NHS Plymouth

Scoping the potential of commissioning Health Trainers for NHS Plymouth

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Abbreviations

AfC…….. ……Agenda for Change
CPHP……..Community Public Health Practitioner
CHD……coronary heart disease
DCRS……Data Collection Reporting System
DH……Department of Health
HIA…….health impact assessment
HLC…….healthy living centre
HT……Health Trainer
LSP……..Local Strategic Partnership
NICE……..National Institute for Clinical Excellence
PH……..public health
PCC……..Plymouth City Council
PHP…….personal health plan
PPCT……Plymouth Primary Care Trust
SHA…….Strategic Health Authority
wte……..working time equivalent

Executive Summary

In 2008 NHS Plymouth were asked to consider the introduction of a Health Trainer service. Health Trainers provide personalised face-to-face support to people suffering from poor health. They were first proposed by *Choosing Health* (Department of Health 2004) and are now operational in 88% of PCT areas in England.

This study has produced 8 key findings:

1) Health Trainers are an effective service, especially for tackling health inequalities.

2) Plymouth's current Community Public Health Practitioner approach works well. Health Trainers could help maximise the positive impacts of this work.

3) We need extra resources to commission Health Trainers, but they represent good value-for-money.

4) Commissioning Health Trainers should become an integral feature of the proposed reorganisation of Health Promotion in the city.

5) Health Trainers could be most effective commissioned with a mixed model approach i.e. hosted in the community sector yet managed by the PCT.

6) The initial proposal is to appoint eight x 0.5 wte Health Trainers (at Level 3) linked to the Community Public Health Practitioners, targeting particular communities.

7) Health Trainers in Plymouth should be described as "Community Public Health Workers".

8) A Health Trainers service could become an important component of the emerging integrated professional development programme for developing skills and competencies for health promotion practitioners in Plymouth**.**

This study estimates that a Health Trainer service (based on eight x 0.5 wte Health Trainers appointed at Level 3) would cost £97,770 (including oncosts, management costs, training costs etc).

1) Background

NHS Health Trainers (HTs) were developed to directly address the need for a personalised approach to supporting people who present the greatest levels of disadvantage regarding improving their health. The need for such a face to face service was identified in the Department of Health white paper *Choosing Health* (DH, 2004).

In 2005 Plymouth teaching PCT's (now NHS Plymouth) Public Health Development Unit (PHDU), in association with partner agencies, drew up detailed project proposals to appoint a team of co-ordinated community based Health Trainers, to practice alongside the PHDU Community Public Health Practitioners. The proposals were put on hold indefinitely following the Strategic Health Authority's withdrawal of Choosing Health funding in May 2006.

In 2008 the DH South West peninsula Health Trainer 'hub' approached PPCT to consider the introduction of HTs, and resourced this scoping paper. (The HT hub provides a communication channel between different HT programmes and the DH. The hub shares best practice and has resources to facilitate training, regional events, sharing learning and so on).

This paper:

- describes the aim and objectives of the study, and the methods used for the scoping (Section 2);
- describes the current situation regarding HTs in England, including a summary of the evidence based and policy context (Section 3);
- summarises current Plymouth teaching Primary Care Trust's operational priorities (Section 4); and
- presents the findings of the study in Section 5.

The Appendices include some important information, such as:

- a summary of current health promotion work in Plymouth;
- the case-study reports from other HT programmes visited for this study, and
- a description of the previous Plymouth HT proposal.

2) Proposal Aim, Objectives and Methods

The aim and key aspects of the scoping project were described in a 1-page proposal from the PHDU:

To produce a scoping paper by 31st March 2009 assessing the resource implications (financial and human) of commissioning a co-ordinated programme of Health Trainers for NHS Plymouth's PHDU.

The Objectives were specified to be to:

- *commission a project worker, 0.5 fte AfC 5 (mid-point) to undertake the scoping exercise;*
- *produce a scoping paper for discussion by NHS Plymouth Executive Board;*
- *revisit the 2005 Health Trainer proposals drawn up by Plymouth teaching PCT;.*
- *liaise with Peninsula Health Trainer Hub lead and members for information of health trainers operational management issues*; and to
- *assess the potential impact of health trainers upon health promotion activity undertaken by the PHDU.*

Methods

This scoping has been undertaken using the following methods and activities:

- reviewing a range of documents concerning HT's and related issues such as health promotion in Plymouth;
- attending SW hub and related meetings;
- undertaking an example of the health promotion training offered to HTs and related staff;
- undertaking a range of informal meetings with HT's and managers from different HT programmes;
- undertaking a range of informal meetings with key stakeholders for this study (eg the Plymouth Community Public Health Practitioner (CPHP) team). (Please note that engagement with the city's voluntary and community sectors has not been undertaken in order to avoid raising expectations); and
- finally, reviewing all the data to identify options and recommendations for NHS Plymouth.

3) What are Health Trainers?

This section describes the current situation regarding HT services across the NHS and partners in England. After presenting a brief description of the HT service in theory (3.1) there is a summary of the policy context and the evidence base (3.2) and a summary of the current national picture regarding HTs (3.3).

3.1 What are Health Trainers? What do they do?

Health Trainers can be described as a '*major policy and workforce innovation established in the White Paper Choosing Health…* (Rushbrook 2008). *Choosing Health* laid the foundations for a HT service which has since been endorsed by subsequent NHS and health policy reports.

