NHS East of England

East of England Health Trainer Service

Evaluation Report

24th August 2011

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Introduction

The Health Trainer (HT) Service is a product of the 2004 “Choosing Health; Making Healthier Choices”, white paper. This document draws knowledge from a wide range of scientific evidence that people are more likely to make and maintain healthy life style changes when they are provided with one to one support.

Over the years, the Health Trainer service has grown across England with about 80% of Primary Care Trusts (PCT) having a Health Trainer Service in operation. In the East of England (EOE) all the PCTs had a HT service. In 2010 there were 2,011 fully qualified HTs in England and they have seen more than a quarter of a million people, supporting them to quit smoking, eat five a day, reduce their fat intake, increase physical activity, reduce alcohol and maintain a healthier weight. With an average success rate of 75%, (88% in the EOE) this is a great community service especially as it targets the seldom seen, seldom heard groups of people who are socially disadvantaged.

The potential health gain and cost savings achieved by HT 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- £33 million per year, according to the 2010 Marmot Review on Health Inequalities.

Recent Coalition government announcements, makes it clear that the NHS will undergo radical changes over the next few years. Whilst it remains unclear as to the shape some of these changes will take, what is clear is that the new focus of government is to empower individuals and communities to take a more active role in improving their own health, and preventing ill health in the future.

This in itself means that the HT Service is perfectly suited to carry forward the vision of government, however, in a time of cuts, there is the possibility that HT Services up and down the country could be a victim of cuts against more traditional services. In the same light, the national support structure for HTs in England was lost last year. Each HT service is part of a regional hub. The majority of the funding for the Hubs will end by September 2011; the last of them will survive only till October 2012.

Scope of the Evaluation

The investigator was tasked by the hub to evaluate the Health Trainer Services across the East of England region in 2011.

The evaluation objectives were:

1. Evaluate the service models of all health trainer services across the East of England by exploring and describing the activity and outcomes of health trainer services.

2. Produce a report on the evaluation findings 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 several specific questions, these were grouped in relation to HT Service processes and development and the impact of the services on service users and workers. The investigator further grouped these as questions relating to outputs, outcomes, inputs, and processes, The report is structured to answer these specific questions.

Findings

With regards to the impact the East of England Services are having, the investigator found that:

Positive impacts are being made on health outcomes.

There have been consistent improvements in key health indicators:

The plus scores: 160% increase in vigorous exercise, and a 58.58% fruit and vegetables

The minus scores: Reductions in BMI -2.95%, and fatty foods -62.93%

There have been consistent improvement in emotional wellbeing scores in all areas:

11.65% increase in Self-Efficacy
40.92% increase in Reported General Health
40.69% increase in WHO-5 Wellbeing

Impacts and Outcomes on the health inequalities

A continued significant growth in clients has been seen year on year, with the majority of East of England services registering more clients' quarter on quarter. However, Mid-Essex have stopped using the DCRS system and Peterborough had to re-focus their service to employ volunteers.

- 10,000 new clients were seen in 2010-11.
- The 10,000 clients contacted the services 24,391 times.
- 52.4% of clients reached by the Health Trainer Services came from the 40% most deprived areas.
- 60.13% of clients fell within (any) one or more of the following indicators for the 20% deprivation threshold:[1] income, employment, health deprivation threshold, disability, barriers to housing & services.
- 1/3 of clients were from minority groups.
- 84 clients (7.79%) were long term unemployed (over one year).
- 222 (20.59%) clients had a long-term condition
- 239 (22.17%) said they had a disability.
- The services also reach seldom heard groups such as 671 (7.47%) individuals that had no GP, 246 prisoners (22.82%) and 9 homeless clients.

[1] [Deprivation data is based on indices of deprivation and grid-link which can be found from the following links: http://www.communities.gov.uk/communities/neighbourhoodrenewal/deprivation/deprivation07/ http://nww.connectingforhealth.nhs.uk/nacs/downloads/officenatstats]

- The majority of clients identified diet as their main health issue 71.1% (3488).

- Over 2,600 full Personal Health Plan assessments were completed in 2010-11 (some carried over from the previous year). Of those 52.21% were classed as fully successful, a further 28.75% were partly successful. These rates are slightly higher than recent national reports, which put fully successful goal achievement rates at 51%.

