Health Trainers
National End of Year Report: 2008-09
(Based on regional end year returns 08/09)

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List of Abbreviations

DH	Department of Health
DCRS	Data Collection Reporting System
EYR	End of Year Report
HT/HTs	Health Trainer(s)
HTC/HTCs	Health Trainer Champion(s)
HTS/HTSs	Health Trainer Service(s)
MDS	Minimum Data Set outcomes
NHS	National Health Service
PCT/PCTs	Primary Care Trust(s)
SES	Socioeconomic status
SHA	Strategic Health Authority
THT/THTs	Trainee Health Trainer(s)

Executive Summary

The Health Trainer (HT) programme aims to reduce health inequalities by targeting people from socially disadvantaged and other 'hard to reach' groups and supporting individuals to change their lifestyle behaviours. The programme is built on psychological science, and uses evidence-based principles to promote behaviour change. Health Trainers (HTs), who are in the main recruited from local communities, assess the factors that trigger clients' unhealthy behaviours, reinforce behaviours that clients wish to change, assist in setting goals and build the confidence required to enable clients to achieve change. Health Trainer services also ensure that clients can better access other local services and support to meet their needs

HT services (HTSs) in the UK are clustered under a National Implementation Team split into 11 regional 'hubs'. Hubs provide annual summaries of HT activities, funding, reach and clients, and document progress towards the four targeted outcomes of the HTS programme (the 'Minimum Data Set' [MDS] outcomes):

- Building the workforce with the right skills to tackle health inequalities;
- Reaching the hard to reach;
- Delivering sustained improvement to the health of the people of England through behaviour change
- Providing access to and encouraging the appropriate use and take-up of NHS and other local services.

This report documents HT activity in the UK in 2008-09[1], as reported by hubs, and is the third of three annual audits (see Wilkinson et al., 2007; D Smith et al., 2008). Where possible, these data are compared with data from 2007-08 and 2006-07 to highlight progress and developments.

Methods

Data summarised in this report were provided by 'hubs' to the DH, and refer to the period 1st April 2008 to 31st March 2009. Data were collected via an End of Year Report proforma, which requests information on HT personnel and clients, stages of development and funding.

1 Other, reports based on 2008-09 data will describe the HT workforce (Murfin, Mitchell et al, January 2010) and summarise data on the effectiveness of HT services for promoting health behaviour among target groups (J Smith, Gardner, & Michie, forthcoming).

Results

Reliable data was received from 169 HTSs across 115 Primary Care Trusts (PCTs).

Service details:

- *Personnel:* 2,076 HT personnel were recorded, indicating a 19% decrease in personnel from 2007-08. (Information relating to the destinations of those leaving the HT service was not collected by hubs, but a forthcoming HT Workforce Audit indicates that HTs leaving the service typically progress to full-time employment, often within health or social care [Murfin, Mitchell et al, January 2010].)
- *Clients:* 77,816 clients were served in 2008-09, 34% more than in 2007-08 and 493% more than in 2006-07. Of these, 28,197 clients reportedly set a Personal Health Plan (PHP), but data were not available to evaluate achievement of PHPs.
- *Stage of development:* 63% of HTSs were fully operational, representing a steady increase from the 58% operational in 2007-08 and 49% in 2006-07. The remainder of HTSs were in pre-operational stages of development, during which clients are generally not served by HTs.

Regional hub activity:

- *Regional HTS activities*: In addition to the core activities, each hub provided information on other regional activities and developments which were mainly centred on the MDS outcomes of building the workforce with the right skills to tackle health inequalities and reaching the hard-to-reach.
- *Changes to models of service delivery:* Eight types of changes were recorded: increase in the use of HTSs; increase in HT recruitment; networking and partnerships; developing target groups; commissioner/provider issues; commitment to data collection; influences of economic downturn and developing a consensus within each hub.
- *Target groups:* HTSs targeted various communities including; demographic-based groups; vulnerable groups; individuals with varying health status; and others.
- *Funding 2008-09:* HTSs received £25.0m funding (£24.0m from NHS, £1.0m from non-NHS sources), 2% more than forecast.
- *Forecast funding 2009-10:* Hubs forecast £25.2m funding for 2009-10 (£23.9m from NHS, £1.3m non-NHS sources).

Monitoring and evaluation

- *Use of Data Collection Reporting System (DCRS):*
  62% of HTSs were using the DCRS, 215% more than in 2007-08.
- *Sustainability:* Five factors were deemed important in sustainability of the HTS: funding; provider and commissioner relationships; reporting; development of the evidence base and staff turnover.

Discussion

Despite apparently fewer frontline HT personnel in post at March 31st 2009, 15% more clients were served by HTSs in 2008-09 than in the previous year, and funding for HT services increased. More robust information on health trainer personnel will be outlined in the Workforce Audit 2008/9 (Murfin, Mitchell et al, January 2010) and report of data retrieved from the Data Collection Recording System (DCRS; J Smith et al, forthcoming).

In comparison to 2007-08 data, there was a 71% reported increase in clients setting a PHP in 2008-09. More robust information on PHP achievement will be available from the forthcoming DCRS annual report for 2008-09 (J Smith et al., forthcoming), which will assess the effectiveness of PHPs, and, by extension, the utility of the evidence-based approach to behaviour change on which the HT service is based.

Introduction

Tackling health inequalities is essential in creating a fair society. The UK has made considerable improvements in life expectancy over the past decade (Department of Health [DH], 2009), but inequalities in health outcomes remain and have in some cases widened (DH, 2008a). Socially disadvantaged groups in the UK remain more likely than other groups to engage in health-compromising behaviours (such as smoking, poor diet, alcohol consumption, and physical inactivity; Office for National Statistics, 2007) and experience greater morbidity and mortality (DH, 2008b; White, Edgar & Siegler, 2008). Reducing health inequalities for socially deprived groups has become a key priority (DH, 2005, 2008a, 2008b, 2009).

In 2005, the DH outlined a series of milestones in order to achieve a 10% reduction in health inequalities by 2010 (DH, 2005). Achieving this target will require innovative healthcare strategies. The White Paper *'Choosing Health: Making Healthier Choices Easier'* (DH, 2004) outlined a series of proposals to empower people in disadvantaged groups to make healthier choices. One proposal was the Health Trainer initiative. Based on psychological science, this initiative applies evidence-based principles of behaviour change to assist people at risk of poor health to assess their health and lifestyle risks, build their motivation, and change their behaviour.

Health Trainers (HTs) assess the factors that trigger unhealthy behaviours, reinforce behaviours that clients want to change, help them set goals and build confidence to enable clients to achieve change. Using Personal Health Plans (PHPs), they help clients plan how to achieve their goals. The PHP is rooted in a personalised care planning approach which focuses on self-care and empowers patients to make decisions about their health and behaviour, by providing information on the options available for managing their health. HTs work in partnership with clients in setting PHPs, so that the professional-patient relationship is one of collaboration and co-operation rather than paternalism.

Usually recruited from the communities they support, Health Trainers bring local knowledge, understanding of local day-to-day concerns and experiences, and a shared commitment to improving the health of these communities. Such "role models" are likely to have more influence if they are similar in background and other characteristics to those they are working with (Abraham & Gardner, 2009)

Health Trainer Services (HTSs) are mainly set up, commissioned and provided by Primary Care Trusts (PCTs), although some HTSs have also been developed through third sector organisations. The development and implementation of the National Health Trainer Programme has been supported by a national 'hub and spoke' model. Each local service is located within a 'hub'. There are currently 11 regional hubs, organised primarily by regional NHS and Strategic Health Authority (SHA) boundaries (due to the number of PCTs it serves London has

two hubs). Each regional hub has a hub lead who, as a member of the National HT Implementation Team, acts as a bridge between the national programme and local services. Hub leads are responsible for supporting the development of local HTSs in their region and meeting regularly to update on progress, share learning and develop shared training and policies. Hubs are requested to provide annual summaries of HT activities, funding, reach and clients, so as to document progress towards the four national HT 'Minimum Data Set' (MDS) outcomes:

- Building the workforce with the right skills to tackle health inequalities;
- Reaching the hard to reach;
- Delivering sustained improvement to the health of the people of England through behaviour change;
- Providing access to and encouraging the appropriate use and take-up of NHS and other local services.

Evidence to date suggests that HTSs are making a significant contribution to the wider government agenda on tackling health inequalities, reinforcing the programme's strategic aims for HTSs to be embedded in regional and local work on tackling health inequalities, lifestyle challenges and health improvement (D Smith, Gardner & Michie, 2008; Wilkinson, Jain, Hyland & Michie, 2007).

This report summarises data received from HT hubs for 2008-09 and documents developments and progress in relation to the overall strategic aims. This report represents the third of three annual audits of HTS activity (see Wilkinson et al, 2007; D Smith et al, 2008), and aims to provide an overview of the HT programme in 2008-09, with comparison to previous years where possible.

This is one of a series of reports that document HT activity in 2008-09. Other reports that cover 2008-09 data include:

- Workforce Audit (Murfin, Mitchell et al, January 2010) – which will provide a detailed overview of the HT workforce and progress towards building a workforce with the right skills to tackle health inequalities
- National Data Collection Reporting System (DCRS) report, which will outline HT and client activity, and the effectiveness of the HT service for changing behaviour, based on a robust and reliable data reporting system (J Smith, Gardner & Michie, forthcoming).

Method and Results

Data summarised in this report were provided by HT hubs to the DH, via an End of Year Report (EYR) proforma. The proforma requests information on HT personnel and clients, stages of development, and funding. The proforma requires HTSs to respond to closed questions (e.g. numbers of clients served) and elsewhere to provide free-text information (e.g. groups targeted by HTSs). In this report, responses to closed questions are presented as percentages and mean averages, and free-text information has been coded into categories.

The period covered by the reports is 1st April 2008 to 31st March 2009. Hubs were given the opportunity to review their reports in September 2009.

Further information, and a hub-by-hub breakdown, are presented in the Appendices.