The key features of the Health Trainer service can be described as:

- Staff specifically designed to tackle health inequalities;
- Providing a one-to-one service to people who wish to improve their health;
- Working at the earliest stages of the patient/care pathway;
- Targeting individuals from *'hard to reach'* and disadvantaged population groups;
- Utilising '*a range of approaches grounded in psychological science'* (DH 07) - along with other approaches for reducing health inequalities - to encourage clients to increase healthier behaviour and to make use of preventative services;
- *being recruited from disadvantaged communities - and so giving 'opportunities for disadvantaged people to gains skills and employment in health care'* (DH 07) – and being knowledgeable about the community they will serve ;
- Being referrers not interventionists – the model suggests that Trainers should work with clients for a limited period (e.g. 14 weeks maximum); and
- Employed with nationally accredited training in a variety of settings.

In summary, Health Trainers give one-to-one support to people with poor health, by offering encouragement and information over a period of a few weeks or months, and by helping the person identify simple ways for changing their behaviour.

This service is aimed at people with poor health who feel isolated and who are often not accessing health promotion and primary health care services (etc).

Trainers work with clients to assess their lifestyle and wellbeing and identify those areas the client wishes to work on. Trainers then help clients to set behaviour change goals and agree an action plan. Individual support is provided where necessary (e.g. accompanying a client on a walk in order to encourage them to undertake greater physical activity). Trainers will help clients monitor and review their progress, and will signpost or refer on the client to more specialist health and wellbeing services as appropriate.

As should now be apparent, Health Trainers are *not* personal 'trainers' or fitness consultants/advisers, despite the potential associations of their title. It can be observed that many HTs and Managers dislike the 'Health Trainers' title and have a concern that it can cause confusion in the public mind.

3.2 Why should we have health trainers? The policy and evidence context

There is widespread published evidence showing how lifestyle factors (smoking, diet, exercise levels etc) can affect cancer, coronary heart disease, diabetes and so on. *Choosing Health* (DH 2004) summarised some of this evidence, and introduced a new emphasis for health promotion:

In keeping with a shift in public health approach from advice on high to support from next door, health trainers will be drawn from local communities. Whilst *information and persuasive messages* provide an *essential framework for changing our way of life, it is rarely enough on its own* (p107).

Choosing Health therefore gave emphasis to supporting health behaviour change through *a range of approaches grounded in psychological science.* HTs were proposed as a means of promoting healthier lifestyles using evidence-based 'psychological' approaches.

Following *Choosing Health*, a specific report – *Health Trainers: A review of the evidence* (Visram 2005) – helped to establish guidelines for best practice from the outset of the HT programme.

Since 2005, relevant evidence-based publications include the National Institute of Clinical Excellence guide to *Behaviour Change* (NICE 2007) which is based on a rigorous review of the evidence base and endorses the HT-type approach. .'a *genetic predisposition to disease is difficult to alter. Social circumstances can also be difficult to change, at least in the short to medium term. By comparison, people's behaviour – as individuals and collectively – may be easier to change'* . NICE noted the innovative nature of the HT approach as *at present, there is no strategic approach to behaviour change across government, the NHS or other sectors.* The NICE *Stop Smoking Services Guidance* (2008) also endorses the use of Trainers.

The *Health Trainer Handbook* (DH 2008) is key tool designed for use by HTs. The Handbook is an exemplar of clear writing and explanation and provides a full range of references (including 24 peer reviewed papers) to underpin the theory behind HTs. Referring to a standard text *Health Psychology in Practice (*Michie S and Abraham C, 2004) the Guide states:

Health psychologists have researched in great detail the most effective techniques for behaviour change and health promotion….This handbook introduces this approach and the main techniques that can help people decide whether, and what, they would like to change, and how to do this. These techniques include goal setting, self-monitoring, creating action plans and building social support.

A recent DH report *Health Inequalities – Progress and Next Steps* (DH 2008) set out government thinking on the key policy aim of reducing health inequalities, and specified the value of Trainers working with disadvantaged communities etc.

Lord Darzi's 2008 report into the future of the NHS, '*High Quality Care for all'* is now a key driver for NHS policy. Darzi states:
The NHS must now focus on preventing ill health for individuals and giving them the opportunities and support to improve their health…

*…Every PCT will commission comprehensive wellbeing and prevention services, in partnership with local authorities, with the services offered personalised to meet the specific needs of their local populations. Our efforts must be focused on six key goals: tackling obesity, reducing alcohol harm, treating drug addiction, reducing smoking rates, improving sexual health and improving mental health. (*Darzi 2008*)*

The Health Trainer central hub team at the DH argue that the HT service is relevant to the eight areas of focus identified by Darzi and that Trainers provide *an essential patient focused contribution to clinical pathways* (Rushbrook, August 2008). They suggest that Trainers offer commissioners opportunities for improving the accessibility and uptake of health services and that therefore there could be in some cases be a shift from *specialist health promotion.*

Citing the examples of Health Trainers being adopted by '*third parties'* such as the Royal Mail and the British Army, the HT hub argue that the *flexibility* of the Trainer model can match different needs; they suggest that Trainer programmes provide *local sensitivity and relationships* and can assist practice-based commissioning – and contribute to *empowering patients.*

Darzi also emphasises *quality at the heart of the NHS* as an important aim and the HT service argues that it is well placed to supply quality evidence around behaviour change, patient experience and feedback. NICE has already used HT services to test public health evidence; and proponents argue that the national Data Collection and Recording System (DCRS) designed for HT's allows the measurable articulation of health promotion and related outcomes.

It can be argued that the HT service has a strong and growing evidence-base, with a focus on behaviour change processes, which enables outcome evidence to be generated relatively quickly and in a manner more consistent with NHS quantitative data. As such it can differ from the longer-term outcome assessments associated with some other health promotion interventions.

