online survey showed most managers were male (n = 23/67.7%) and white British (n = 30/88.2%). Two thirds held management roles, (n = 23/67.6%) and represented Championship (n = 12/35.2%), League 1 (n = 13/38.2%) and League 2 clubs (n = 9/26.5%). Trusts provided physical activity and most provided diet (n = 31/91.2%) as well as smoking (n = 20/58.8%) and alcohol (n = 19/55.9%) interventions. Weight management, (n = 25/73.5%), mental health interventions (n = 28/82.4%) were offered. Trusts provided male-specific (n = 20/58.8%), with fewer providing female-specific interventions (n = 15/44.1%). Most trusts (n = 30/88.2%) evaluated interventions. 80.8% (n = 21/26) used public health guidance for programme design, 69.2% (n = 18/26) delivery, 57.7% (n = 15/26) needs assessment and 50% (n = 13/26) evaluation. Interviews and qualitative reports identified strengths including, using football, the 'club brand', 'meeting health needs' and 'working as a strategic collaboration with partners'. Challenges included 'short-term funding staffing, mainstreaming, and evaluating interventions'.

**Conclusion:** Football Community Trusts deliver interventions, but challenges were encountered when implementing these programmes.

## 1. Introduction

Although the health benefits of physical activity (PA) are well established [1–4], physical inactivity levels continue to be a public health concern in the United Kingdom [5]. As such, effective interventions including novel approaches in diverse settings are needed to support lifelong participation in PA [6,7]. Given the community centric focus of contemporary approaches to public health [8–10], there has been a growth in the use of professional and community sports clubs for delivering PA and health improvement interventions [11–13]. This includes professional football clubs with provision variously aimed at tackling physical inactivity and health conditions in several health priority groups [14]. Over 1.5 million people are reached with PA-led health and

education programmes delivered in Football League clubs [15]. Indeed, football-led health programmes can result in over 100,000 contacts within a single club [16]. This is significant given that health improvement programmes which have shown to be effective at promoting PA and health improvement, have been rolled out nationwide [17]. While for its relevance to communities at the 'wrong end of the health gap' [18], it has been suggested that football-led health improvement schemes offer a template for health promotion at a global level [19]. This development is in part reflected by (i) substantial investment of resources by football's charitable organisations, football clubs and their local health partners [15,20,21], and (ii) Government strategy in the UK to promote PA participation for health improvement [21]. Further, research confirms the effectiveness of football-based interventions for improving health

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including, overweight and obesity [22], CVD risk factors [23,24], mental well-being [7,25,26] and social support [27].

In Football club community trusts (FCCT), typically interventions involve the delivery of PA led health programmes packaged around the branding of sport, football and/or the football club [16,28]. Supported by local partners, activities are delivered by the FCCT; charitable organisations linked to their parent football club. The representation of trusts or foundations comes from clubs across the English football leagues [7,15,29,30]. In the English Football League (FL), 72 professional association football clubs from England and Wales compete in (i) the Championship and (ii) Football Leagues 1 and (iii) 2 [15]. While the FCCT are connected to their parent professional football club, in many cases they represent separate charitable entities [15]. Each FCCT has strong connections to their local community and the people and agencies located within these areas. This makes trusts and foundations viable channels for connecting a range of priority groups to health improvement opportunities [10,31]. Recognizing this, FCCT have become a strategic focus of football's governing agencies and health commissioners a like [15]. While reports on the impact of football-led health improvement are increasingly commonplace [7,22–27], there is a need to identify and understand the difficulties and challenges that FCCT encounter in delivering health improvement services to local communities. Understanding the challenges associated with the implementation of interventions is important for learning the lessons that shape future practice [7,32]. This study audits health improvement provision and interventions delivered by FCCT in the professional Football Leagues and reports strengths and challenges around the implementation of their health interventions.