Data available for report

Of the 152 PCTs in the UK, 144 (95%) provided data for this report. This represents an 8% increase in PCTs providing data relative to 2007-08 (133 PCTs; D Smith et al., 2008), and 35% more than responded in 2006-07 (107 PCTs; Wilkinson et al., 2007).

There were missing data within each completed proforma. Data availability is noted in each section.

Service details

Health Trainers

Number of Health Trainer Services (HTSs)

Data presented within this report relate to HTSs that were explicitly named in the proforma. 34 unnamed HTSs are excluded from this report.

29 PCTs reported only unnamed or no HTSs. Hence, 169 named HTSs were reported across 115 PCTs. This represents a 34% increase in named HTSs from 2007-08 (126 HTSs), and 50% more than were reported in 2006-07 (113 HTSs).

33 (20%) HTSs targeted offender populations, and 136 (80%) HTSs focused on the general population. On average, within each hub, 12 HTSs targeted the general population and 3 HTSs focused on offender populations.

Stages of development of Health Trainer services

165 (98%) of 169 HT services reported 2008-09 data for this section

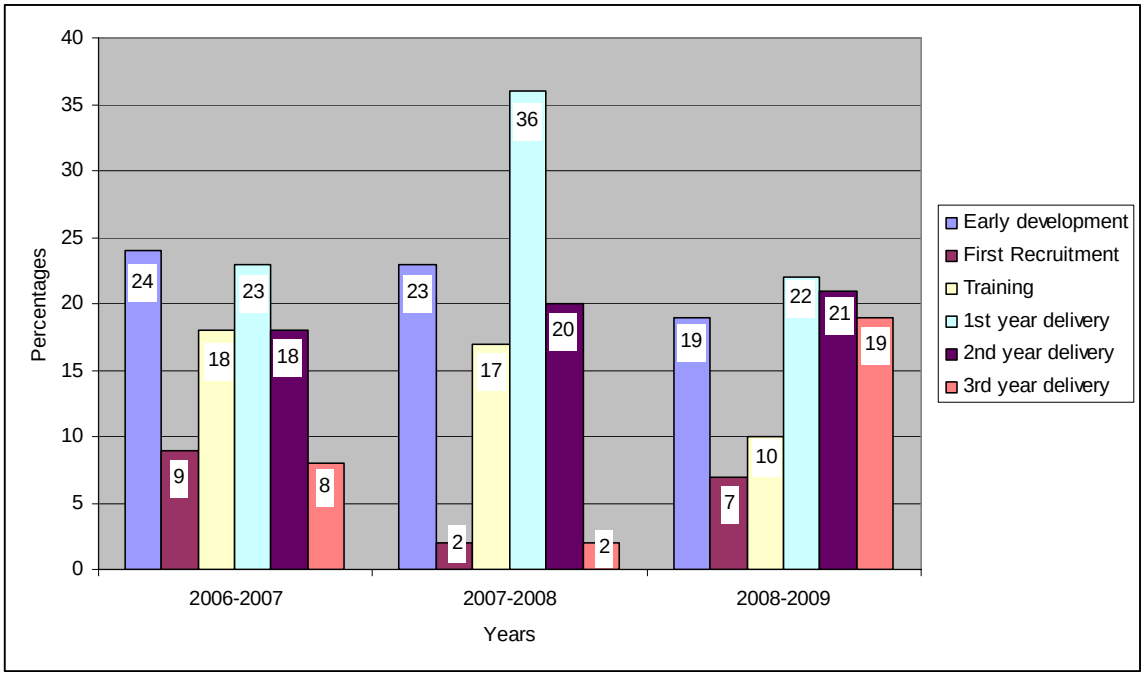
HTSs can be divided into pre-operational and operational stages of development. Pre-operational stages precede delivery of services to the client, and can be further categorised into:

- *early development stages,* where services have administrative structures in place, but have not yet started to recruit health trainers;
- the *first recruitment stage,* in which services are recruiting HTs; and
- the *training stage,* in which services are training HTs.

Operational services, which are available to clients, are categorised by the number of years in which they have been operational: *first year*, *second year*, or *third or fourth year* of operation.

Figure 1 shows HTSs within each stage of development between 2006-07 and 2008-09. In 2008-09 the majority of HTSs (104; 63%) were in the fully operational stages, representing a steady increase in the proportion of operational HTSs, from 58% documented in 2007-08 and 49% in 2006-07.

Figure 1 - Stages of Development of Health Trainer services- 2006-07 – 2008-09



Numbers of Health Trainer Personnel

147 (87%) of 169 HT services provided 2008-09 data for this section.

Health Trainer personnel include:

- *Health Trainers (HTs)*, who have completed training and been assessed as competent against national competences and undertake work with clients
- *Trainee Health Trainers (THTs)*, who are studying for the nationally recognised City and Guilds Certificate. Upon completion of this qualification, they become HTs.
- *Health Trainer Champions (HTCs)*, who facilitate uptake by providing information and promoting Health Trainer services, signpost and support clients to appropriately access other services within local communities. The HTC role has been in operation since 2007.

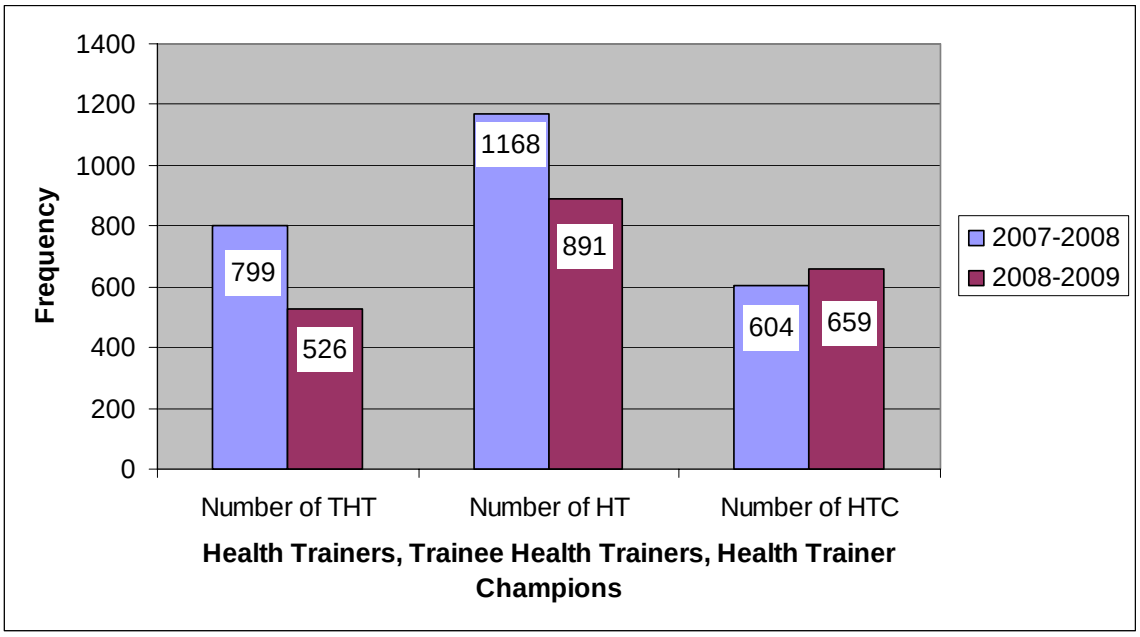
Data relating to numbers of HTs, THTs and HTCs were available from 2007-08, but not 2006-07[2]. In 2006-07, there were at least 646 HTs in training or seeing clients.

In total, 2076 HT personnel (HTs, THTs, HTCs) were reported across 147 HTSs, indicating an overall 19% decrease in personnel from 2007-08. As with 2007-08, number of HTs relates to a head count of existing HTs in HTS. There were fewer HTs (891) and THTs (526) in 2008-09 than in 2007-08 (respective decreases of 23% and 34%), but 9% more HTCs (659) than in 2007-08 (see Figure 2)[3].

[2] Comparison cannot be made with 2006-07 data, because 2006-07 data do not discern HT and THT personnel, and HTCs have been in operation since 2007 only.

[3] HT personnel figures from hub leads focus primarily on head counts (rather than Whole Time Equivalent), and subsequently may underestimate the total number of HTs. More robust personnel data might be found in the 2008-09 Health Trainer workforce audit (Murfin, Mitchell et al, January 2010).

Figure 2 - Health Trainer Personnel, 2007-08 – 2008-09



Each hub contained a mean average of 81 HTs, 48 THTs, and 60 HTCs.

Clients

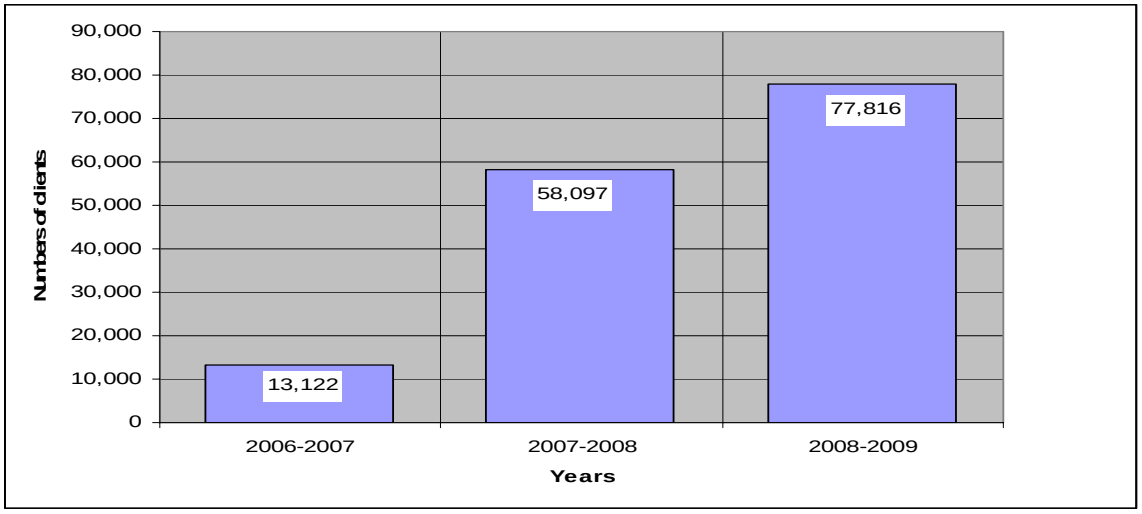
Clients supported by HTSs
136 (80%) of 169 HT services provided data for this section

77,816 clients were supported in 2008-09, 34% more than in 2007-08, and 493% more than in 2006-07 (see Figure 3).