There is a growing amount of research exploring the health and economic 'value' of promoting mental health and wellbeing. In February 2009 the Government Office for Science published '*Mental Capital and Wellbeing':*
'people with a low level of wellbeing, even if they do not have a mental disorder, function far less well and have poorer health and life expectancy… (They are) *unlikely to come to the attention of specialist mental health services, but constitute a large part of their population who are neither flourishing nor disordered, yet could benefit greatly from having access to interventions to improve their wellbeing*.

A report on this research published in The Guardian (18/02/09) cites the London Borough of Greenwich's PCT 5-year plan. The Director of Public Health states *that quality of life is as important as length of life… anyone working in frontline services knows this. Most services aren't dealing with death, they are dealing with disability*,… *If you want to be effective in addressing premature mortality, you have to take mental health needs seriously*.

Greenwich interventions include training for frontline voluntary and statutory sector staff in '*mental health first aid'* and a social prescribing programme that offers people a wide range of leisure, sports, creative, educational and social activities that can benefit mental health. The health trainer programme is an important component of these interventions. Apart from their

direct work with clients, Greenwich HTs have also trained 25 frontline health and social care staff and 45 resident volunteers in motivational interviewing and behaviour change skills.

3.3. Health Trainers now – the national picture

A BBC Radio 4 programme *Who's Health?,* first broadcast on March 10th 2009, focused on HTs. The DH national Lead for HTs, Rachel Carse, was a key interviewee and she stated that *as of now 88% of PCTs have HTs.* She pointed out that £77 million of NHS *'baseline'* funding is committed for HTs and that this is a recurring or permanent budget (not 'one-off' funding), adding that *all PCT's should be able to afford HTs… they should all be able* (to use HTs) *to support the most deprived communities in their areas*.

The DH HT Lead also stated that 69.5% of the HT clients achieve at least one of their health behaviour change goals. The BBC programme emphasised how HTs differ from traditional health promotion methods, shown by the HT application of a personal approach grounded in psychological science.

A national evaluation of the HT service is being undertaken by the University of Birmingham, to be published in September 09. However researchers from University College London (UCL, 2009) have been summarising the HT data available up to January 2009. Further details are available from the *National Health Trainer Data Collection and Reporting Service* (Birmingham Primary Care NHS 2008).

Please note that the researchers acknowledge that there are some shortcomings with the Data Collection and Reporting Service (DCRS) system i.e.:

- Efficient and adequate reporting of HT data by most PCTs is estimated to have been achieved only by July 2008;
- some Trainers believe they cannot accurately record their work within the prescribed data categories. In particular the researchers suggest that a *patient/client satisfaction measure* is required on the DCRS.

Analysis of DCRS data to date shows that:

- Just under 22000 clients had been added to the database from April-December 2008;
- 46% of clients are drawn from the 20% most deprived areas in England;
- At least 93% of clients were registered with GPs;
- 27% of women complete their *personal health plans* (PHP) as compared with 20% of the men;
- 27% of *more-deprived* clients complete their PHP compared with 23% of *more-affluent* clients;
- Clients aged 18-35 years are the most likely to miss appointments;
- Males are most likely to be referred to smoking cessation programmes;
- Females are most likely to be referred to exercise programmes; and
- Clients from *more deprived areas* are referred more frequently to all of the health promotion services available (e.g. smoking cessation) excepting *social support* and *weight management.*

A majority of primary client health issues appear to be diet and activity related, with overall diet and exercise accounting for 93% of all personal health plan primary issues. The researchers note however that such high proportions may warrant some deeper investigation.

A more recent feature of the DCRS data collection system allows PCTs to record emotional wellbeing as a local issue (and further sub-define this locally, i.e. as stress, social isolation etc): it is therefore anticipated these numbers will grow.

The highest proportion of clients (24%) find out about the service via NHS organisations. However promotional events are also important and there is an encouraging number of 'word of mouth' responses (16%) which are not only highly cost effective but also assumed to be the result of positive feedback/experiences.

HTs are asked to record the community of interest relevant to the client. However many client records are missing this information altogether, and over 60% of the rest are classified as 'other'. (The DCRS allows only one 'community' to be recorded whereas many clients can be regarded as belonging to multiple communities of interest). Notwithstanding the above, 12.97% of clients are recorded as being over 65, 6.07% as being over 1 year unemployed and 5.85% are described as presenting mental health issues.

Of those clients signed up for help with weight over 66% of respondents recorded successful weight loss. Based on *before* and *after* results the Health Trainer service is showing clear and consistent improvements in self-efficacy and even more so in general health, a very positive result overall e.g.: *in general I think that I can achieve health outcomes that are important to me*.

That up to 69% of clients have achieved/part achieved their Personal Health Plan can be seen as a positive result. For many clients the main outcome of the HT service will be successful referral, the provision of useful information and signposting for the client.. This is seen as an area where Health Trainers are adding value.

The evaluators suggest that a clear focus for Health Trainer services should be to find ways in which to reduce '*did not attends'* as this does mar otherwise positive results. They note that although success rates have improved when targeting alcohol and smoking, this area remains significantly less successful than targeting diet or exercise goals.

The researchers conclude that the HT service appears to be reaching the 'hard to reach', addressing key health issues affecting clients and supporting appropriate behaviour change

When considering the characteristics of HTs themselves, from a sample size of 481 HTs, it can be seen that a clear majority of HTs are female, white British, and graded as Agenda for Change (AfC) band three.