## 2. Methodology

### 2.1. Instrumentation and sampling

In this study, research objectives were achieved through the use of three research approaches: (i) desk research – involving visiting the official webpage of the FCCT (n = 72) to confirm the involvement of the FCCT in delivering health improvement activities; (ii) an online survey with FCCT intervention managers to identify demographic (age, gender, ethnicity, role) FCCT profiles (league affiliation, financial turnover, staffing) and intervention profile (health topic, groups targeted, evaluation strategies, as well as an open ended qualitative option that invited managers to report additional information about their interventions); (iii) a semi-structured interview with managers from a sub-sample of the FCCT who completed the online survey, this was used to investigate strengths and challenges affecting delivery of interventions in greater depth and was developed from the literature [30]. Prior to deployment and to ensure rigor, the methodology underwent a process of development, piloting and refinement reflecting similar research approaches in this setting also reported in the literature [30,33].

### 2.2. Research ethics

Prior to any data collection, including piloting, ethical clearance was secured through the Carnegie Faculty Research Ethics Sub-Committee at Leeds Beckett University. All participants were provided with pre information letters in advance and which highlighted the volitional nature of participating in the research and that the reporting of data would be anonymous. Participants were required to consent to participate in the research and were made aware that they could withdraw at any time without giving a reason and informed how they could do so.

### 2.3. Data collection and analysis

The final invitation to participate in the online survey was sent out to named email contacts/contact groups at the 72 FCCT. As part of the survey, an invitation was made to managers to take part in an interview. A total of 11 managers agreed and participated in an interview from the

following leagues, Championship n = 4, League 1 n = 4 and League 2 n = 3. Interviews took place within eight weeks of the participant completing the online survey, usually much sooner and at a FCCT venue or venue that was convenient to the interviewee. For the purposes of convenience for participants, exceptionally the interview was undertaken by telephone (n = 2). Descriptive statistics were used to analyse the desk research survey of FCCT websites and the online survey data. Following transcription and reading of the face-to-face and telephone interview transcripts to saturation, coding identified interesting features in the data, and these were grouped into coherent themes. Two researchers (AP/SZ) met to refine the specifics of the themes and to generate clear definitions and names for them as well as relationships between themes [34]. These themes were used to organise the findings of the interview data. These data occasionally were supplemented by qualitative responses from managers that were provided via the online survey and this is shown in the results.

## 3. Results

### 3.1. Engagement of FCCT in health improvement interventions

All FCCT (n = 72) reported implementing PA-led health improvement interventions. In some instances, there was no mention of specific programmes, but a general reference to health-related interventions was made. N = 34/47.2% of participants responded to the request to participate in the online survey and the results are presented in the following section.

#### 3.1.1. Profile of managers of the FCCT delivering health improvement interventions

Table 1 shows the demographic profile of Football Club Community Trust managers and league affiliation.

#### 3.1.2. Number of employees and annual turnover of FCCT

Table 2 shows the number of employees and annual turnover of football club community trusts.

#### 3.1.3. Priority groups and health topics covered by FCCT interventions

Table 3 shows the age groups and health topics covered by FCCT Interventions. 58.8% (n = 20/34) of the responding clubs delivered men only sessions and 44.1% (n = 15/34) delivered women only sessions. Regarding age groups, 17.6% (n = 6/34) worked with early years groups aged 0–4 years, 82.4% (n = 28/34) worked with children and young

**Table 1**

The demographic profile of Football Club Community Trust managers and league affiliation.

Demographic Variable		Proportion of Respondents % (n)
Gender	Male	67.6 (23)
	Female	32.4 (11)
Ethnicity	White British	88.2 (30)
	Black or Minority Ethnic	11.8 (4)
Age	20–29 years	17.6 (6)
	30–39 years	41.2 (14)
	40–49 years	23.5 (8)
	50+ years	17.6 (6)
FCCT Job Role	Head/CEO	38.2 (13)
	Manager	29.4 (10)
	Co-ordinator	14.7 (5)
	Other	17.6 (6)
League Membership	The Championship	35.3 (12)
	League 1	38.2 (13)
	League 2	26.5 (9)

**Table 2**  
Number of employees and annual turnover of football club community trust.

Characteristic		Range	Average (SD)
Number of Employees	Permanent Full-Time	3–54	19.5 (±11.60)
	Permanent Part Time	0–70	8.2 (±13.86)
	Casual Staff	0–154	28.3 (±30.77)
	Volunteers	0–150	18.9 (±29.75)
Annual Turnover	Turnover in £	£150 k - £3 m	£871,973 (±536803.8)

people aged 4–17 years, 91.2% (n = 31/34) worked with adults: 18–64 years and 76.5% (n = 26/34) worked with older adults aged 65+ years.