Number of clients with a Personal Health Plan (PHP)
106 (63%) of 169 HTSs provided data for this section

28,197 clients reportedly set a PHP in 2008-09. This represents a 71% increase from 16,451 clients with PHPs in 2007-08.

Figure 3- Number of clients – 2006-07- 2008-09



Information on PHP achievement will be accessible and available from the forthcoming DCRS annual report for 2008-09 (J Smith et al, forthcoming).

Regional hub activity

Regional activities and developments

All hub leads provided free-text summaries of actual regional activities and developments in 2008-09 and forecast regional activities and developments for 2009-10.

Actual 2008-09 and forecast 2009-10 regional activities and developments were reviewed and categorised according to Minimum Data Set (MDS) outcomes. Primarily, HTS activities were in support of advancing work around outcomes 1 ('building the workforce with the right skills to tackle health inequalities') and 2 ('reaching the hard to reach').

Actual activities – 2008-09

Across the 11 hubs, in 2008-09, regional activities were primarily focused on building the workforce with the right skills to tackle health inequalities and reaching the hard to reach.

Example responses which indicated achievement of the MDS outcome of building the workforce with the right skills to tackle health were:

- 'Developing e- learning, ongoing training, links and support work'
- 'Identifying and developing work with third party organisations to support the HTS'
- 'Training 'Changes 4 Change' (Big Lottery Fund) project staff to Royal Society for Public Health Level 2 [2] including SHA lead members of staff'.
- 'Working with CSIP (Care Services Improvement Partnership) Mental Health promotion lead, two day workshop and follow up meetings'
- 'Working with HT coordinators around low-level mental health support'

Example responses indicating that HTSs were seeking to reach the hard-to-reach were:

- 'Working with older people, young people and clozapine users'
- 'Developing the HTS in 6 prison settings'
- 'Meeting with Royal National Institute of Blind People to scope new settings'

Forecast regional activities and developments - 2009-10

Responses which suggested that HTSs anticipated building the workforce with the right skills to tackle health in 2009-10 included:

- '15 mentors and bail hostel workers from offender settings trained as HTCs'
- 'Royal Society for Public Health Training with new HTC services, delivering training to up to 20 people'
- 'Awareness training for HTs, support for development of care pathways and referral protocols with their local mental health services'

Example responses indicating that HTSs expected to reach the hard-to-reach in 2009-10 were:

- 'Uptake of HTS by third party sector'
- 'Scoping potential workplace HT programmes'
- 'Identifying more new settings, target groups consulted to enable promotion of HT programme to target group'
- 'Working with travellers'

[2] Royal Society for Public Health Level 2 qualification aims to equip candidates with a knowledge and understanding of the principles of promoting health and wellbeing and of how to direct individuals towards further practical support in their efforts to attain a healthier lifestyle.

Models of service delivery

9 hubs (81%) gave free-text comments to indicate changes in models of service delivery since 2007-08

Free-text comments concerning changes in service delivery models since 2007-08 were coded into eight discrete categories. These are outlined below, with examples of responses indicative of this category.

Increase in use of the HTS

Three hubs referred to increased use of the HTS; for example, integrating the HT workforce in wider areas, and more and better established community services.

Example comment: '*HTs are now integral part of the workforce in many areas'*

Increase in recruitment, development and training of HT personnel

Three hubs commented on the increase, development and training of HT personnel. Responses referred to, for example, better ways to prepare HT personnel for facilitating behavioural change choices where health literacy and skills were barriers to choice, and more specialized training and support for HTs. One hub commented that the training component for HTs had become increasingly more flexible.

Example comment: *'HTs are receiving increasingly more specialist training and support following Level 3 training, e.g as healthy walk leaders in mental health, in oral health and are thus specializing in settings that include a focus on these areas'*

Networking and partnerships with other organisations, and/or other HTSs

Three hubs commented on the networking and partnership aspects of HTS**.** This theme included better communication and networking among managers of services, and partnerships with, for example, adult education services and Diabetes UK.

Example comment: *'some PCTs developed partnerships which have helped refine models'.*

Wider target groups

This theme was cited by three hubs, each of which reported giving greater attention to offender populations. Two hubs reported targeting a wider range of groups as a result of increased networking with other organisations.

Example comment: '*We anticipate HTs will be asked to broaden scope of their work and move towards more clinical areas'*.

Commissioner/provider issues

Two hubs discussed the potential impact of commissioners and providers, and in particular the potential divide between the commissioner and the provider, on models of service delivery.

Example comment: *'increasing number of PCTs commissioning from non public sector providers may bring changes to target populations/geographical areas'.*

Commitment to data collection and findings from the HTS

One hub reported greater commitment to collecting data collection so as to build the evidence base, which was seen as a means to ensure sustainability of the service.

Comment *'Change regarding commitment to data collection to build the evidence and ensure sustainability'*

Effects of the economic downturn on HTS

One hub felt that the 'credit crunch' had impacted negatively on service delivery since the previous year.

Comment: '*Credit crunch impacting on HT service'*

Developing a consensus within each hub

One hub had developed a consensus within the hub that each PCT area required a mixture of service delivery models, rather than each PCT employing different models.

Comment: *'Consensus within the hub that each PCT area needs a mixture of models rather than the current position of each PCT with different models'*

Groups/communities targeted by HT services

131 (78%) of 169 HTSs provided information for this section

Free-text indications of target groups or communities were coded into four categories: demographic-based groups; vulnerable groups; individuals with varying health status; and other groups.

79 (60%) of 131 services focused on multiple target groups, with the remaining 52 (40%) HTSs focusing on one target group only.

Hubs also disclosed information on the rationale for focusing on particular groups or communities. For example, one hub reported that:

'All services report targeting areas known by their PCT to be deprived/have the greatest need. Sources of information quoted include individuals of high deprivation status, inequalities mapping, health needs assessments'.

However, the focus on groups and communities by the HT services differs according to PCTs. For example, as one hub disclosed:

'PCTs vary in the types of information they use to inform the targeting of their HT service'.

For example, one hub commented on the usage of key national targets as a rationale for focusing on key target groups;

'Key national targets including circulatory disease mortality; cancer mortality; life expectancy; smoking cessation; PSA targets for people with long-term conditions; and links to suicide target. Health Needs Assessments in Neighbourhood Renewal Areas have been used in some PCTs. Health Inequalities audits have also been used. Index of Multiple Deprivation is an important source'.

Table 1 presents the frequency with which target communities were cited in responses. The table illustrates that HTSs targeted a broad range of disadvantaged communities and communities at greatest risk of experiencing poor health. BME groups, older adults, individuals from deprived communities and individuals considered to be of high risk in developing diseases were most frequently mentioned.

Table 1 – Groups targeted by HT services[4]

1. Demographics[5]	**Counts***	**%**
Black and Minority Ethnic communities	20	8
Adults- general population (18 yrs+)	15	6
Males	9	4
Focus on European communities	3	1
Adolescents and Young people (12-17 yrs)	3	1
2. Vulnerable groups		
Older adults	8	3
Adults with mental health problems/ service users of mental health services	7	3
Adults with learning disabilities/ service users of learning disability services	3	1
Vulnerable adults, general	3	1
Adults with physical disabilities	2	1
Vulnerable adults residing long term care facilities/ sheltered housing	2	1
Vulnerable children within local authority care- Foster homes, hostels	2	1
Adults with sensory impairments	1	<1
Hospital patients	1	<1
3. Individuals with varying health status		
Adults considered to be of high risk in developing diseases/ developing lifestyle risk behaviours	14	5
Medical conditions (e.g. obesity)	7	3
Clients with diseases	6	2
Adults with long term health conditions	4	2
Adults with medical conditions/limitations after operations	1	<1
4. Other groups		
Focus on adults within identified deprived communities/Super Output areas	77	30
Forensic population- offenders, ex offenders and prison inmates	20	8
Service users from public sector organisations/health enhancing organisations/ Health promotion organisations/ Referral from GPs	11	4
Relatives /Carers/Parents/Visitors	7	3
Unemployed	5	2
Asylum seekers/refugees	3	1
Focus on adults within manual occupations	3	1
Families	3	1
Adults on benefits	2	1
Focus on adults within the workplace: i.e. office based occupations	2	1
Focus on adults within education institutions: University, FE/sixth form students	2	1
Homeless populations	2	1
Focus on adults living within rural communities	2	1
Local communities	1	<1
Gypsy and travellers	1	<1
Focus on adults living within homes with previous history of incidents of fire	1	<1
Total	255	100

4 Due to multiple responses provided by 79 (60% of) HTSs, the sum total exceeds total (131) HTSs.

5 This table includes only HTSs which focus on adult populations, although two HTSs reported on targeting teenagers or infant/preschool children.

Health Trainer Service funding

128 (76%) of 169 HTSs provided data for this section

HTSs are funded by NHS sources and/or non-NHS bodies (e.g. football teams, local authorities, other third sector organisations). Data were collected on *actual* funding amounts and sources for 2008-09, and *forecast* funding amounts and sources for 2009-10 (see Table 2). In 2006-07, the sources of funding were reported as allocated from the Department of Health. In 2006-07, for the 75 services which provided data for the period 2006-2007, just over £5m of allocated funding was reportedly received. For the 73 services which provided data for the year 2007-08, £10.5m was reportedly received.