The HT 'peninsula' hub 'lead' supplied some further information of interest for this study:

- Estimate that it can take 6 months from recruitment before a HT is fully operational;
- Estimate that an average HT can see 100 new clients per year;
- The general model is that a HT will see a client for up to 6 sessions, usually for at least 30 minutes each time, over a period of a few months.

4) Current health priorities in Plymouth

This section aims to scope how the HT programme could contribute to the priority targets of the PCT as outlined in the (draft) *Operating Framework* for Plymouth PCT for the 09/10 financial year. This gives a current NHS Plymouth context for considering the value of investing in HT services.

(Please see the Appendix for a more specific discussion of health promotion priorities in Plymouth, including the recent review of local provision.)

Plymouth teaching Primary Care Trust's *Operating Framework* (PPCT 2009) is intended to '*crystallise the strategic priorities identified in*:

- the *Plymouth Joint Strategic Needs Assessment*;
- *Plymouth's Health Strategy*;
- the *Children and Young People's Plan*;
- the *Strategic Framework for Improving Health in the South West*;
- the *Strategic Framework for Improving Health in Plymouth*; and
- the outcomes measures selected as part of the *World Class Commissioning Assurance Programme'.*

Plymouth's Health Strategy (Plymouth 2020) is important because it is supported by the multi-sector members of the Plymouth 2020 Local Strategic Partnership (LSP). It prioritises:

- addressing health inequalities in all plans;
- shifting investment to address prevention and health promotion;
- (specifically) mental health promotion;
- addressing issues of access and take-up of specified services; and
- promoting independence for service users.

The draft *Operating Framework* divides the PCT's work into 9 *health programme groups.* Each group has identified three priorities for the 09/10 financial year, presented in the following Table. ***Bold italics*** have been added to show where HTs could contribute to an estimated 13 of the priority areas.

Plymouth PCT draft operating framework 09/10 – priority work areas (as of March 09):

Health Programme Group	**Work Area**	**Work Area**	**Work Area**
Staying Healthy	***Smoking cessation***	***Obesity - healthy weight services***	***Reducing cardio vascular risk***
Maternity and Newborn	***Breast feeding uptake rates***	Midwifery unit	Information Technology – improve communication links across organisations
Children & Young People	Movement of acute care into the community	Services for children with learning disabilities	CAMHS Palliative care ***Children's health promotion***
Long Term Conditions	Pulmonary rehabilitation	***Community neurological-rehabilitation***	Development of self care policy for the organisation
Mental Health & Well-being	***Improving Access to Psychology Therapies and psychological therapy secondary care***	***Liaison psychiatry for adults and older people***	***Reduced use of longer term beds***
Learning Disabilities	***Cancer screening***	***Diabetes***	***Mental Health***
Planned Care	Service redesign; musculo-skeletal	Service redesign; dermatology	***Referral protocols – low priority pathways***
Acute Care	Extending primary care across the front door.	Ambulatory Care – managing inpatients as outpatients	Stroke and TIA
End of Life Care	Co-ordination centre	Establishment of end of life register	Continued roll-out of Gold Standard Framework and Liverpool Care

HTs can target particular communities such as people with learning disabilities. In Bristol (see Appendix) people with learning disabilities have been recruited and trained to work as HTs with clients who also have learning disabilities.

In Exeter HTs have begun making connections with the Hospital. Using HTs can help the Hospital relieve pressure on beds by giving earlier release times for patients with certain conditions who live alone.

5) the potential impacts of Health Trainers in Plymouth: findings and options identified

The conclusions of the scoping can be summarised as 7 key findings (see below). Business case costings are also supplied at the end of this section.

Please note that stakeholder contributions to the scoping study have also suggested that there is a need to identify and map existing health promotion services from all sectors in Plymouth (see Appendix 1).

Key findings:

1. **The evidence-base shows that Health Trainers work!**
2. **Plymouth's current Community Public Health Practitioner approach works well. Health Trainers could help maximise the positive impacts of this work.**
3. **We need extra resources to commission Health Trainers, but they represent good value-for-money.**
4. **Commissioning Health Trainers should become an integral feature of the proposed reorganisation of Health Promotion in the city.**
5. **Health Trainers could be most effective commissioned with a mixed model approach i.e. hosted in the community sector yet managed by the PCT.**
6. **An initial Plymouth Health Trainers proposal is for eight x 0.5 wte Health Trainers linked to the Community Public Health Practitioners, targeting particular communities.**
7. **Health Trainers in Plymouth should be described as "Community Public Health Workers".**
8. **A Health Trainers service could become an important component of the emerging integrated professional development programme for developing skills and competencies** for **health promotion practitioners in Plymouth.**

5.1 The evidence-base shows that Health Trainers work!

HTs can be a valuable tool for promoting health and reducing inequalities. The growing national evidence base and the experience of fellow PCTs shows that HTs can offer a unique service based on one-to-one person-centred support - which can be especially positive for people experiencing health inequalities: the '*value of personal and holistic support in improving health'* to quote a Devon HT.

For example, a HT Manager interviewed for this study described how some people with poor health - perhaps living in a neighbourhood where long-term unemployment is the norm – will regard health promotion messages as '*not for them'*. They can be seen as having an expectation of long-term illness and a lack of aspiration. They might only visit a GP when they need to prove a benefits claim. They might perceive health professionals as intimidating, whereas the HT service can offer *'someone to help you who isn't going to judge you'*.