Every club completing the online survey (100%, n = 34/34) reported delivering PA interventions, 91.2% (n = 31/34) delivered healthy eating sessions, 55.9% (n = 19/34) covered alcohol advice and 58% (n = 20/34) covered smoking cessation. Further, 73.5% (n = 25/34) delivered weight management sessions, 82.4% (n = 28/34) covered mental health and 64.7% (n = 22/34) delivered education and training for attendees.

In terms of deploying evaluations, the majority of FCCT, 88.2% (n = 30/34) reported that they evaluated their health improvement interventions, of which, 63.3% (n = 19/30) reported that these were undertaken 'in-house' and 36.6% (n = 11/30) reported that they deployed externally commissioned arrangements. For respondents who reported that they did not evaluate, time and money were the most common reasons for not evaluating.

Regarding awareness of public health guidance, 58.8% (n = 20/34) were aware of Public Health England/local public health guidance, 41.2% (n = 14/34) were aware British Heart Foundation, 38.2% (n = 13/34) National Institute of Health and Care Excellence (NICE) guidance and 29.4% (n = 10/34) football-charity public health guidance. Most, 76.5% (n = 26/34) of managers reported using public health guidance. Regarding the motives for using public health guidance, 84.6% (n = 22/26) said that it 'was good practice', 65.4% (n = 17/26) said that 'it helped with planning', 34.6% (n = 9/26) said it 'was a requirement of funding' and 23.1% (n = 6/26) said it was because they 'had used it before'. Over 80% (n = 21/26) used guidance for programme design, 69.2% (n = 18/26) delivery, 57.7% (n = 15/26) needs assessment and 50% (n = 13/26) for evaluation tasks.

### 3.2. The accounts of FCCT managers delivering health improvement interventions

A selection of outcomes from both the interviews (N = 11) and managers qualitative accounts from the online survey (N = 15) that was completed by FCCT managers are reported in the following section. Outcomes are framed around key implementation themes with a focus on both the strengths and challenges of providing PA and health improvement in FCCTs.

#### 3.2.1. Using the reach of the football club brand/football brand to connect with people

It has been suggested that the brand of football is made up of *Place, Product, People and Process* [35]. We offer accounts from FCCT managers that reflect the influence that both football and the football clubs have in connecting participants to health improvement activities. This included the attraction of both sport and football.

*The unique selling point of the programme is the fact that it's a healthy lifestyle programme attached to a football team, and I think as soon as you attach any health provision that's targeting men on to a football club, I think you've engaged an audience almost immediately. (Club B, League 1, Interview)*

More specifically linking programmes to the affiliation that fans had for 'their' club and club players was important when recruiting new

participants.

*We were asked to work with hard-to-reach middle age men, we ran three campaigns on a match day [on cancer awareness] we focussed on bowel cancer in the first instance, lung and prostate cancer. The campaign on a game day had the players wearing the T-shirts with Cancer Awareness on and we tried to think this into National branding and straplines such as Men United UK. We had adverts and a video running on the big screen on a match day. We had a past player or ambassador and the club acted as a hub for people. We worked very closely with the CCG and their Communication Departments when they were putting out press releases, we were putting things out on our website where we interviewed a survivor of bowel cancer who as a fan who gave his story. The picture we took [to support the campaign] went on 90,000 prescription bags across the City. (Club J, League 1, Interview)*

As part of the 'brand', the place (i.e., football club venues and stadia) was seen as important and the use of club branded facilities helped with reaching participants; A number of managers illustrated this to good effect, for example one manager reported.