- The majority of clients that needed support, in order to change their behaviour, identified diet as their main health issue 71.1% (3488). A further 13.25 % of clients (650) identified smoking, another 12.15% exercise (596); only 1.41% (69) asked for help to reduce alcohol units consumed.

Primary Issue	Overall	
	Count	Percent
Diet	3488	71.10%
Smoking	650	13.25%
Exercise	596	12.15%
Alcohol	69	1.41%
Local issue – Emotional wellbeing[2]	103	2.10%
	4906	100.00%

Of those clients who fully achieved or part achieved their personal health plan, 88% reported their change had been successfully maintained.

[2] NB: Organisations have been recording emotional issues (and further sub-define these locally, i.e. stress, social issolation), since the DCRS v2.2 in December 2008. Only those clients who generate personal health plans record primary issue.

Differences in service models, appropriateness and implications for effectiveness:

Below are the different models of HT Services being implemented across the EoE, these include:

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1. NHS community HTs (still in the commissioning arm of the PCT and awaiting commissioning),
2. HT services commissioned by PCTS through a variety of providers, in a range of settings and using different combinations of HTs and HTCs.
3. HTs in GP practice,
4. HT service run by a social enterprise
5. Probation HT services
6. Prison HTs

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.

Recruitment, Training and Retention:

The recruitment of HTs and HTCs has evolved and improved as the different services have learned how best to attract both workers and clients to the services, the majority of services focussed their recruitment on people from the most deprived communities. In 2010, 19 Health Champions, 37 Trainee Health Trainers and 93 Health Trainers joined the service.

The largest proportion of Health Trainers are from Q4 (30.11%), the second largest group then being the 'most deprived' quintile 1 with 22.58%. When Q1 and Q2 are combined 41.93% of all the HTs come from the 2 most deprived areas.

Health Trainer Postcode Deprivation Status	Overall	
	Count	Percent
Q1 - Most deprived	21	22.58%
Q2	18	19.35%
Q3	14	15.05%
Q4	28	30.11%
Q5 - Least deprived	9	9.68%
Not recognised	3	3.23%
	93	100.00%

The services have found that recruiting, managing and supporting individuals who start out with no qualifications or relevant work experience takes considerably more time and effort. Yet as can be seen below those without formal qualifications achieve excellent results.

HT Education Vs PHP outcome

Sample Size: 3122	Achieved or part achieved		Not achieved		Outcome unknown		Total	
Na	248	91.18 %	12	4.41 %	12	4.41 %	272	8.68%
School (e.g. GCSE)	521	64.24 %	88	10.85 %	202	24.91 %	811	26.00 %
College (e.g. A-level)	631	56.09 %	252	22.40 %	242	21.51 %	1125	35.83 %
University	599	65.54 %	129	14.11 %	186	20.35 %	914	29.49 %
	1999	64.03 %	481	15.41 %	642	20.56 %	3122	100.00%

Surprisingly this result shows a very significantly higher PHP achieved/ part achieved rate for those without any formal qualifications. Both not achieved and very interestingly outcome unknown (i.e. Did not attend) results are in significantly lower proportions. Therefore, HT without qualifications are more successful in assisting their clients in achieving their personal health plan than their more educated colluegues.

Some services that have re-recruited, a balance has been struck between recruiting people from deprived backgrounds with no qualifications along with people who already have qualifications.

Training: All HTs and HTCs have received appropriate initial training, i.e RSPH level 2 and City & Guilds level 3. There is, however, significant variation in how the different services ensure Continuing Professional Development (CPD). This was true for HTs, HTCs and Co-ordinators/ Managers of the services. HTs and HTCs 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. The regional hubs training needs assessment identified mental health training as an urgent training need (for some services) and the majority

of HTs, HTCs and some Co-ordinators have now undertaken the Mental Health 1st Aid training course.

The majority of HT Co-ordinators and Managers had received no formal management training to run these complex services and reported their CPD/ PDP's to be poor. This gap was identified by the hub lead as a training need (whilst undertaking a training need assessment on the whole of the hubs services) and the problem was rectified using hub money; with 14 service co-ordinators undertaking the level 5 Institute of Leadership and Management course in 2011.