The Cornwall HT service has recently won a Sustainable Communities award. The description of the service supplied by Cornwall for the judges explained that:

.'*Most clients need one central point to gain support and access to knowledge and other partners who may be able to help. One of the most important skills of the HT is to be able to signpost clients to the specialist support, and to be there as a constant to offer support in often what can be very hectic lifestyles…* (and/or isolated situations)…. *Clients are supported by setting SMART goals and a process of review on the terms of the client'*

5.2 Plymouth's current Community Public Health Practitioner approach works well. Health Trainers could help maximise the positive impacts of this work.

Although 88% of English PCTs have HTs, far fewer have the innovative CPHP team resource that Plymouth benefits from. The current Plymouth team enables a multi-level strategic and local approach to reducing health inequalities. The Plymouth CPHP evaluation (see Health Promotion in the Appendices) helps to show that the CPHP approach is having an impact upon health inequalities and the determinants of health.

The Plymouth CPHP team is unanimous that HTs would provide a valuable addition to this work.

5.3 We need extra resources to commission Health Trainers, but they represent good value-for-money.

This scoping has not identified any current unused resources available to fund HTs. Rather it requests that the PCT considers the value of investing in HTs:

- HTs can represent good value for money. The average cost of a half-time Level 3 HT is £10,500 p.a (with oncosts but not including training or other costs – please see the Business Case costings below);
- They can provide a focused and measurable method of reducing health inequalities; and
- They can help achieve the priorities of the PCT's operational framework for 2009/10.

5.4 Commissioning HTs should become an integral feature of the proposed reorganisation of HP in the city.

The PHDU review, *Taking health promotion forward in Plymouth* (PPCT 2008a) proposes that '*the strategic and operational functions of the PHDU would be significantly strengthened, and* (would) *benefit population health and partnership working, by creating a discrete, but not separate, 'health promotion function' of the PHDU Directorate. .'.*

The review proposes a new combined *'Community Health Development Team' …of practitioners from existing teams / areas of: Smoking Cessation, Teenage Pregnancy, Health Promotion Resources, Business Health Network, Breastfeeding, Community Public Health Practitioners, and Health Impact Assessment….*with the appointment of a new *Head of community health development (etc)…. The implications of this HP review also requests that the PCT increase investment in health promotion'.*

The commissioning of HTs, as proposed by this scoping, should be combined with the *Taking health promotion forward in Plymouth* proposals.

5.5 **Commissioning Health Trainers could be most effective with a mixed model approach e.g. hosted in the community sector, managed by the PCT.**

A mixed model approach to commissioning HTs would build on the 2005 Plymouth proposal for HTs.

If HTs were hosted by relevant community-based organisations, then it may be easier for HTs to access 'hard-to-reach' clients experiencing health inequalities. This might also help develop the health promotion capacity of the relevant community organisations themselves.

It would be preferable for the PCT to retain management and supervision of the HTs. This could help ensure the quality and the health promotion efficacy of their work.

So, although HT's could be regarded as '*joint appointments'* made by Plymouth PCT with host organisations, there will be a very clear line of professional and management accountability between the HTs and Plymouth PCT.

5.6 An initial Plymouth Health Trainers proposal is for the appointment of eight 0.5 wte Health Trainers linked to the Community Public Health Practitioners, targeting particular communities.

- Positive health impacts (eg creating local employment opportunities) could be maximised by recruiting eight 0.5 wte Health Trainers.
- HTs could engage with at least 100 new clients per year per HT.
- The HTs would be mentored by the existing 4 CPHP practitioners to help ensure the quality and relevance of their work and maximise health promotion synergies. (For example, the development of a local structure for referrals and support that includes clinicians, local neighbourhood organisations and community development workers).
- Recruitment of the HTs would be targeted at the relevant communities experiencing health inequalities.
- HTs should be appointed to AfC Level 3.
- Plymouth NHS would work with local education providers to ensure that accredited City and Guilds Level 3 HT training (etc) can be undertaken locally.
- HTs could be used to target deprived geographical areas which have not benefited from Neighbourhood Renewal funding (e.g. Keyham, Ford, Mutley/Greenbank).
- HTs could be used to target communities of interest such as offenders/ex-offenders, the homeless, BME communities, people with learning disabilities, and perhaps men aged 40+.
- Targeting HT services through particular organisations and at particular groups could help the PCT access other non-NHS resources to help support the service (eg local authority funding, individual social care payments, resources from the sporting industry, the criminal justice sector etc).
- HTs could be directed in particular to build links with mental health and GP services in the city.

- Coordination and management of the HT service could be provided by a part-time Level 6 post to complement CPHP mentoring.
- Public health staff including HTs would monitor the work to enable patterns of need to be identified in a way that can influence local public policy.

5.7 Health Trainers in Plymouth should be described as "Community Public Health Workers"

As discussed in Section 3.1, Health Trainers are *not* personal 'trainers' or fitness consultants/advisers, despite the potential associations of their title. It can be observed that many HTs and Managers dislike the 'Health Trainers' title and have a concern that it can cause confusion in the public mind.

The Scoping study therefore proposes that HTs in Plymouth will be described locally as *Community Public Health Workers.*

5.8 A Health Trainers service could become an important component of the emerging integrated professional development programme for developing skills and competencies for health promotion practitioners in Plymouth

The PCT review, *Taking health promotion forward in Plymouth* (PPCT 2008a) proposes that a professional development programme for health promotion practitioners in Plymouth should be established for practitioners to develop skills and competencies in health promotion.

A HT programme could provide an essential component of such a professional development framework. As described in 5.6, Plymouth NHS could work with local education providers to ensure that accredited City and Guilds Level 3 HT training (etc) can be undertaken locally.