*We hold a weekly Fans Fitness Club based at First Team Training Ground, for all abilities and different types of activity each week, circuits, box fit, etc. (Club A, League 2, Online Survey)*

Conversely, we came across occasional examples from managers where football was not as seen as influential as reaching some groups.

*We have struggled for [participant] numbers in terms of engagement. Partly I think that is because the promotion and the marketing material is very much focused on football, and I believe that immediately puts off people who aren't that necessarily keen on the football side of things for programmes they run, they really struggle to recruit generally, so I don't think having the brand actually made much of a difference at all. (Club G, League 2, Interview)*

We also encountered examples where local health services wanted to collaborate with the FCCT because of how football and the football club could be used to positively connect people to health interventions. Working with local partners provided many benefits including, funding, capitalising on the momentum of national campaigns, help with participant recruitment and the provision of specialist knowledge and skills. One manager illustrated the benefits with the following example of a dementia intervention run by the FCCT.

*I think having a partnership with the relevant organisations helps. For example, in having the Alzheimer's Society on board – if we were not working in collaboration with them, I think we would struggle to recruit participants more than anything else. And if you cannot recruit participants, then it's a no-go from the start. (Club M, League 2, Online Survey)*

While there were some excellent examples of health improvement work on-going in FCCT, there were several challenges associated with building up a reputation for working in health and community work, as one manager reported.

*I think probably one of the biggest challenges we have as a Foundation, is because they [the club] have built up quite a bad reputation locally, if I'm honest, yeah. Because of their background in terms of being a non-league club that at one point we got quite a lot of money and rose up through the leagues quite quickly ... and probably didn't spend the money in the right areas, such as infrastructure. So that reflected quite badly on the club for quite some time. I definitely think that's actually the problem. But that's our job, I guess, to increase the profile. (Club G, League 2, Interview)*

#### 3.2.2. Adopting a strategic approach to health improvement

Many of the FCCT we spoke to reported adopting a strategic approach to health improvement in their local community. Some FCCT were more advanced in their preparations than others. A number were working with

**Table 3**  
Types of intervention offered by each participating football club community trust.

	Gender Specific		Targeted Priority Age Groups				Targeted Intervention Type						
	Male	Female	Early Years (0–4 years)	Children (5–17 years)	Adults (18–64 years)	Older Adults (65+ years)	Physical Activity	Weight	Healthy Eating	Smoking Cessation	Alcohol Advice	Mental Health	Education Training
Club 1	✓						✓	✓	✓		✓	✓	
Club 2	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Club 3	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Club 4					✓		✓	✓	✓	✓	✓	✓	
Club 5	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Club 6				✓	✓	✓	✓					✓	
Club 7	✓			✓	✓	✓	✓	✓	✓	✓		✓	✓
Club 8				✓	✓	✓	✓		✓	✓	✓	✓	✓
Club 9				✓	✓		✓	✓	✓	✓		✓	✓
Club 10					✓	✓	✓	✓	✓	✓	✓	✓	
Club 11	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓	✓
Club 12	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Club 13				✓		✓	✓		✓				✓
Club 14				✓	✓		✓		✓	✓		✓	✓
Club 15	✓	✓		✓	✓		✓	✓	✓	✓	✓	✓	✓
Club 16	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Club 17				✓			✓						
Club 18	✓		✓	✓	✓	✓	✓	✓	✓			✓	
Club 19	✓			✓	✓	✓	✓	✓	✓	✓		✓	✓
Club 20					✓		✓	✓	✓				
Club 21				✓	✓		✓	✓	✓	✓	✓		✓
Club 22	✓	✓		✓	✓	✓	✓		✓			✓	✓
Club 23	✓	✓	✓	✓	✓	✓	✓		✓			✓	✓
Club 24					✓	✓	✓	✓					
Club 25				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Club 26		✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Club 27	✓	✓		✓	✓	✓	✓	✓	✓			✓	✓
Club 28				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Club 29	✓	✓			✓	✓	✓	✓	✓	✓			✓
Club 30	✓	✓		✓	✓	✓	✓	✓	✓				
Club 31	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Club 32	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	
Club 33	✓			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Club 34	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	

Clinical Commissioning Groups (CCGs), local authorities and charities to embed football into their local health plans.