Table 2 – Actual and forecast sources and amounts of funding

	Actual 2007-08 *£ (% of total for year)*	**Forecast 2008-09** *£ (% of total for year)*	**Actual 2008-09** *£ (% of total for year)*	**Forecast 2009-10** *£ (% of total for year)*
NHS source	16,937,955 *(92%)*	22,691,862 *(92%)*	23,966,810 *(96%)*	23,889,083 *(95%)*
Non NHS Source	1,467,059 *(8%)*	1,943,759 *(8%)*	1,039,015 *(4%)*	1,290,366 *(5%)*
Total	**£18,405,014**	**£24,635,621**	**£25,005,825**	**£25,179,449**

Actual funding for 2008-09

Across the UK, HTSs received £25 million funding in 2008-09, which exceeded the forecast figure (£24.6m) by 2%. £23.9m (96%) was provided by the NHS, which exceeded the forecast 2008-09 NHS contribution by £1.3m. NHS sources for 2008-09 provided 41% more funding than in 2007-08. Across the 11 hubs, the mean average funding given by the NHS was £2.2 million.

Funding from non-NHS sources (£1.0m; 4% of total) was 29% (£892,256) less than was received in 2007-08, despite a forecast 32% increase. For 2008-09, the mean average of non-NHS funds received across the 11 hubs was reported at £94,456.

Forecast funding for 2009-10

£25.2m funding (£23.9m from NHS sources, £1.3m from non-NHS services), a 1% increase on actual 2008-09 figures, is anticipated for 2009-10. The mean average of NHS funds expected across the 11 hubs is £2.1m, and the mean forecast non-NHS funds £117,306.

Monitoring and Evaluation

Use of the Data Collection Reporting System (DCRS)

118 (70%) of 169 HTSs provided data for this section

The DH has supported the development of a standardised national Health Trainers Data Collection and Reporting System (DCRS) so as to provide a broad and in-depth service profile of the HT programme. The Minimum Data Set (MDS) is an integral part of the DCRS and all data fields within the MDS have been made mandatory within the DCRS. Data reported via a standardised system are easier to synthesise and summarise than data provided in hub proformas, and hubs are encouraged to use the DCRS. Figures 4a and 4b summarise the HTSs that were using, planned to use, or neither used nor planned to use, the DCRS in 2008-09, and, for comparison, 2007-08 (D Smith et al., 2008).

Figure 4a- Use of the DCRS - 2008-09

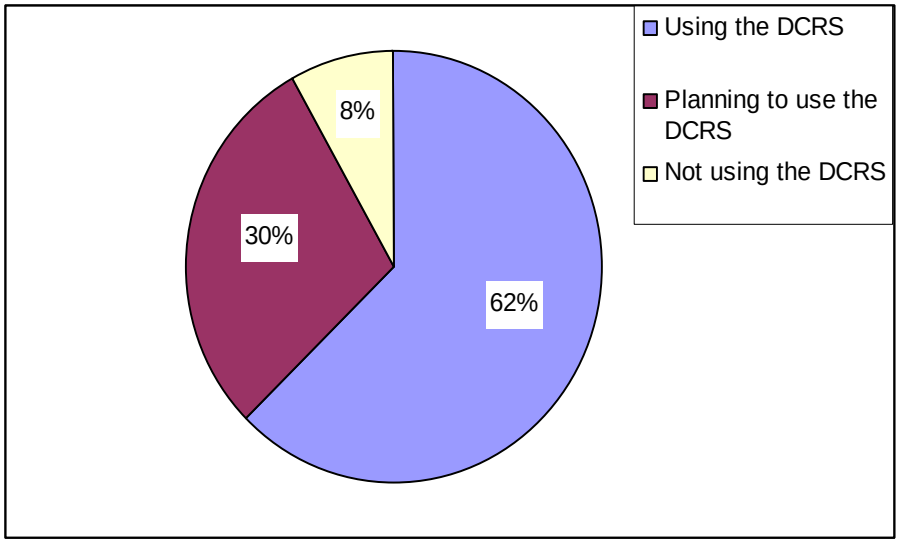
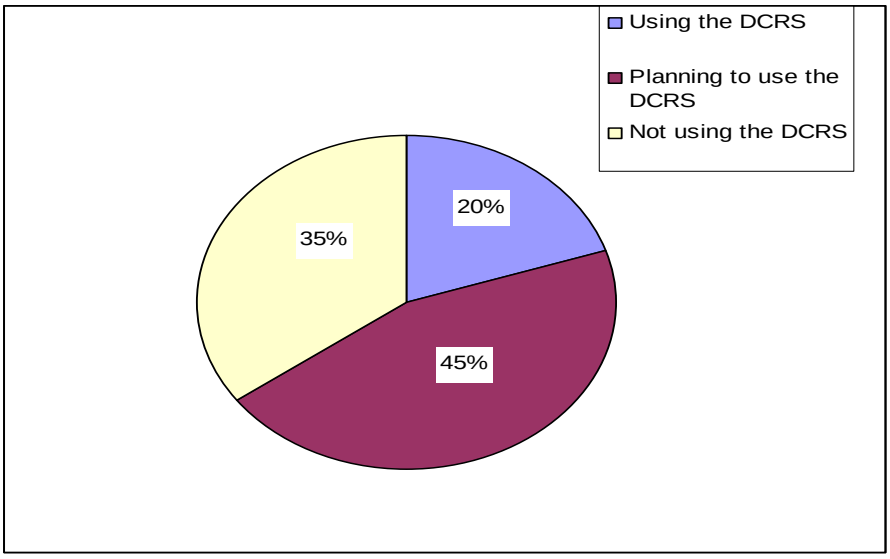


Figure 4b- Use of the DCRS- 2007-08



The majority of the 118 HTSs (74; 62%) were using the DCRS in 2008-09, which was 215% more than in 2007-08. The increase in DCRS usage results in a 33% reduction in HTSs at pre-installation phase and a 77% decrease in HTSs not using the DCRS.

61 (84%) of HTSs using the DCRS, and 7 (77%) of the 9 HTSs not using the DCRS, were within the fully operational stages. Of 35 HTSs planning to use the DCRS, 18 (51%) were within pre-operational stages.

Alternatives to DCRS

MDS data collected from sources other than the DCRS included data from Prison Health Trainer services, and data recorded in paper form due to lack of resources for using the DCRS. One hub reported using the national spine for data collection 'System One' which is still under development.

Sustainability of services

All hub leads gave free-text comments on HTS sustainability

Multiple factors were perceived to influence the sustainability of HTS. These are outlined below, together with an indication of how many hubs cited each factor.

Funding (cited by 81% of hubs)

Issues surrounding funding were discussed both as making positive contributions to sustainability, and as threats to HTS sustainability. For example, whereas one hub commented that HTS were more likely to be sustainable if PCTs invested more in HTSs, other hubs commented on the unpredictability and instability of funding as a potential challenge to sustainability. Similarly, while one hub

anticipating HTS funding cuts from PCTs due to the recession, another hub felt that the current economic climate could have a positive effect on HTS.

> *'[The] financial downturn has led to [the] need to offer alternative value for money approaches, primarily HTCs and integration with community health champions who target those with greatest health inequalities. [This] adds value to existing HT services.'*

Provider and commissioner relationship (37% of hubs)

Two hubs commented on the commissioning and provider separation in assessing sustainability of the HTS. Other hubs discussed the positive impact of significant interest and support from other organisations on the sustainability of the HTS.

Reporting (9%)

One hub commented on the value of sustaining HTS through the reporting of HTSs within key regional publications.

> *'Placing HTs into the NHS East of England, Staying Healthy Clinical Pathway Group Final report 2008 hopefully will help to ensure sustainability.'*

Integration with other health services (9%)

One hub felt that sustainability was influenced by how integrated the HTS was in relation to health services.

> *'Sustainability is still dependent on embedding the services which can be difficult in PCTs where there is limited or no activity.'*

Staff turnover (9%)

One hub commented on the impact of staff turnover in assessing sustainability of HTSs.

Discussion

The number of Health Trainer Services (HTSs) continues to grow, and most services are fully operational. Despite a notable reduction in frontline HT personnel, 15% more clients were served by HTSs in 2008-09 than in the previous year. This might suggest that a considerable number of part-time personnel are becoming full-time HTs and so are able to serve more clients, and/or that HT services are becoming more efficient in serving clients. Although not directly assessed in the hub data, the reduction in frontline HT personnel could be due to various reasons such as leaving to pursue employment opportunities or undertake further training; this is explored further in the Workforce Audit report (Murfin, Mitchell et al, January 2010).

HT personnel are receiving greater training in approaching and working with socially deprived groups. HTSs are also increasingly developing partnerships and networking opportunities with other organisations, and a wider range of hard-to-reach and socially disadvantaged groups are being reached by HTSs.

Funding for HT services has continued to increase, which is encouraging given the current economic climate. The vast majority of these funds came from NHS sources. Non-NHS sources contributed less financial support than the previous year, and fewer funds than was forecast for 2008-09. This may suggest the need for a review of funds from alternative non-NHS sources, especially given the importance placed on funding in relation to HTS sustainability.

It is unclear from the data we have summarised where the increased funding of HT services is being allocated, given observed reductions in HT personnel. One possibility is that the apparent drop in HT personnel is unreliable and reflects missing data and/or underestimation of HT personnel. We anticipate reliable data on health trainer personnel to be outlined in the Workforce Audit report (Murfin, Mitchell et al, January 2010).

Further information relating to achievement of Personal Health Plans (PHPs), which are key to the HT initiative, is required for future HTS hub reports. Lack of data relating to PHPs precludes assessment of the effectiveness of PHPs, and, by extension, the utility of the evidence-based approach to behaviour change on which the HT service is based. Further evidence is required to demonstrate the clinical and cost effectiveness of the HT programme as a means of empowering clients to choose healthier lifestyles. More robust information on PHP achievement will be available from the DCRS report (J Smith et al, forthcoming).

The value and continued acknowledgement of using the DCRS will promote recording of better quality data in subsequent years. It is therefore imperative that all hubs support local HTSs to adopt the DCRS, and that full data are recorded by hubs using it. But recording progress and achievements, we will be able to gain a clearer picture of the development and achievements of the HT programme.