Also, the DH is currently preparing new HT-related Level 1 and 2 qualifications (accredited by City and Guilds) which could help provide a complete health promotion educational and career pathway. The different levels of accreditation can be described as:

- Level 1 – how to get people interested and engaged in basic health-related learning activities. It can address 'health literacy' and the very first steps in health care. This could be motivational, vocational and health promoting in its own right, developing capacity especially for people lacking some '*functional skills'* who are more likely to experience health inequalities;
- Level 2 - how to make changes in health-related behaviour; the principles of health promotion; sometimes described as becoming a '*health champion'*; and
- Level 3 – how to 'do it' – how to be a professional Health Trainer.

Business Case costings for a Health Trainer service

The following Table shows the proposed Business Case annual costings for a new HT service in Plymouth.

Item	Annual cost £	Quantity	Annual total £
0.5 wte Health Trainer salary mid-point Grade 3	8, 349	X 8	66,792
Oncosts @ 24% of salary	2,004	X 8	16,032
Training	400	X 8	3,200
Travel	200	X 8	1,600
Activities (eg room hire, promotional events)	250	X 8	2,000
ICT costs*	125	X 8	1,000
0.2 wte health trainer manager/coordinator salary at mid-point Grade 6	5,763	X 1	5,763
Oncosts @ 24%	1,383	X 1	1,383
TOTAL annual cost (excluding ICT costs)			**£97,770**

Notes: * re ICT costs. PC costs for health trainers are expected to be covered by the PPCT IT Capital Allocation budget. For this HT Scoping budget £1000 has been included to cover potential ICT 'networking' costs.

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Appendix 1: Current health promotion in Plymouth

1.1: Context

Health promotion is identified as a priority by the Darzi report of 2008, and the PPCT's own *Draft Commissioning Framework* (PPCT 2008e) sets out a clear mandate for investment in health promotion across the Trust.

Plymouth benefits from a large and active Public Health Development Unit (PHDU) team which is engaged in a wide range of partnerships. The recent publication of the *Joint Strategic Needs Assessment for Plymouth* (PPCT 2008d) and the city's *Health strategy* (PPCT 2008c) have identified unmet health needs which resulted in a review of health promotion (PPCT 2008a). However the PCT is currently preparing its *Operating Framework* for the 09/10 financial year and this will identify the key targets and drivers for the year ahead.

1.2: Reviewing health promotion in Plymouth

This review reiterates the challenge of addressing health inequalities and the burden of ill health in order to help raise the city's general health status to match the English average.

The review proposes a community health development approach to health promotion is adopted which integrates primary healthcare, health promotion and community development into community health practice (Huang 2005).

The functions of the PHDU, with 42 fte staff, are summarised as commissioning or operational delivery activity occurring in three overlapping domains:

- Health Improvement;
- Health Protection; and
- Service and Quality Improvement (Figure 2).

The Director of Public Health is a joint appointment between the PPCT and PCC, reflecting the Local Authority's key strategic role and responsibility to promote community well-being, in partnership with the local health community and non-statutory sector.

The health promotion review recommendations include:

- creating a discrete, but not separate, '*health promotion function'* of the PHDU Directorate, to be known as the '*Community Health Development Team'*;
- a senior manager post of '*Head of Community Health Development'* would be created, as a joint appointment with the Local Authority, to lead this team and to act as the operational lead for health promotion for Older People;
- a. *'Principle Public Health Specialist'* post would be created to lead the development of the expanded Community Public Health Practitioner CHDT sub-team and have the operational lead for Mental Health Promotion; and
- that a professional development programme for health promotion practitioners in Plymouth should be established for practitioners to develop skills and competencies in health promotion.

The health promotion review recommendations await discussion by PCT staff and decision-making by the PCT executive. Approval would be required from the Local Strategic Partnership (*health theme group*) and the PCT Board.

1.3 Evaluation of the existing CPHP programme

From 2004 the PHDU initiated a new approach to local level work by employing Community Public Health Practitioners (CPHPs) to work with a specific focus on neighbourhoods that had been identified as priority in terms of multiple deprivation. This is an important and innovative component of the PHDU's work, and the potential role of HTs in Plymouth cannot be considered without a knowledge of the CPHP work An evaluation of this work has recently been completed, led by the University of Plymouth (2008).

The CPHPs have employed a community development approach to improving health in target neighbourhoods, working alongside local residents and frontline staff to focus on areas of health inequality; utilising a broad view of health that recognises the central role of communities and community organisations in improving the quality of life in their areas. They also undertake some work with communities of interest across the city.

CPHPs aim to build the capacity of organisations and community members and groups to participate in a partnership approach to identifying health needs and improving health. A large component of their work is with community and voluntary organisations to ensure that a public health agenda is included in their work and that capacity for health improvement reaches its potential. The Community Practitioners also work directly with groups to carry out health interventions and facilitate health promotion groups.

The current Community Public Health Practitioner team is based in 4 community centres and cover 10 of Plymouth's 43 neighbourhoods. The team's work is set by the specific health promotion needs of each neighbourhood and typically involves helping communities to reduce the risk factors associated with circulatory disease and cancers. Interventions such as providing training for local residents in healthy food preparation on low budgets, promoting exercise opportunities, breastfeeding and parenting support groups and quit smoking initiatives are provided either directly or through services purchased from local partners and other providers.

