East Midlands Health Trainer Service Evaluation Report Executive Summary

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Executive Summary

The East Midlands Health Trainer Partnership Hub commissioned Solutions for Public Health to undertake an evaluation of the Health Trainer Services across East Midlands region in 2010. The evaluation objectives were:

1. Evaluate the service models of all health trainer services across the East Midlands by exploring and describing the activity and outcomes of health trainer services
2. Produce a report on the evaluation findings and its methodology with recommendations for service sustainability and development, and future investment decisions
3. Advise the hub on a future evaluation framework

The evaluation scope of work asked a number of specific questions to be answered by the team. These were grouped in relation to Health Trainer Service development and processes and the impact of the services on workers and clients. The team further categorised these as questions relating to inputs, processes, outputs and outcomes. The report is structured to answer these specific questions.

With regards to the impact the Services are having, the evaluation team has found that:

- 61% of clients reached by the Health Trainer Services come from the 40% most deprived social quintiles. In some parts of the service, such as those targeting rural areas, socially isolated individuals are also being reached.
- At least 60% of Personal Health Plans have been achieved, with another 21% 'part achieved' in the region. These rates are considerably higher than the most recent national reports, which put goal achievement rates at 51%.
- Positive impact is being made on health outcomes. Out of 2,310 clients reporting changes, there was a: 5% reduction in BMI, 76% increase in daily fruit and vegetable intake, 49% increase in moderate exercise per week, 53% reduction in cigarette smoking and a 53% reduction in alcohol units consumed.
- Overall 44% of Health Trainers (HTs) and Health Champions (HCs) come from the two most deprived social quintiles. Those working in the Service indicate that they find the work highly rewarding, are highly committed to the work they do, and are changing their own behaviours to adopt healthier lifestyles.

The potential health gain and cost savings achieved by Health Trainer Services, which focus on tackling inequalities and lifestyle choices, are enormous. Health inequalities, deprivation and poor lifestyle choices are costing the country upwards of £30 to £33 million per year, according to the 2010 Marmot Review on Health Inequalities.

i) Differences in service models, appropriateness and implications for effectiveness:

Different models for Health Trainer Services are being implemented across the East Midlands, commissioned through a variety of providers, in a range of settings and using different combinations of HTs and HCs. Each of the models explored is appropriate for the area and community being targeted.

There is some anecdotal evidence to indicate that services that are provided through community based organisations have easier access to more deprived communities.

The service model used appears to have less of an impact on recruitment and retention than other good management practices, such as good supervision and support, and having clear work plans and targets.

Recommendations:

- Health Trainer Services should ensure active supervision, and clear lines of accountability and support are in place for all staff.
- Commissioners should agree with provider's clear targets and outcomes for all health trainer services and for each service model. These targets should inform work plans and services monitored against target achievement.

ii) Recruitment, Training and Retention: Recruitment of HTs and HCs has evolved and improved as the different services have learned how best to attract both workers and clients to the services. As the services have developed a better balance has been struck between recruiting people from deprived backgrounds with no qualifications along with people who already have qualifications. The services have found that recruiting, managing and supporting individuals who start out with no qualifications or relevant experience takes considerably more time and effort.

All workers in the services have received appropriate initial training. There is, however, significant variation in how the different services ensure Continuing Professional Development (CPD).

HTs and HCs have indicated that many of the people they work with, individually or in groups, have far more complex psycho-social problems that are at the core of the lifestyle

problems they experience. Health Trainer Services have been less successful in providing the training and backup to HTs and HCs in handling clients with pressing emotional problems.

Workforce retention has also varied across the region. In at least 50% of cases HTs who have left the service have gone on to do better paid jobs in a similar field, either within or beyond the NHS. This employment progression can be seen as an, as yet, unquantified benefit of the service for its workforce.

There is anecdotal evidence that in some cases HTs and HCs have left because they have found the work too challenging and/or did not feel they were receiving adequate management support and guidance.

Recommendations:

- Health Trainer Services in early stages of development should consider recruiting HTs and HCs from a range of backgrounds, experience and qualifications.
- The region wide guide to CPD should be followed consistently across all services, with local CPD provision tailored to meet service need.
- CPD sessions should include attention to the boundaries of service provision, especially in terms of working with people with complex psycho-social needs.
- Reasons for leaving the service, both positive and negative, should be consistently monitored. Where appropriate, this information should be used to inform development of Service supervision, management and training systems.

iii) Measuring and monitoring impact and value for money: The evaluation team found that Health Trainer Services are not routinely monitoring the full impact of the Service, nor have they had the means to measure value for money.