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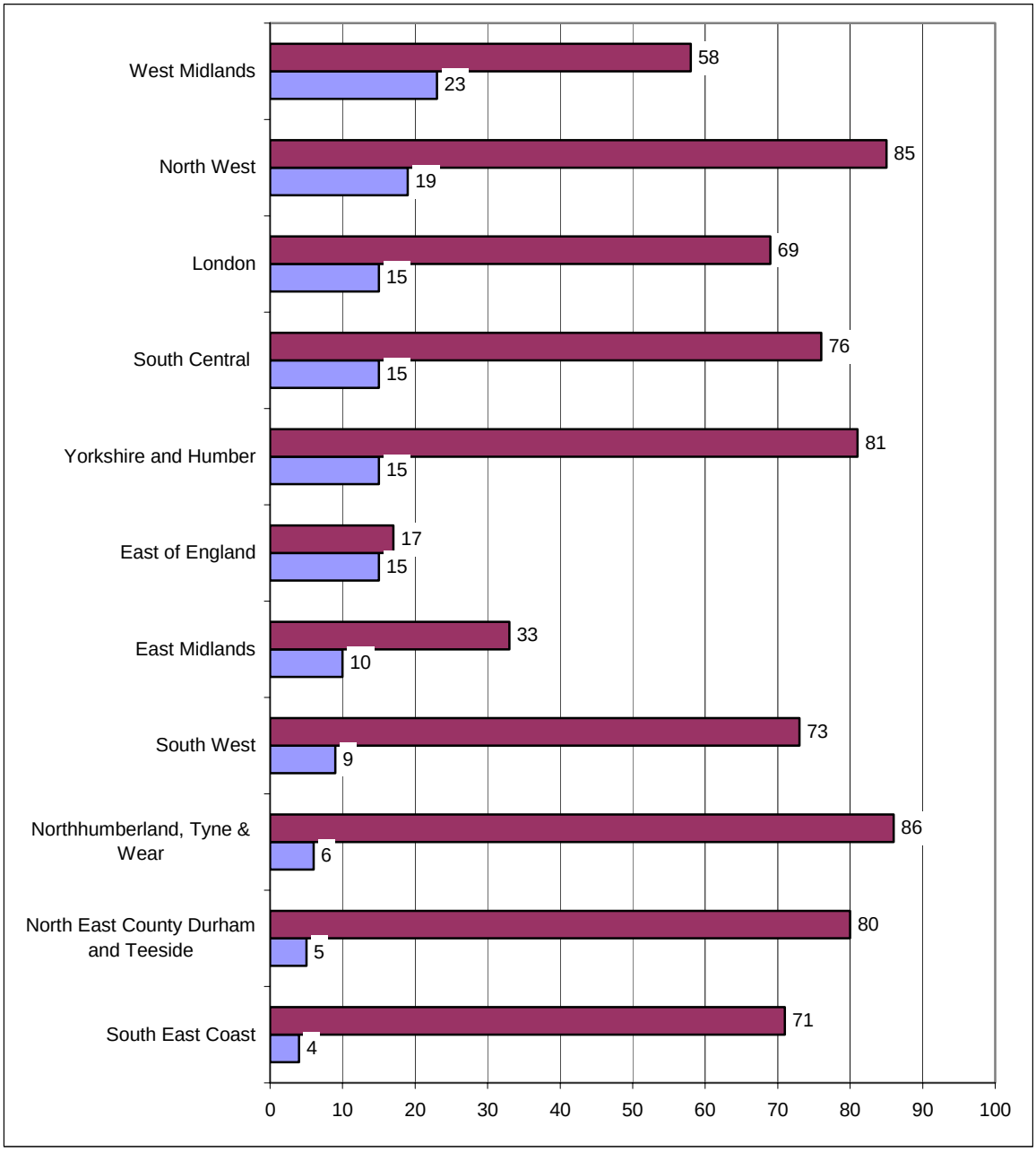
Appendix: Regional data charts

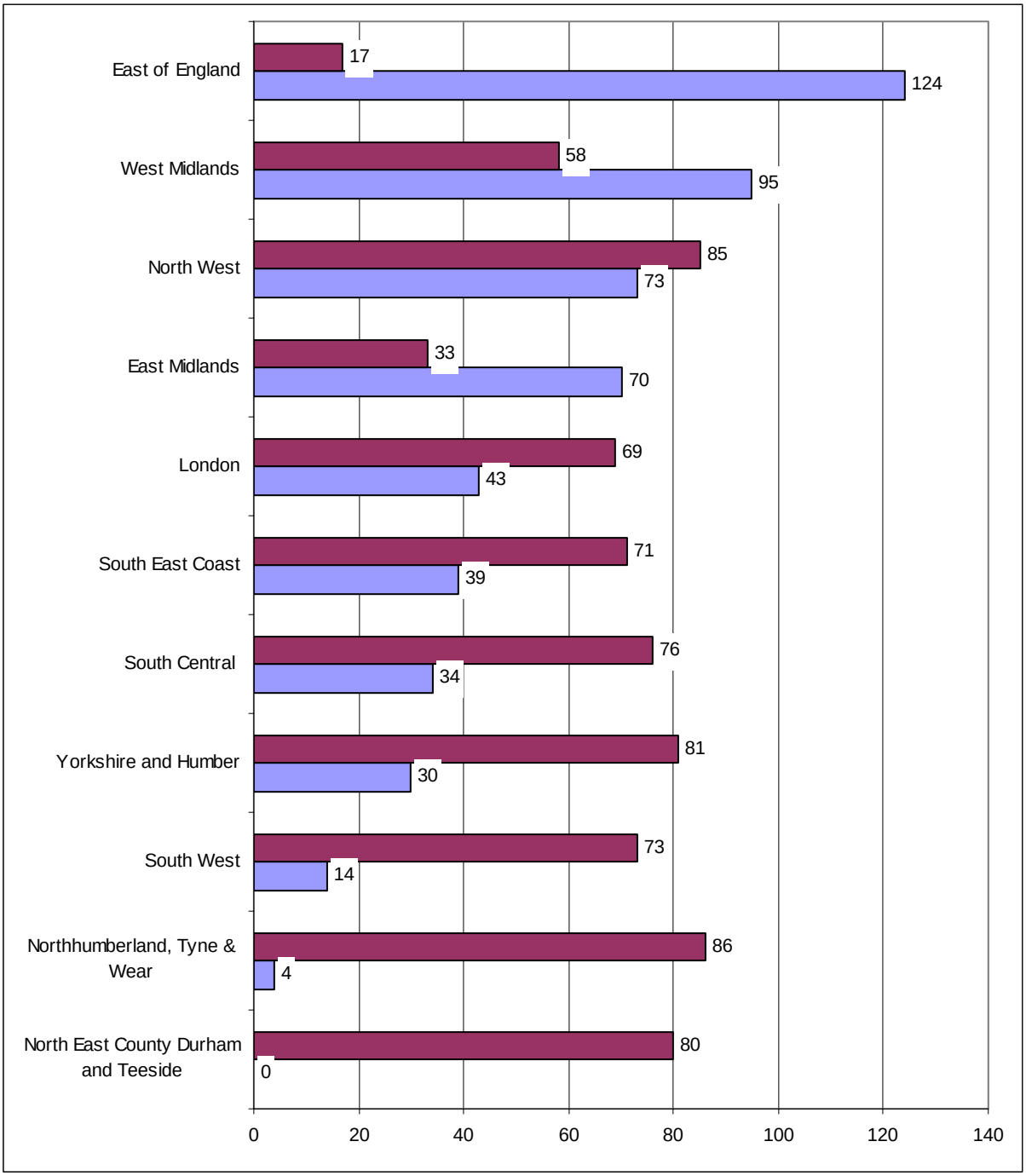
These charts summarise raw data relating to HT service activity for individual hubs. Fully operational HTSs are likely to be more active in supporting clients than are pre-operational services. Hence, to aid interpretation, the number or percentage of fully-operational HTSs within each hub are included in each graph.

1. Number of Health Trainer Services (HTSs)



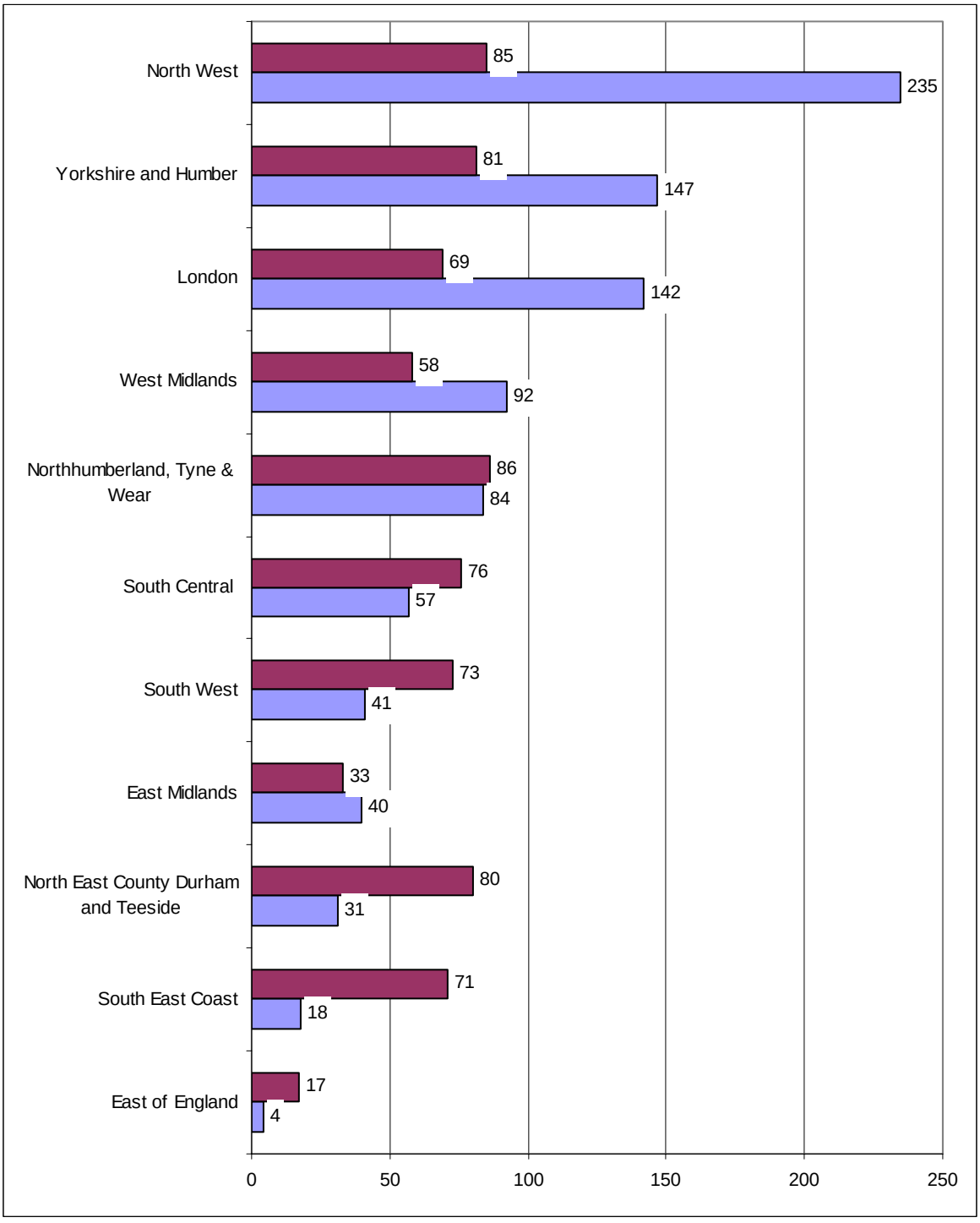
Pink bars represent the *percentage* of named HTSs which are fully operational within each hub. *Blue bars* represent the *number* of HTSs within each hub.