The key evaluation findings are:

- Great advances have been made in engaging with local residents and setting up groups and initiatives to tackle the problems they have identified;
- the value of working '*bottom up'* with people in each neighbourhood to discover what they actually want; providing an essential bridge between community groups and the organisations and agencies who are the providers of healthcare, community work, public order and education;
- supporting new health and community facilities in a number of neighbourhoods has led to an improved sense of image in these areas;
- CPHPs are effective as facilitators; they can help others to run groups, perhaps stepping in to offer advice, links with other organisations or financial help;
- however the full opportunity for '*differential commissioning'* in favour of deprived neighbourhoods has not yet been realised;
- *there is a problem with the poor involvement of many primary care staff in regeneration programmes, including those programmes focused on non-acute healthcare issues such as nutrition, obesity and exercise*;

- *there is also a need for health 'acute sector' professionals from the Hospital Trust to become involved in the community which they serve*.

1.4 Other health promotion stakeholders

Both the Health Promotion Review and the HT scoping have identified how health promotion is an important aspect of the work of staff and volunteers from other parts of the local NHS, the local authority and a range of voluntary organisations.

This scoping study has suggested that there is a local need to map, network and market the existing health promotion provision in the city. For example, there is a great range of mental health related provision provided by all sectors, including the mental health departments of the PCT.

The suggestion is to establish an easy-use/easy-change on-line directory of health promotion services in the city. This could be of benefit for health and social care professionals (etc) and for the public.

- This would help the best use to be made of existing resources.
- This would help provide an excellent foundation for the introduction of HTs in Plymouth.
- It is important to note that the Plymouth 2020 LSP (Promoting Health group) has in February 2009 identified a similar need and will undertake an audit of HP activity in the city.
- Members of the public would be able to self-refer to many services.
- There is a growing need for this facility because (i) there is now more health promotion provision available from all sectors; (ii) there is now a greater policy and operational emphasis on health promotion and (iii) it is potentially a cost effective way of reducing (for example) the present and future levels of obesity and mental ill-health in the city's population.
- The need is to improve how we (i) make use of existing resources, (ii) market health promotion services, and (iii) increase the integration of health promotion, primary health care, social care, mental health related services and GP services
- This could help maximise the positive health impacts of existing services and be particular useful for GP's and health professionals when they advise and/or refer patients.

The PCT and partners could consider making available the necessary resources to establish and maintain this facility.

Appendix 2: Some key issues arising from other Health Trainer programmes

This section presents a summary table of the key issues arising following visits to different aspects of the HT programmes in Cornwall, Devon, Torbay and Bristol. A phone interview was also held with the PCT's HT Commissioner in Portsmouth.

Please see the other appendices for descriptions of each of these HT programmes (including a description produced by Cornwall for their successful entry into the Sustainable Community Awards 2008).

Theme	Issues arising from the scoping
Recruitment	• Recruiting from target communities is desirable but can be hard to achieve • The high turnover of HTs can cause problems • Improved career development opportunities needed • Bristol aiming to develop a trained and voluntary HT 'bank' (HT Champions?) that can be rapidly called upon as needed
Training	• Most HT managers agree training is lengthy (on average 3-6 months) • Shadowing is an effective form of training • RSPH health promotion Level 2 can now be delivered in Plymouth but many practitioners agree it could be improved • Most HTs seem to find the HT Manual limited – useful to a degree but possibly over 'simplified' (?) • There seems to support for HTs to have specialisms (eg which can relate to key PCT targets)
Management	• There is great variety in HT service including AfC grading, job roles, management structures etc (every service appears to be quite different) • How much to define and prescribe the role for individual HTs? • Identifying the best venues for HTs to be based and the best venues to work from (eg for HT 1-2-1 'clinics') Management choices of: • ……commissioning • ……NHS employed • ……mixed model (NHS employed but placed e.g. in the community sector)
Marketing	• Is vital! • A range of methods needed: word-of-mouth, posters, radio, local press, presentations • Nobody seems to like the HT title! Short of a DH review, we have to use it: but we need to ensure we explain the role when marketing the service.

Impacts	• Value of personal and holistic support in improving health • The value of 'mini-steps' for change • Reaching people who think health promotion is 'not for them' • Motivating people; 'yes you can improve your health' • Most HTs appear to be engaging with 'hard-to-reach' clients (although there is an element of the 'worried well') • HT clinics can be 'fun' (in contrast with the obvious 'seriousness' of many primary health care services) • Can be difficult to measure the impact of building confidence in clients (especially as the DCRS system does not allow for recording self-efficacy measures). • 100's of clients have been helped by the HT programmes studied for the scoping • Could predict excellent impacts from linking/integrating HTs with Plymouth's 4 Community Public Health practitioners
'Low-level' mental health issues eg isolation	• Appears to be a key factor/common denominator for the great majority of clients; e.g. isolation • Important to build relations with NHS mental health services although many service changes are underway and this can take time
Working with groups	• not included in the Choosing Health model or AfC Grade 3 KSF, but appears to be an essential tool/option in-its-own-right and for supporting 1-2-1 HT work
What are the main issues presented by clients?	• Overweight • Inactivity • Diet • Depression/insecurity/isolation/'stress'/demotivation • Accessing services • Smoking • (Alcohol) (and the most common 'social' issues =) • (Long-term dependency on 'sickness' benefits) • (Debt) • (housing)
What are the best tools for HTs?	• '*you've got to be a people person'* • Motivational interviewing • Giving personal support • Encouraging clients to take mini-steps for change • Good knowledge of referrals • Using a 'health contract' tool can help maintain boundaries/reduce dependency
Relations of HT service with wider health promotion and tackling inequalities work?	• HT experience can contribute to tackling some of the barriers which make services less accessible/equitable and restrict their 'outreach'

