East of England

Health Trainer Service Models

Evaluation Report

2nd March, 2012

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1. Introduction

The Health Trainer (HT) Service came about as a result of the 2004 “Choosing Health; Making Healthier Choices”, white paper, this document draws information 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 peer support.

Over the years, the Health Trainer service has grown across England with 80% of Primary Care Trusts (PCT) having a Health Trainer Service in operation; including all the East of England (EoE) PCTs. 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% in England, (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 further 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.This trend is already beginning to be seen with Peterborough’s HT service being cut, due to their continuing financial constraints.

In the same light, the national support structure for HT services in England was lost in 2010. Each HT service is part of a regional hub. The majority of the funding for the running of regional Hubs ended in September 2011; the last of them will survive only till March 2013, including the EoE hub.

The national funding for the Data Collection Recording System (DCRS) came to an end in March 2012. The EoE Hub lead paid £24,000 towards the use of the DCRS for 2012-2013, but each service had to find the additional money to pay for the remote access tokens; this varied from £1,500 to £7,000 pa. Several services stopped using the DCRS as this additional cost had not been included in their service level agreemenst. One service will be using system one, two others an in-house data collection system. Therefore this will be the last year that data can effectively be collected for the region, as such this will be the final regional evaluation .

2. 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:

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

2. 2. Produce a report on the evaluation findings with recommendations for service sustainability and development, and future investment decisions.

2.3 The evaluation (scope of work) asked a number of specific questions, these were grouped in relation to HT service development and processes and the impact of the services on workers and clients. The investigator further categorised these as questions relating to inputs, processes, outputs and outcomes. The report is structured to answer these specific questions.

3. Outcomes on Health Inequalities

3.1 The investigator found positive health outcomes.

There have been **consistent improvements in key health indicators:**

The plus scores: Increases in

- +160% vigorous exercise
- +58.58% fruit and vegetables

The minus scores: Reductions in

- -2.95% in BMI
- -62.93% Fatty food intake

There have been **consistent improvements in emotional wellbeing scores** in all areas:

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

4. Impacts on Deprived areas

4.1 A continued significant growth in clients has been seen year on year, with the majority of EoE services registering more clients' quarter on quarter. However, Mid-Essex and South West Essex have stopped using the DCRS system and Peterborough had to re-focus their service and hope to use volunteers in 2012.

- 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 (2.22%) clients had a long-term condition
- 239 (2.39%) said they had a disability.
- The services also reach seldom heard groups such as 671 (6.71%) individuals that had no GP, 246 prisoners (2.28%) and 9 homeless clients.
- Over 2,600 full Personal Health Plan assessments were completed in 2010-11 (some overlapping from the previous year). Of those 52.21% were classed

[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]

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%

4.2 Findings

- Of those clients who fully achieved or part achieved their personal health plan, 88% reported their change had been successfully maintained.
- The EoE HTS are reaching the hard to reach, reducing health inequalities as shown by their consistent improvements in key health indicators and emotional wellbeing scores.

[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.

5. Different service models and appropriateness

5.1 HT Service models being implemented across the EoE, include:

- NHS community HTs (still in the commissioning arm of the PCT and awaiting commissioning),
- HT services commissioned by PCTS through a variety of providers, in a range of settings and using different combinations of HTs and HTCs.
- HTs in GP practice,
- HT service run by social enterprises
- Probation HT services
- Prison HTs services
- Lottery funded HT services

5.2 Findings

- Each of the models explored is appropriate for the area and community being targeted. There is some anecdotal evidence to indicate that services provided through community based organisations have easier access to more deprived communities.

6. Recruitment, Training and Retention:

6.1 Recruitment

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 service. 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.

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 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.

The majority of services found that recruiting, managing and supporting individuals who start with no qualifications or relevant work experience a challenge. Some service co-ordinators felt they were ill prepared to work with this group of HTs and felt they required training themselves to get the best from their staff. Some services stated that when they re-recruit, they hope to strike a balance between recruiting people from deprived backgrounds with no qualifications and people who already have qualifications.That said, commissioners wanted recruitment from these deprived groups to continue. Commissioning decisions regarding employing the aforementions groups are sound; as can be seen from the excellent results below.

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%

(Na: Not applicable: i.e No formal qualifications before becoming a HT/HTC)

Surprisingly this result shows a very significantly higher PHP achieved/ part achieved rate for those without any formal qualifications (91.18%). 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.

6.2 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/ PDPs 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 hub's services) and the problem was rectified using hub money; with 14 service co-ordinator/ managers undertaking the level 5 Institute of Leadership and Management course in 2011-2012.

6.3 Retention

Has also varied across the region.

6.3.1 Staff turnover

- Peterorough PCT's HTs service was lost due to financial constraints. Herts and Norfolk PCT's HTC services were commissioned for two years, Norfolk's SLA has ended and Herts is due to end in March 2012; discussions are taking place as to whether the service will continue.

- 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 record this information showed that, of the 30 volunteer community HTCs that had left, 3 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 and another a MSc.

- Therefore there is some evidence that HTs who 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.

- 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.

- 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; after gaining work experiance.

- 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.

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

6.4 Recommendations:

- Health Trainer Services should have clear lines of accountability and ensure active supervision, and support is 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 should be monitored against target achievement.

- 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; as the evience provided above shows they get better results than their educated counterparts.

- 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.

7. Monitoring and Measuring impact

7.1

- 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.