*Health is one of the key things that the Community Trust would like to look at over the next three years. so, what we've also done is set up an action plan with [Local Public Health], just to act as a sort of template document, really, so that we know, we understand the health needs of the Borough then we can identify how we can support with those. (Club L, League 2, Interview)*

In other cases, FCCT were in the early stages of developing their own strategy for public health provision and this was illustrated by the following account.

*We've been running for about two and a half years. We're quite small comparatively to a lot of other foundations. We work at the moment mainly locally, but obviously the plan for the longer-term is to expand out regionally. (Club G, League 2, Interview).*

There were a number of occasions where the FCCT encountered difficulties in embedding their health improvement service into local health improvement strategies after initial start-up funding had expired.

*Getting commissioned isn't quite as easy as people think ... and getting cash out of the CCG and trying to get funds from them is difficult They are talking about hospital, about ambulance radio, you know, that's their agenda, not necessarily health programmes. (Club O, League 1, Interview).*

### 3.2.3. Sustaining existing health improvement interventions

Sustaining health improvement programmes was a challenge in all FCCT and reflected in several reports by managers who found it difficult to secure longer term funding. For example, one manager reported:

*There should be a duty of care tagged on to a club [for health improvement]. It is a frustration of mine, because you're proving it [the programme] is working, it does work, but yet you're still cap in hand to all funders, begging and scraping, and scrounging. It's a real sort of let-down. (Club B, League 1, Interview)*

In another example, the FCCT had to fund and secure participant contributions in order that the provision was sustained.

*The Trust's Imagine your Goals project was originally set up in 2009 / 2010 season and funded through the Premier League and Sports relief. We initially engaged with over 300 participants. Once the funding had stopped we sustained the programme with participation contributions and funding from the NHS. (Club K, Championship, Online Survey)*

### 3.2.4. Local knowledge and understanding the needs of the local community

In some cases, FCCT were working strategically with their local health partners who had skills and expertise in performing needs assessment processes. Moreover, partners were routinely performing needs assessment as part of their strategic function in meeting the health needs of the communities they served. The FCCT could then link their activities into meeting the needs of communities which had already been mapped out and fed into local health plans. In other cases, FCCT were at a much earlier stage and exceptionally we came across challenges in meeting expressed needs by local people.

*I guess part of my job is to look at what the needs are in our local area. So the guys have obviously been talking about their health programme, and I had a group of ladies approach to ask if they can run a female version, through the Weight Management Centre. They initially said no because they thought it there was already provision out there for females. But I think we managed to persuade them [The Trust]. So for the ladies it's looking likely that they will have a female-specific programme. (Club G, League 2, Interview)*

## 4. Discussion

To the best of our knowledge, few published studies, have investigated health improvement provision in the English 72 FCCT. Key outcomes from this study identify that FCCT deliver health improvement interventions for a range of groups and health issues. In doing so, they make an important contribution to the health agenda, including physical activity, obesity, mental health, social inclusion and supporting an ageing society in their localities. That said, our research identified that FCCT face several challenges, particularly around reaching some audiences, meeting needs and the funding and long-term sustainability of health interventions. Identifying what works and why offer valuable considerations for those FCCT who aspire to advance health interventions in football-led settings [7,36]. Similarly, sharing news on what works 'less well' is an important learning outcome that can shape future intervention practice [7,10].

### 4.1. Strengths and challenges of FCCT in contributing to health improvement

In local communities, places and people make important contributions to public health [8,9]. Professional football clubs clearly combine these important components of the 'football club brand' and at times, 'club branded' resources to deliver community-centric health programmes for local people [7,14,30]. In this study, FCCT reported numerous examples of interventions using 'the brand of football' to effectively engage local communities, including people from disadvantaged and health needy populations [7,37]. For some people, the NHS is seen as one of most trusted brands in the world and is a recognized brand in local communities [38]. Similarly, people's allegiance to 'their football club' can go back a generation and fandom can be viewed as an extension of the individual, shaping the person's identity and social processes [39, 40]. To many people, their football club is viewed as 'a trusted brand' and are highly recognized within their local communities and these people's social networks [7,30,41]. It is for this reason that many FCCT managers in this study indicated football's powerful reach should not be underestimated [30] and capitalised upon when developing health interventions.