2. Number of Trainee Health Trainers (THTs)



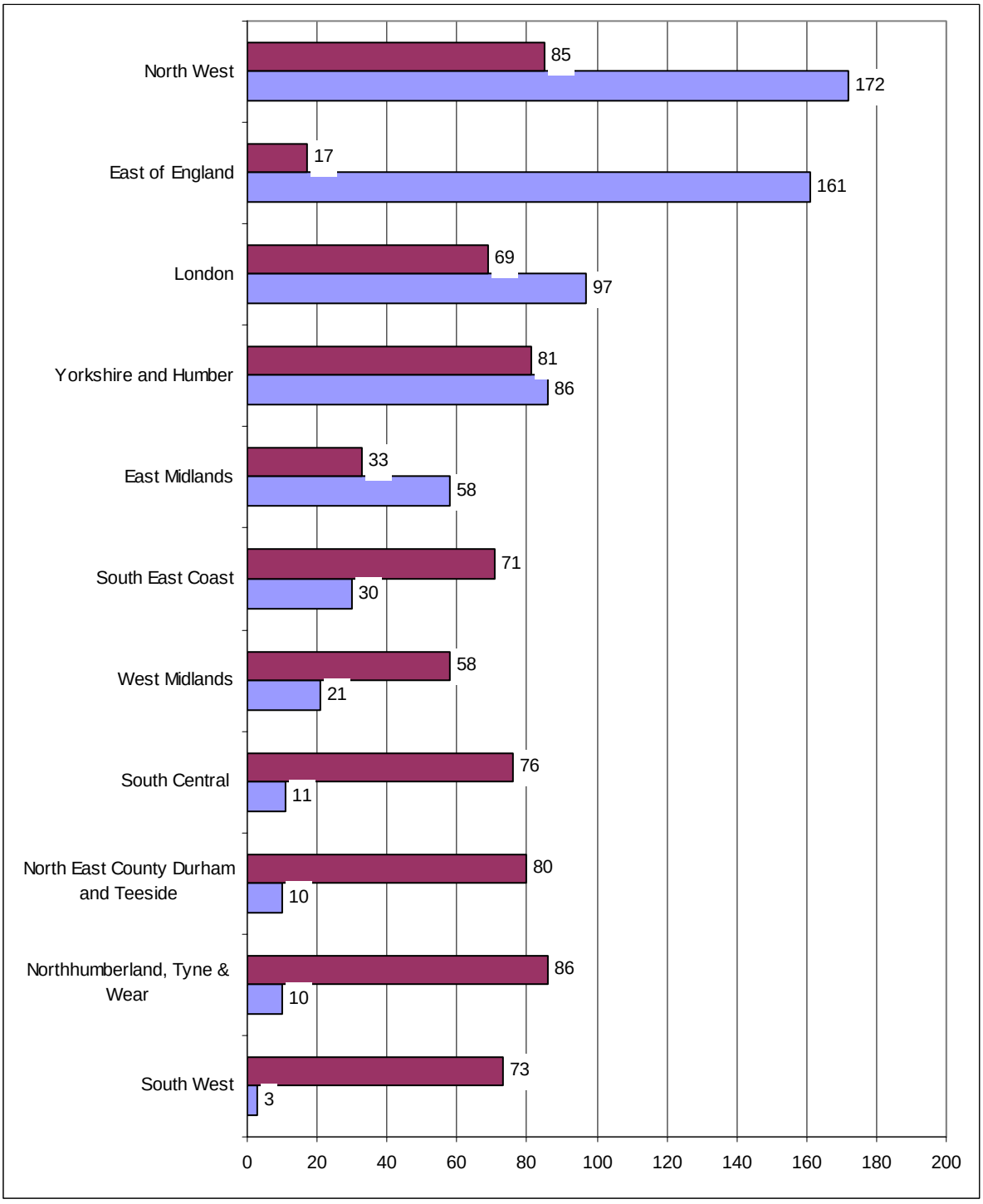
Pink bars represent the *percentage* of named HTSs which are fully operational within each hub.
Blue bars represent the *number* of THTs within each hub.

3. Number of Health Trainers



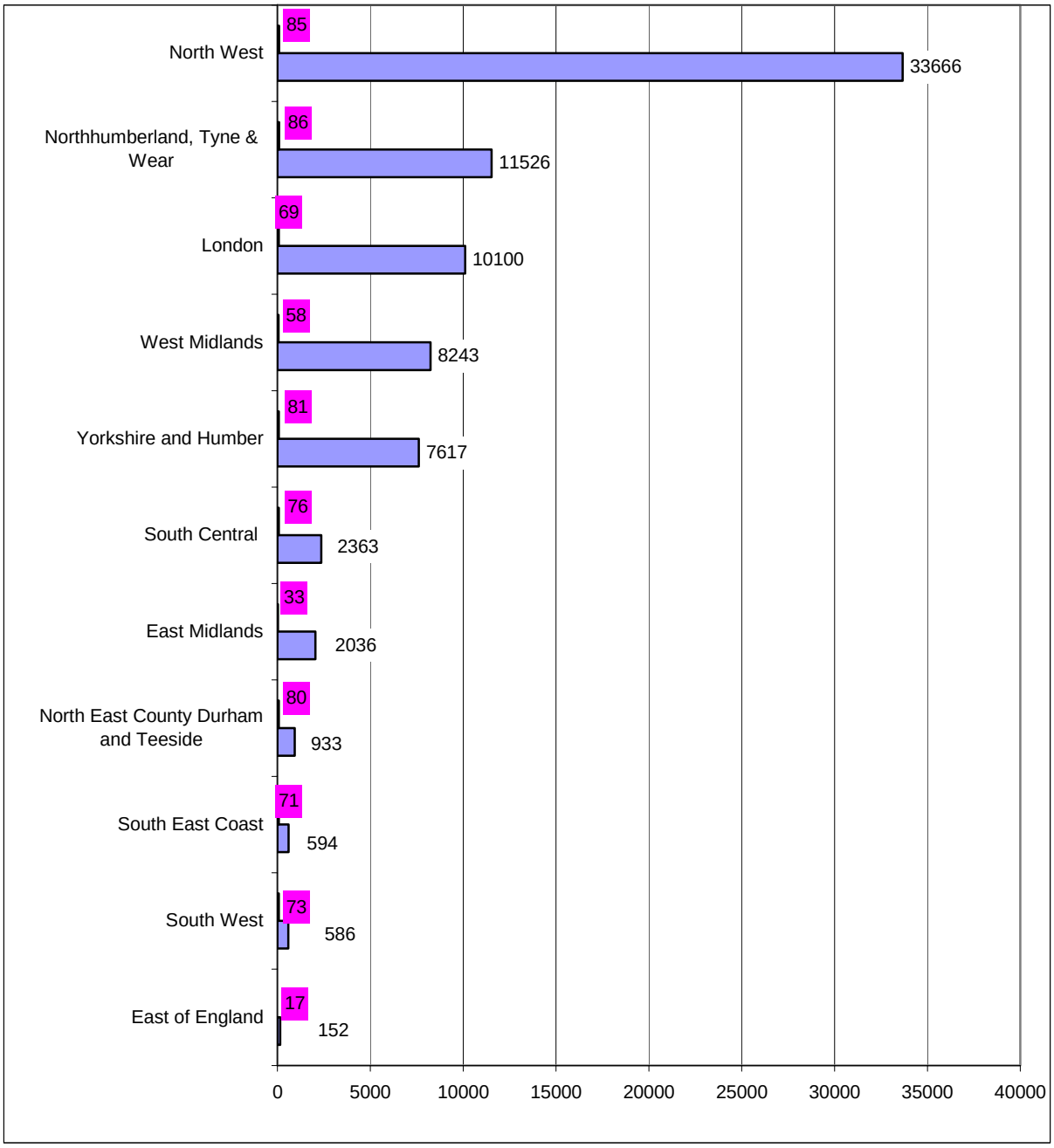
Pink bars represent the *percentage* of named HTSs which are fully operational within each hub.
Blue bars represent the *number* of HTs within each hub.