Routine reporting, and use of reported data, varies between the different services. In most cases, where routine reporting is required through quarterly reports, providers have been asked by commissioners to report on outputs (e.g. numbers of clients seen and goals set) rather than outcomes (e.g. number of goals achieved). While this approach has had an effect on more clients setting goals, there has not been as positive an impact on goal achievement (e.g. % of clients setting goals then successfully achieving them).

Recommendations

- Future commissioning of and investment in Health Trainer Services will be influenced by demonstrable outcomes. All services should put in place routine reporting and review mechanisms to assess progress against local targets.
- Monitoring and evaluation of services needs to be done using criteria that reflect the original aims of the service i.e. achieving measurable behaviour change, and more effective and timely use of health and wellbeing services in the target groups.

iv) External Perceptions of the Service: Service providers and commissioners interviewed reported that PCT staff and others who work directly with HTs and HCs see them as a highly valued and important part of their health improvement workforce. There is a perception that HTs and HCs can devote more time and care at community level than can other clinical or health improvement staff.

However, HTs and HCs report that they have had considerable difficulty in establishing credibility with other stakeholders outside the immediate circle of Health Trainer Services, including primary care and probation service managers. HTs reported that they had particular problems establishing credibility with some GPs.

There is a perception amongst service providers and commissioners that there are highly variable expectations of the service across different stakeholders. Limited understanding of the breadth of services provided, including client focused and client responsive approaches, can result in inappropriate expectations of services.

Recommendations

- Health Trainer Services need to be actively promoted by commissioners, providers, and partner organisations (i.e. Local Authorities) in order to maximize uptake and benefit to all stakeholders.
- The development of GP commissioning clusters makes it of particular importance that GPs understand the potential of Health Trainer Services.
- Shared resources and marketing materials should be available across the East Midlands region to support the promotion of the services.
- Clear targets and outcomes must be set between commissioners and providers for each service.

v) Access to and appropriateness of health trainer services: Clients are using multiple access routes to Health Trainer Services. HTs and HCs have been successful in promoting their services and engaging with communities. As a result, the majority of clients refer themselves to the services. Other clients are being referred via practice nurses or GPs and other community services or organisations.

In most cases clients have been interested in losing weight and increasing their fitness, and the health trainer services are able to address these needs.

vi) Monitoring the full breadth of activity: DCRS provides variable data. There are three main challenges to using DCRS. The first is the fact that DCRS is limiting in the types of Health Trainer Service activities that can be inputted. Individual client data is entered, but at the time of the evaluation, group activities and community engagement activities were not.

Secondly, the quality and completeness of the data entered into the system remains problematic as HTs and HCs may not always fill in all the information requested in DCRS forms.

Thirdly, as DCRS is a live database, the data for any particular report and time period changes, making it difficult to pull of consistent reports from one day to the next about the same activities over the same time period.

The high levels of commitment, energy and interest in their work that HTs, HCs and THTs typically demonstrate is notable. Whilst such added value is difficult to quantify it is important to capture it in some way.

Recommendations

- HTs, HCs and supervisors should be encouraged to complete DCRS forms in an accurate and timely way, with ongoing review and revisions on ease of use. However it is important to note that DCRS is perceived by those providing the service as being secondary to service need.
- Community engagement activities and group activities should be routinely captured and monitored. Further work is needed to consider the community engagement activity that best suits both the generic health trainer service, and the various models of delivery.
- Commissioners of services need to understand and value the often exceptional commitment and individual investment in roles.

vii) Implications for the future: The services in East Midlands have changed and evolved in response to local need, learning from good practice, and in response to local and national priorities. They hub and spoke model supports this flexibility and dissemination of lessons learned.

The Health Trainer Service has demonstrated that it is well placed to respond to the demands of current government policy for locally determined services and community engagement in a 'Big Society' ideology.

Recommendations:

- Early strategic discussions should take place between emerging GP commissioning clusters, Local Authorities and current Health Trainer Service commissioners on the potential role of the service in future health and wellbeing services.
- The role of the hub in guiding and coordinating service development and sharing good practice should be retained to maximize the impact of a developing service and workforce.

In conclusion the evaluation team suggests building on the positive reputation that the regional Hub has created to help move these recommendations forward.

Annex 1: Glossary of Terms

CPD	Continuing Professional Development
DCRS	Data Collection and Reporting System
HC	HC
HT	Health Trainer
NHS	National Health Service
PCT	Primary Care Trust
PHP	Personal Health Plan
RSPH	Royal Society of Public Health
THTs	Trainee Health Trainers