It has been reported that the Football League Trust reaches over 1.5 million people through health-related projects annually [15]. Activities are typically delivered in football-branded venues, including club stadia and club-branded and/or local community facilities; this creates interest in both fans and non-fans [30,41]. It is little wonder local agencies wanted to partner with many of the FCCT we spoke with in this study. In part, this justifies strategic approaches for sport and PA [42] recommending the engagement with professional sports clubs as a means of capitalising substantial reach in local communities [15,30]. Moreover, the unique potential reach towards 'hard-to-engage or unreached groups' may be one that some statutory services such as local authorities and the NHS on occasions find difficult to achieve through their normal working practices and channels [10,30,41]. Given calls for bold and innovative approaches for PA and health improvement, professional sport club community trusts have been suggested as a complimentary channel for this to occur [7,42,43].

Our managers reported the importance of offering needs-led health improvement and this manifested at two levels. First, at a strategic level, several FCCT were working with Community Clinical Commissioning Groups and local authorities, when responding to the outcomes from local health needs assessments. In turn, managers reported that this informed strategic plans for health improvement going forward in local areas. This approach underlines the benefit of drawing on a comprehensive and detailed understanding of local health needs and the role and expertise of local health services in completing this exercise [32]. Confirming that FCCT were at different stages of preparedness in this respect, we encountered FCCT who were still aspiring to develop these strategic and coordinated approaches for assessing and meeting local needs.



Working with health partners with expertise in mapping local health needs or who have previously undertaken a strategic needs assessment is a valuable asset in this respect.

Secondly, at an operational and programme level, several FCCT reported actively responding to participant needs. Exceptionally, we encountered some reluctance among trust partners for meeting the expressed health needs of local groups. For instance, in an example that was not the norm, one FCCT had decided not to provide a weight management service for female football fans, despite their being an expressed need but subsequently offered this service to male supporters. This decision was informed by the perceived widespread availability of local commercial weight management services, yet the decision failed to address the expressed needs of female football supporters. These women felt that services in the community were neither suitable nor timely in meeting their preparedness to change their behaviours. Moreover, this decision missed an important opportunity capitalise on the role of football and the club in reaching and helping to meet the health needs of these women. Gender sensitized and commercial weight management services may not be acceptable to all women and in this example, the reach of their club was an important feature in wanting to adopt health improvement services. For these fans, this important ingredient was absent in the extant commercial weight management services. While football settings can act to attract men to participate in health programmes [14,44,45] we have found that football clubs can also appeal to women when delivering health interventions [46].

While so-called 'hard-to-engage' groups [30] may be 'hard-to-avoid' when they are provided with acceptable, affordable, and accessible health services [7,43], they can also be 'easily lost' when health services are unresponsive to their initial and longer-term needs [47,48]. Continuing to review and meet the on-going and emerging requirements of new programme adoptees is vital in supporting behaviour change [13,32]. In this respect, the need to sustain health services was a powerful driver among the FCCT we spoke with. Managers expressed the importance of providing exit strategies at two key time periods. The first was after the initial intervention was completed, typically this was offered over three months. The second key time point was after funding had ceased to continue to support the programme. Yet all managers reported, to varying degrees, the on-going challenge of securing resources to keep programmes running after initial start-up funding had expired. To sustain services, managers informed us of both a shortage of resources and at times, unresponsive commissioners who placed a low priority of continuing to deliver these health improvement programmes. As such, FCCT were faced with the unenviable position of having to inform current participants that future programmes run by the FCCT and which they have come to rely on would need to be supported to a greater extent by participant contributions.