4. Number of Health Trainer Champions (HTCs)



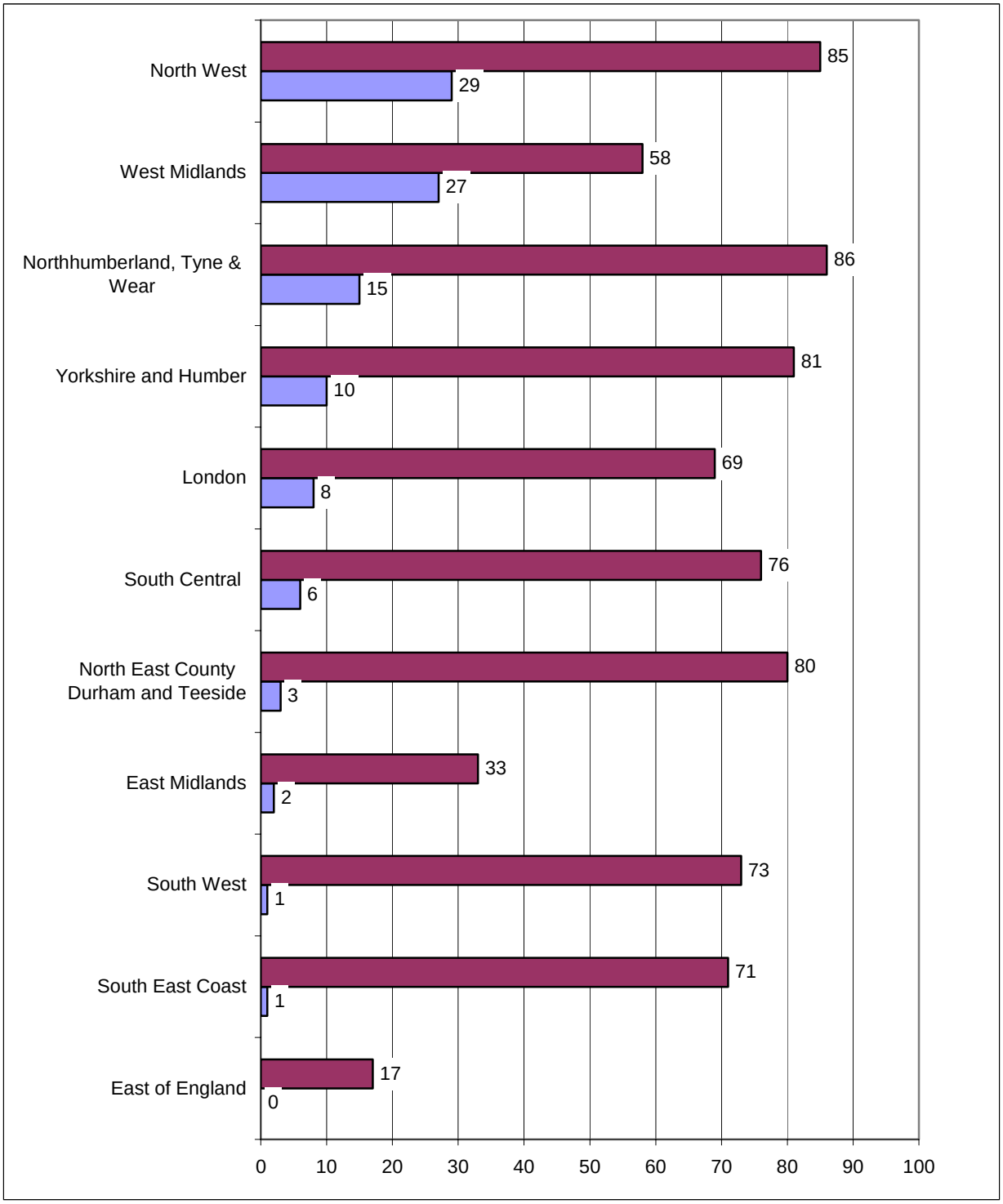
Pink bars represent the *percentage* of named HTSs which are fully operational within each hub. *Blue bars* represent the *number* of HTCs within each hub.

5. Number of clients



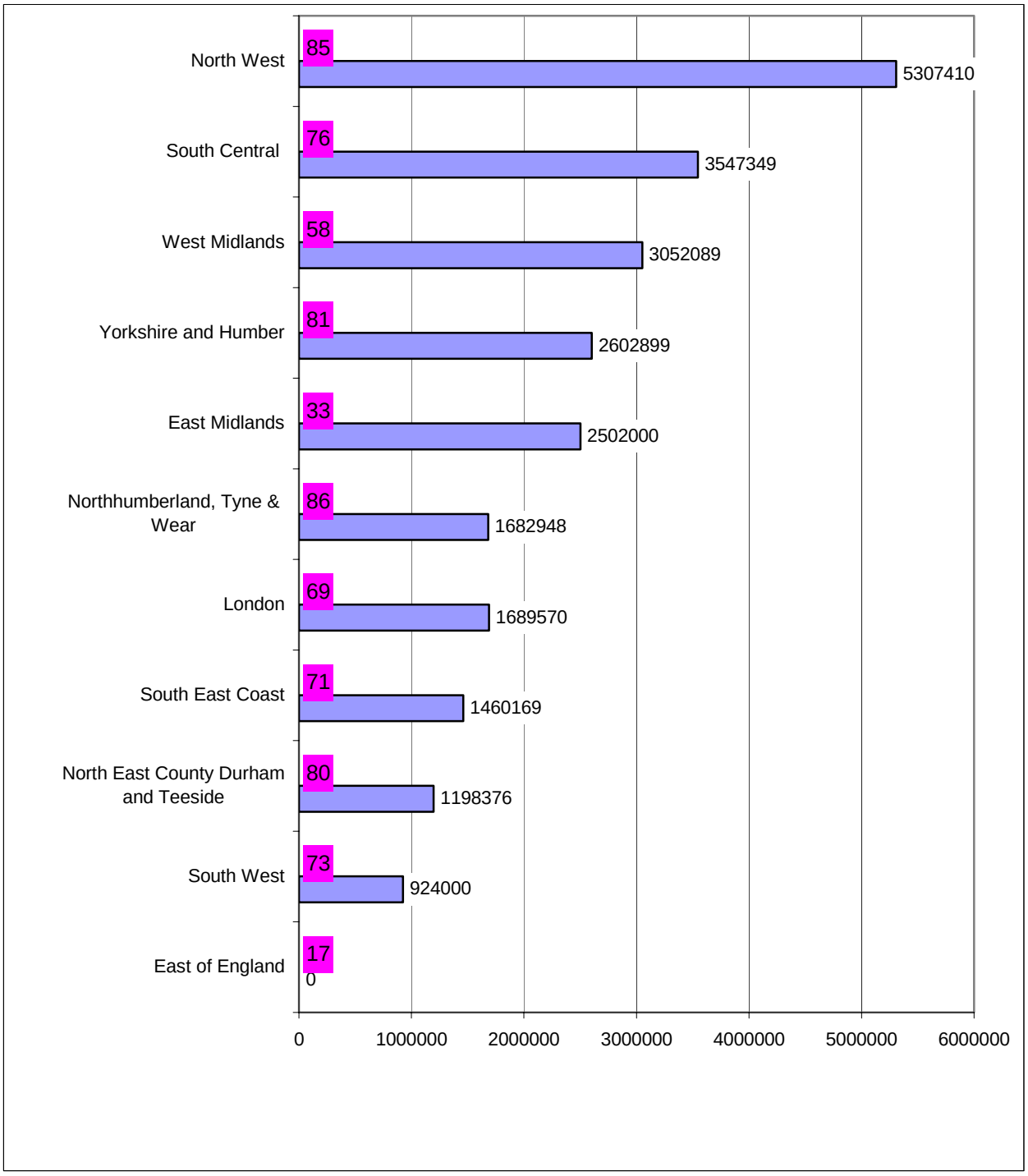
Pink bars represent the *percentage* of named HTSs which are fully operational within each hub. *Blue bars* represent the *number* of clients served within each hub.

6. Percentage of clients with a Personal Health Plan (PHP)



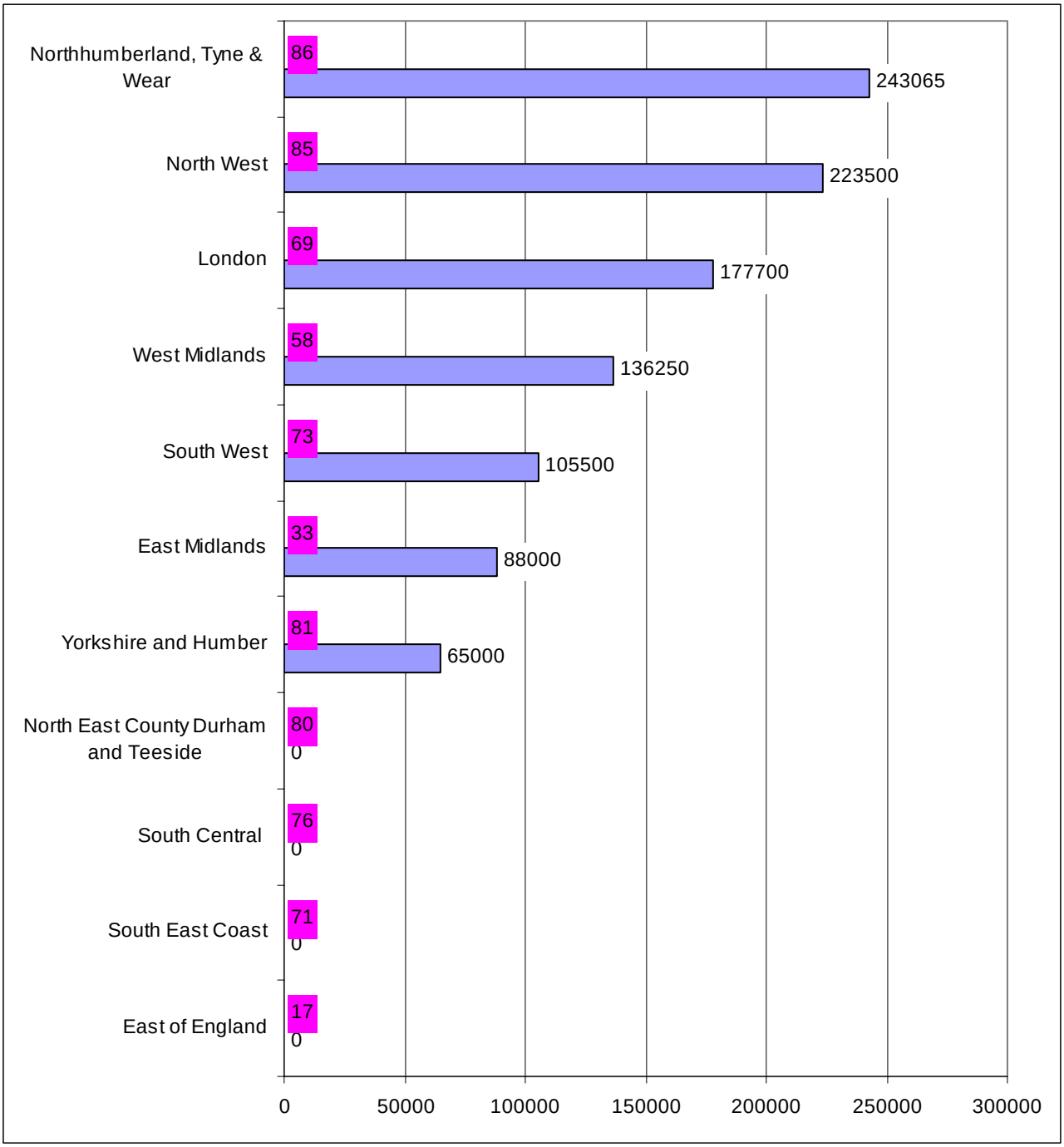
Pink bars represent the *percentage* of named HTSs which are fully operational within each hub.
Blue bars represent the *percentage* of clients with a PHP within each hub.