Retention has also varied across the region.

Staff turnover

1. Two PCT's HTs services and one HTC service were lost due to financial constraints or service re-alignment.

2. Of the 85 HTs/ HTCs that left the service, the managers of almost half of the staff did not record where the individual moved onto. Those that did showed that, of the 30 volunteer community HTCs that had left, 3 of these went onto be employed as paid HTs; (as stated above the service's contract has ceased). Of the remaining leavers, 10 people gained employment outside of the NHS,e.g. as support workers, advocates and community assisstants and 3 gained a higher level post within the NHS (2 x band 5 and 1 x band 4). 2 went onto higher education to do a degree.Therefore there is some evidence that HTs who have left the service went 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, un-quantified benefit of the service for its workforce.

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

previous lack of work experience made the challenges and discipline of work too much for them and they either left or were asked to leave.

4. There is also anecdotal evidence that HTs with Degrees and higher educational backgrounds use the HT post as a means of attaining work experience and then leave to move onto better paid jobs.

5. 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 and their family's behaviours to adopt healthier lifestyles.

6. The service models 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:
i)Health Trainer Services should have clear lines of accountability and ensure active supervision, and support is in place for all staff .

ii) 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 should be monitored against target achievement.

iii) Health Trainer Services in early stages of development should consider recruiting HTs and HTCs from the deprived areas that do not have prior work experience and qualifications.

iv) The region wide guide to CPD should be followed consistently across all services, with local CPD provision tailored to meet service need.

v) CPD sessions should include attention to the boundaries of service provision, especially in terms of working with people with complex psycho-social needs.

vi) 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.

Measuring and monitoring impact and value for money:

The investigator found that HT Services are not routinely monitoring the full impact of their Services, despite them having the means to measure data using the DCRS and value for money tools.

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

i) Future commissioning of and investment in HT Services will be influenced by demonstrable outcomes. All services should put in place routine reporting and review mechanisms to assess progress against local targets.

ii) **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.

iii) **External Perceptions of the Service**

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

However, HTs and HTCs report that they have had considerable difficulty in establishing credibility with other stakeholders outside the immediate circle of HT 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

i) HT 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.

ii) The development of GP commissioning clusters makes it of particular importance that GPs understand the potential of HT Services.

iii) Shared resources and marketing materials should be available across the Eastern region to support the promotion of the services.

iv) Clear targets and outcomes must be set between commissioners and providers for each service.

v) Clients are using multiple access routes to HT Services. HTs and HTCs 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**:

The DCRS provides variable data. There are three main challenges to using DCRS.

a) The first is the fact that DCRS is limiting in the types of HT Service activities that can be inputted.

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

c) Thirdly, as the 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, HTCs and THTs typically demonstrate is notable. Whilst such added value is difficult to quantify it is important to capture it in some way.

d) The free use of the DCRS will end at the end of February 2012 and PCTs will have to pay to use the system and in a time of financial cut backs this will be problematic.

Recommendations

i) HTs, HTCs 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 and this clearly needs to be changed; as commissioners require the data to inform their commissioning decisions.

ii) 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 HT service, and the various models of delivery.

iii) Commissioners of services need to understand and value the often exceptional commitment and individual investment in roles.

iv) Monitoring the full breadth of activity: The services in East of England have changed and evolved in response to local need, learning from good practice, and in response to local and national priorities. The hub and spoke model supports this flexibility and dissemination of lessons learned.

Recommendations:

i) Early strategic discussions should take place between emerging GP commissioning clusters, Local Authorities and current HT Service commissioners on the potential role of the service in future health and wellbeing services.

ii) 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. The HT 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.

Annex 1: Glossary of Terms

CPD Continuing Professional Development

DCRS Data Collection and Reporting System

HTC Health Trainer Champions

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

Appendix 2, Evaluation objectives

1. Evaluate the service models of all health trainer services across the East of England 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

Specific Questions to answer

1 Impact the Services are having
2 Differences in service models, appropriateness and implications for effectiveness
3 Recruitment, Training and Retention
4 Measuring and monitoring impact and value for money
5 External Perceptions of the Service
6 Access to and appropriateness of health trainer services
7 Monitoring the full breadth of activity