This study also identified the difficulties encountered by FCCT when attempting to embed interventions in local public health plans. This outcome will inevitably result in services being reduced or worse still, lost altogether, along with those participants who had been so hard-to-engage in mainstream health services in the first place. Further, it is difficult to see how this approach acknowledges that successful change in health behaviours is a process rather than a series of short-term events [7, 32,49]. Paradoxically, managers told us that it was the attendees who understood this issue; some had little optimism that they would sustain healthful changes after programme support was terminated. Given the requirement to meet the health needs of underserved groups, such an outcome is disappointing [44]. Being part of an 'institution' or 'group' is important in supporting on-going behavioural change, and when these services are removed, some people 'fall by the wayside' [7,50]. Moreover, communities who feel let down by the withdrawal of local services may become angry and disillusioned when new, short-term interventions are once again offered as part of a new health initiative that promises more than it can deliver. People will be more sceptical about 'yet another good idea' when it reappears again!

Instead, interventions that help individuals to keep developing and refining skills that support core health enhancing behaviours (i.e. PA)

such as planning to exercise and time management, as well practicing those successful health enhancing behaviours are important for the maintenance of health improvement actions [51]. To establish health-enhancing habits and networks, on-going support of, and investment is required both for the people and places that support health interventions [8,9]. Another inherent challenge for successful preventive programmes, is that 'when prevention is successful, it can be invisible' (Fineberg, p.47) to all those outside those health improvement interventions [52]. While it is possible to show the impact of short-term changes emerging from programme adoption, it is more difficult to attribute longer-term changes to health outcomes from attending programmes, such as fewer people having heart attacks [52]. This invisibility may also influence the decision balance of policy makers who invest scarce resources to maintain these programmes often in short term time frames. Ongoing dialogue with commissioners is important in order to increase awareness of the difficulties associated with short term funding arrangements.

The austerity surrounding contemporary UK public services will continue as local authority budgets are reduced further. The UK Comprehensive Spending Review reports that spending will fall by at least £600 million in real terms by 2020/21, an annual reduction of 3.9% [53,54]. In any climate of scarce resources, only convincing arguments and evidence will command support for financial investments [32]. In this respect, monitoring and evaluation will become even more important [10]. All of the FCCT we spoke to evaluated their programmes; most adopted in-house or partnership designs (where deliverers work alongside evaluators) [10]. While evaluation was universally endorsed as 'good practice', in some cases, evaluation evidence was insufficient to justify further investment of interventions. Beyond endorsing evaluation as an important activity, the FCCT in this study also identified the importance of recruiting skilful and well-trained staff. Many talked enthusiastically about the competencies of colleagues who delivered health improvement services – this was typically seen as a 'real strength' of football-led public health provision. When successful programmes are withdrawn through lack of funding, means that not only are participants lost, but also the skills and expertise of the delivery staff. We came across staff facing uncertain futures and a number have since left the football charitable sector to seek employment elsewhere in the public health field. Managers reported that this can be dispiriting, because it takes time to build experienced staff with relevant competencies and connections and who are trusted within local communities they serve.

It makes better business sense to retain and develop existing skills, connections and expertise rather than repeating the cycle of losing then rebuilding valuable human resources for public health when a new funding cycle emerges later down the line. Moreover, retaining skills values the importance of both people and place in community-centric health strategies [8,9]. Guidance on community engagement considers the importance of the local context for public health which extends to enlisting volunteers, supporting recruits, and spreading the word to 'new like-minded' participants [55]. It has been argued that improvements in prevention are unlikely to occur unless there is a 'Wider Public Health Workforce' (WPHW) with the right skills and competencies; (Kent, 2016) [56]. The WPHW has been defined as '*any individual who is not a specialist or practitioner in public health but has the opportunity or ability to positively impact health and wellbeing through their (paid or unpaid) work*' (Centre for Workforce Intelligence and Royal Society for Public Health, p.4) [57].