- 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, amount of weight lost etc). 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).

- Some of the services, especially those that had not been put out to tender, fail to produce quarterly reports, despite collecting and inputting data onto the DCRS. These services were offered additional training on how to run the reports their services require and the training is now complete. For the services that received external funding (eg Lottery) there was no requirement for the services to use the DCRS, although they were expected to collect output data.

7.4 Recommendations

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

8.Monitoring the full breadth of activity:

8.1 The Data Collection Recording System provides variable data. There are five main challenges to using DCRS.

- The DCRS is limiting in the types of HT Service activities that can be inputted (although the DCRS team have included new activities in recent months.

- 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 by their commissioners.

- 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.

- The free use of the DCRS will end at the end of March 2012 and PCTs will have to pay to use the system and in times of financial cut backs this will be problematic. In fact some of the services have failed to include the cost of using the DCRS into their service level agreements.

8.2 Recommendations

- HTs, HTCs, THTs and supervisors should be encouraged to complete the DCRS forms in an accurate and timely way, with ongoing review of training needs. However it is important to note that data collection is seen 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.

- 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. The efficacy and costs related to this engagement should also be captured in order to produce value for money reports.

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

- 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..

- Early strategic discussions should take place between emerging GP commissioning clusters, Local Authorities, current HT Service commissioners and the EoE regional HT hub lead 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. The service leads and commissioners take full advantage of the knowledge, help and advice gained from the regional hub lead; and they value the support and training they receive.

9. Value for money:(VFM)

9.1 The regional hub lead, trained the HT service leads to use the VfM tool early in 2010 but has not received any independent VfM reports to date.

- Norfolk PCT's commissioner contacted the hub lead and asked for assistance to do a VfM report. This has been completed and the results show that for an investment of **£600,414,** Norfolk's HT service's total cost savings to the NHS were **£336,036** and total net savings to other public sector services of **£411,748** (such as Social services).This produces a **value for money** net public sector saving of **£747,784** per equity weighted DALY/QALY.

- Great Yarmouth & Waveney PCT state they have undertaken a VfM assessment but the results have not been shared with the hub.

- The hub undertook a further training session on using the VFM tool at the hub meeting in Novemeber 2011.

9.2 Recommendations

- The VfM assessment tool is a valuable resource that can be used for assessing value for money, The , the tool was developed in close consultation with experienced.HTS commissioners and providers, takes as its starting point an analysis of the objectives of the services and their impacts on the agencies and people involved. In each case a set of indicators is proposed so that the performance of the HTS in relation to its objectives can be measured and compared to costs. This provides a framework to clarify outcomes and sets the specific measures of value for money (VfM) in the context of national and local World Class Commissioning objectives. We therefore, recommend that the VfM resource be used as a matter of course to show the full value and savings HTS can make.

10. External Perceptions of the Service:

10.1

- Multiple access routes into HT services are being used by clients. 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 GPs, practice nurses 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.

- 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 an 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.

- 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.

- 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.

10.2 Recommendations

- 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.

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

- Shared marketing and resource materials should be available across the Eastern region to support the promotion of the services.

- Clear outcome targets must be set between commissioners and providers for each service.

- It could be seen that this evaluation fails to take client's views into consideration. The author did speak to an ethics research expert to check if ethical approval was required and was told it was not necessary for a service evaluation. The author did ask the service co-ordinators for telephone, emails etc, contact details of clients (to be shared with the author with their permission). Unfortunately very few were received, so it was felt their comments may not reflect the feelings of other clients accurately. Therefore, this can be seen as a weaknessweekness within the document and the author accepts this.

11. Conclusion

The evaluator suggests building on the positive reputation that the East of England 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.

12. Acknowledgements

While the author takes full responsibility for the content of this report and any errors or omissions, it is important to note that its production would not have been possible without the enthusiastic support and input from the EoE Regional hub services managers, many Health Trainers, Health Trainer Service Providers, Commissioners, Co-ordinators.
The Midland HT service evaluation document was used as a template for this evaluation and the author thanks them for allowing this.

Appendix 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

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

Grouped by Additional Personal Info (L)
Filtered by Date added between 01/04/2010 31/03/2011 And Additional Personal Info (L) <> 'not recorded'

	Count	Percent
Asylum Seeker / Refugee	2	0.11%
Carer	40	2.20%
Difficulty accessing services (eg NHS)	41	2.26%
Disability/ vulnerable group	312	17.19%
Elderly (65+)	90	4.96%
Ethnic Minority Group (BME)	114	6.28%
Ex- offender	9	0.50%
Full time carer	29	1.60%
Gypsy / Traveller	4	0.22%
Homeless / No Fixed Abode/ Rough sleepers	1	0.06%
Immigrant - EU	5	0.28%
Immigrant- EU	2	0.11%
Immigrant- Non-EU	4	0.22%
Learning difficulty	33	1.82%
Long term condition	412	22.70%
Long-term unemployed (1yr+)	134	7.38%
Mental health issues	65	3.58%
Military Personnel/Family of Military Personel	5	0.28%
Offender	5	0.28%
Other	99	5.45%
Physical/ sensory disability	23	1.27%
Pregnant	1	0.06%
Prison	321	17.69%
Probation	41	2.26%
Single parent	18	0.99%
Traveller community	5	0.28%
26 Additional Personal Info (L) group listed	**1815**	**100.00%**

Results are correct as of 08/03/2012 23:00:00 [Ref:73829]