7. Actual NHS sources of funding, 2008-09



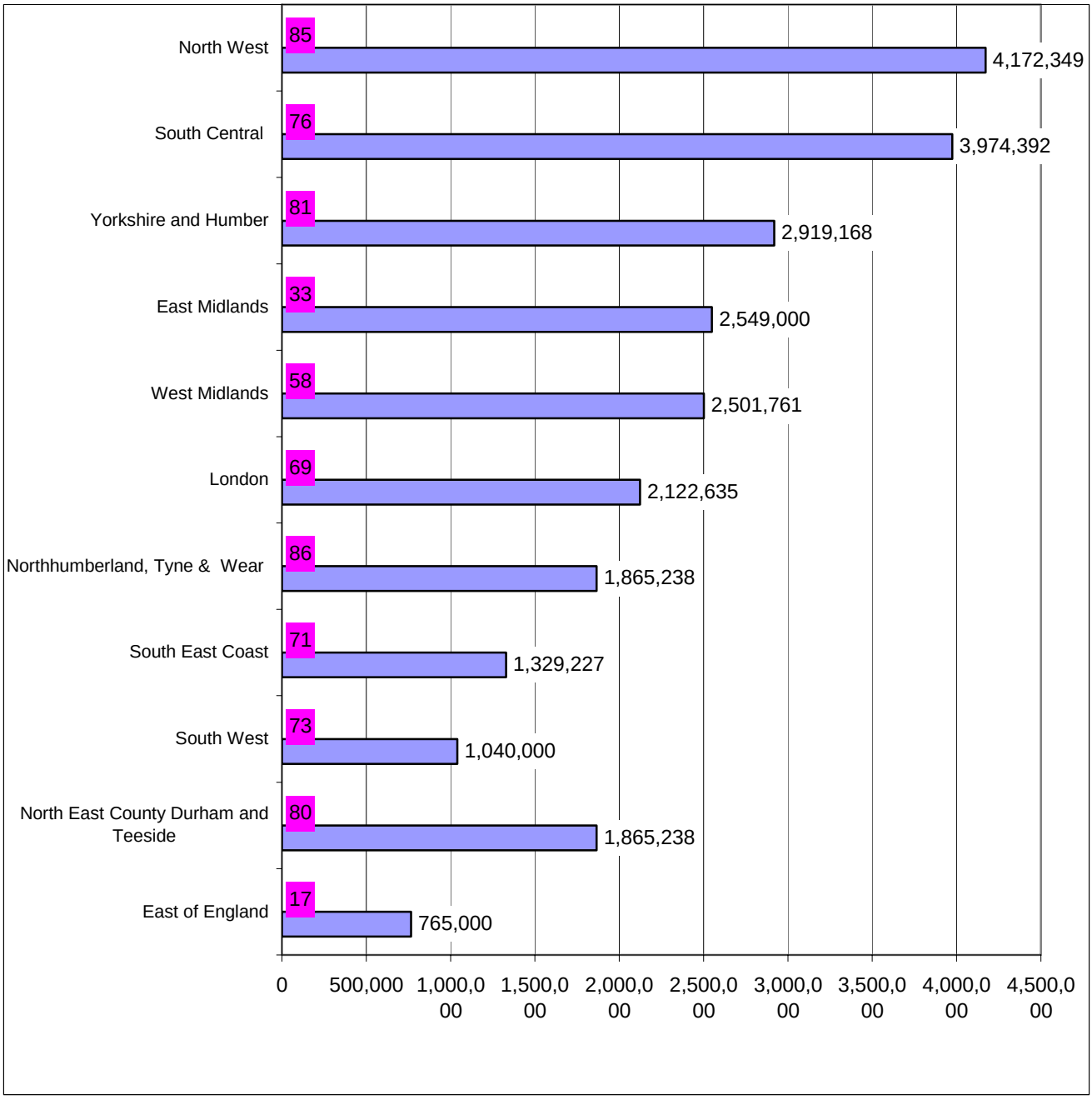
Pink bars represent the *percentage* of named HTSs which are fully operational within each hub.
Blue bars represent the *amount* of funding within each hub received from NHS sources.

8. Actual non-NHS sources of funding, 2008-09



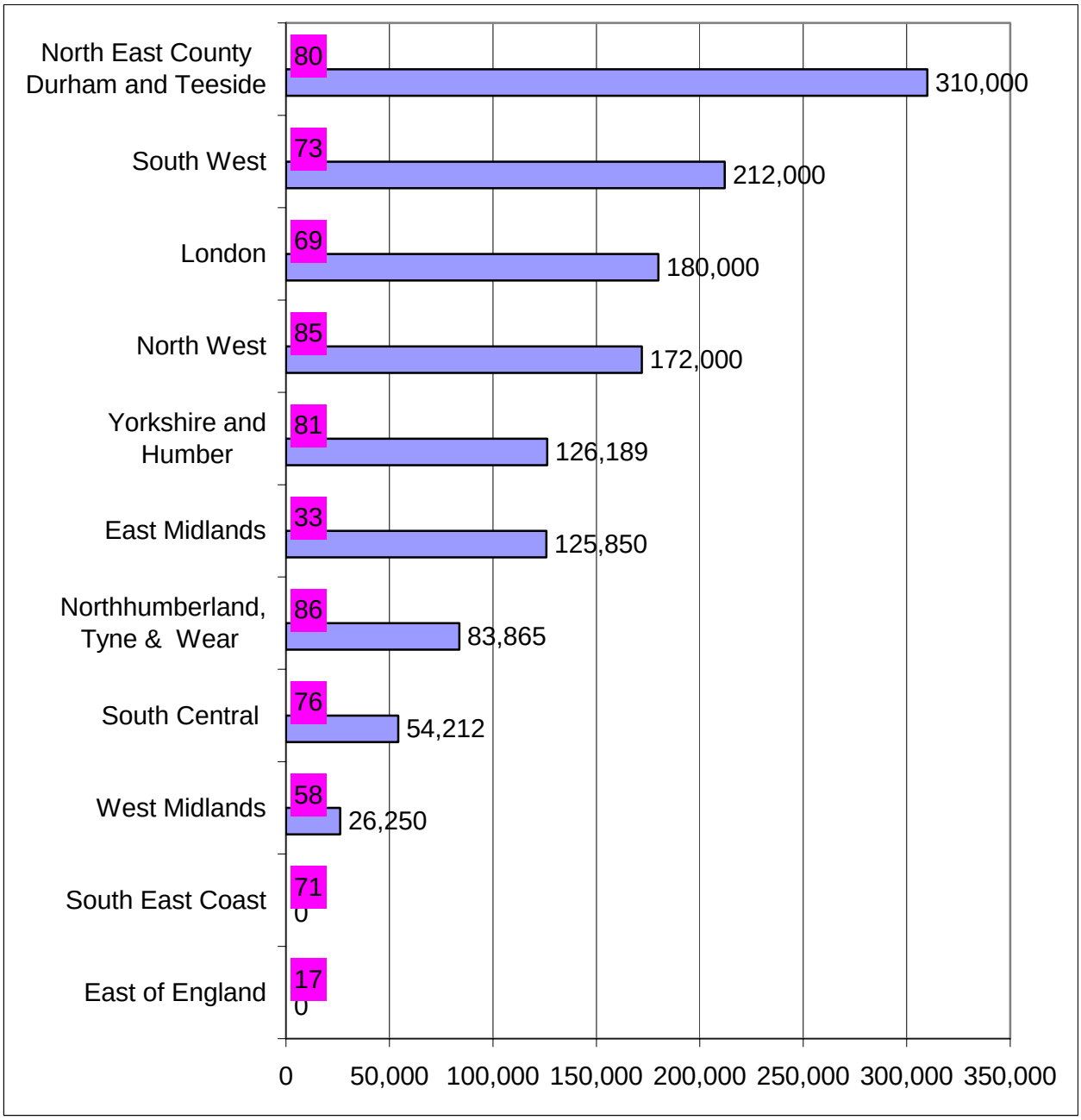
Pink bars represent the *percentage* of named HTSs which are fully operational within each hub.
Blue bars represent the *amount* of funding within each hub received from non-NHS sources.

9. Forecast NHS sources of funding, 2009-10



Pink bars represent the *percentage* of named HTSs which are fully operational within each hub.
Blue bars represent the *amount* of funding within each hub anticipated from NHS sources in 2009-10.

10. Forecast non-NHS sources of funding, 2009-10



Pink bars represent the *percentage* of named HTSs which are fully operational within each hub.
Blue bars represent the *amount* of funding within each hub anticipated from non-NHS sources in 2009-10.