We encountered several examples where WPHW contributions were both evident and important on several levels; many of these reflect influences within local community and social networks such as volunteering and peer delivery of sessions. Indeed peer-delivery has also been found to match the effectiveness of PA interventions delivered by professionals [58]. In times of financial stringency, (Fineberg p.48) recommends 'marshalling likeminded citizens to support constructive public health change' and the contributions of volunteers in this study exemplify this [52]. It is little wonder that volunteering and local advocacy is

seen as an important community asset and a key feature of the public health and policy [9,57]; the WPHW is frequently a mainstay, in football-led health improvement and when trained is an important resource for delivering football-led public health [59]. Keeping people involved when projects comes to an end is important and this might involve looking at other projects' volunteers can contribute to in order to maintain this resource and keep people involved.

Finally, when developing interventions, it is encouraging to see FCCT adopting the use of public health guidance across intervention mapping phases, that is when assessing needs, planning, implementing, and evaluating interventions [60]. This is also encouraging when we consider that FCCT are part of the WPHW and so awareness and use of guidance by NICE and BHF is important. We encountered managers who had a background in working in the NHS and local authority and were familiar with these resources. That said, it was clear several participants from football/sports backgrounds were unaware and or less familiar with public health guidance such as the NICE guidance. Given the role that FCCT play in providing health improvement services and as an important player in the WPHW, this is an area for further investigation and development. On occasions managers reported not seeing the benefit of using public health guidance in their work. NICE deploy a range of strategies and resources to increase the uptake and use of public health guidance. This includes a 'Field Team' and a 'systems engagement programme' who through various campaigns interactions and resources aim to increase awareness and the uptake of guidance [61]. Given that the role of clubs in providing health improvement services has been growing, connecting FCCT who are unaware, not able to see the benefit or not using guidance and resources and support, would be useful step in helping to plan future health improvement work.

#### 4.2. Limitations and strengths of this research

Limitations in this study relate to the number of completions of the online survey; a higher level of participation would have been desirable, although this can still be deemed acceptable level and as providing valuable insights into this subject. We would also like to have heard more from the 'less active' FCCT on matters relating to football-led health improvement, including their views for why this area was underdeveloped. Strengths would have been added by triangulating participant responses with those of other stakeholders or groups, such as programme participants, commissioners, and partners. Further, we did not scrutinize the evaluation reports of health improvement interventions reported by FCCT for effectiveness; this would be a useful addition to all evaluations and for being reported on the web sites of every programme. Study strengths relate to deploying a multi-method evaluation research design. This secured rich and informative accounts from the intervention managers at the FCCT. Their contributions identified what was working and what was not and helped to generate insights into the challenges relating to implementation. Participants contributed informative accounts including challenges and ineffectiveness which is seldom explored in this context, especially notions surrounding 'less successful' activities. These areas are important because they offer avenues for improving future provision [62]. Importantly for FCCT, securing prolonged funding is an on-going concern and more compelling evidence that meets the needs of local funders will be needed to secure resources. Understanding the challenges of planning and implementing health improvement interventions is a valuable exercise, especially when professional sports clubs have been identified as part of the landscape for PA promotion [21]. Further, this research design provides a template for investigating health improvement in other sports and football leagues.

#### 5. Conclusion

Football-led health improvement is effective in recruiting participants into programmes that improve the problematic health profiles in many local communities. Yet, our paper identifies that these effects may be

brittle. FCCT face several difficult challenges for implementing these programmes; securing sufficient resources was inseparable from the problem of being prioritised in local public health policy documents. Clearly, FCCT offer substantial strengths for health improvement and align with Government strategies for community-based public health. FCCT should be mindful to highlight these assets when making the case for future investment with local health partners. Our paper offers practitioners with important considerations for developing football-led health improvement delivered in football club foundations and trusts who are important players in the PA and health improvement field of play.

#### Declaration of interests

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

#### Ethical approval

Ethical approval was provided by the Faculty Research Ethics Committee at Leeds Beckett University.

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#### Author contribution

AP, SZ, LL were involved in the conception and design of the study, and acquisition of data, management of the data, recording/transcription, analysis, and interpretation of data sets, and (2) drafting the manuscript and revising it critically for important intellectual content, and (3) final approval of the manuscript to be submitted. [AP] led and managed the project throughout with support from [SZ and LL]. AP/SZ sought ethical approval for this project and managed ethical procedures. AP managed communications with the partners and the host institution.

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