Relations with health professionals and services	• We already have • HTs should not be seen as '*jack of all trades'* by the PCT • Can take time to establish productive relations with GPs HTs but it should be a priority • HTs based in GP surgeries appear to be effective (Devon/Bristol etc) • Important to sell HTs to NHS clinicians and encourage referrals (eg physiotherapists, Health Visitors, Occupational Therapists)
HTs = NHS employed	• NHS brand is positive • NHS employment terms are good • Good training and CPD opportunities • Can restrict engagement with hard-to-reach? • HTs more vulnerable to diversion into PCT targets (eg smoking cessation)
HTs = embedded in another organisation	• Best of both worlds? • Potential conflicts of interest? • Line management and programme management
HTs = commissioned from another organisation	• Can build crosscutting health promotion capacity across the host organisation(s) • Risky? • How to ensure the quality of HT work?
Resources!	• Average cost of £10k pa for Grade 3 HT (including oncosts) • Need resources for hiring community (etc) rooms for clinics

And some selected HT quotes!

- *Be good to have more definition for the role*
- *Can be a bit like being a big woolly blanket*
- *Covers a multitude of issues*
- *Can be like being an underpaid social worker*
- *You've got to enjoy having a chat and being able to connect.*
- *A HT is someone to help you who isn't going to judge you*

Appendix 3: Health Trainer service case-studies

3.1 Cornwall & Isles of Scilly PCT case study

The Cornwall and Isles of Scilly PCT (CIOSPCT) was one of the first areas to adopt HTs and now has 11 HTs (AfC Grade 3) and 3 Community Health development Workers (Grade 5), who manage the HTs. The PCT also employs a HT Lead (Grade ?).

CIOSPCT has three major strands to the HT programme:

- HTs directly employed by the PCT;
- HT's employed by Cornwall Neighbourhoods for Change (CN4C), a charity and a social enterprise which aims to transform the quality of life for the residents of Cornwall's social housing estates in particular; and
- HT's employed by the environmental charity the British Trust for Conservation Volunteers.

For this study, the author simultaneously interviewed an NHS-employed HT and a Community Health Development Worker; and subsequently a Community Health Development Worker based with CN4C. A brief telephone interview was held with the HT Lead.

The NHS-employed HT spoke of obtaining referrals from GPs, Health Visitors, Social Services and even local faith leaders. The HT is also investing time in getting to know the area, 'cold calling' various community groups and emailing referral forms. It was particularly necessary to be pro-active when identifying older people for HT support.

The HT also observed that it could be useful to be perceived (at least in part) as an *'outsider'* by potential clients when addressing personal health issues in small, close-knit and relatively isolated communities.

Management and peer support for HTs is perhaps particularly important in Cornwall which presents a rural population with deprivation commonly scattered across relatively isolated small towns.

The 3 HTs and 1 Community Health Development Worker commissioned from the community organisation, Cornwall Neighbour hoods for Change (CN4C), are using a community development approach to target social housing residents on estates in towns such as Bodmin and Truro.

The HTs 'sympathetic' approach aims to demonstrate that local residents and their problems are the priority for the HT service – thus aiming to make a difference in communities where illness and incapacity and the reliance on associated state benefits can become normalised. According to the Healthy Neighbourhoods Project - the partnership body for coordinating the PCT, CN4C and BTCV HT programmes – over 27,000 jobless people of working age in Cornwall claim sickness-related benefits (from a total of 37,000 working age people claiming jobless benefits).

Perhaps unsurprisingly it can be harder for these HTs to develop good relationships with different NHS services, although they have been developing good relationships with a range of organisations (Citizens Advice Bureau, Childrens Centres etc) and community groups working with deprived neighbourhoods. They have now received over 100 referrals.

Overall the service to date has supported 235 clients (not including 43 clients supported through Level II HTs for whom they are awaiting l information regarding support offered). which 45% have been referred to other agencies and support services (152 referrals made) including Citizens Advice Bureau, Link into Learning, Young People and Family Services, Cornwall Drug and Alcohol Service and local colleges. Over 30 clients have gained employment after working with a HT and many after a considerable amount of time unemployed (13 years in one case).

3.2 Devon PCT study

The Devon service is delivered by geographical area with HT bases in Newton Abbot (2 HTs), Cullompton (3 HTs) (both visited for this scoping) and Barnstaple. Each HT tends to cover a large geographical area although they are also directed to target their service (eg Cullomtpon-based staff target disadvantaged wards in Exeter and Exmouth). There are apparent variations in the delivery of Devon's service in the different areas, stemming from the different skills and interests of HTs and Managers, and the strengths or weaknesses of relationships between health promotion and other primary care services and external agencies.

At least one HT receives referrals from being partly based in a GP surgery, although the HT noted that the GPs '*think I'm a fitness consultant'*. Good referral sources include:

- Exeter Drugs Project (a voluntary sector organisation covering a wide geographical area and engaging with diverse health issues)
- The Royal Devon and Exeter Hospital are also good at referrals.
- Fitness First leisure centres (they have over 3700 sites in the UK)
- HTs are in the process of building relationships with social care services by engaging with Devon's Area 'cluster meetings', the social care 'wellbeing coordinators' and the network of children's centres.

In common with other PCTs, staff noted that it takes time to establish HT 'clinics' and to promote and explain the service to potential clients and potential partners. There is also a lack of funding to hire locations for clinics. Good locations ca be particularly difficult for the critical 5-8pm time-slot – which tends to suit those clients who are in work - as many NHS and Local Authority sites are closed and/or otherwise deserted of staff (which can raise health and safety issues).

Devon PCT staff have had to cope with a much change and restructuring recently (and a final decision on the future configuration of Devon local government is still awaited).

HTs have also been under pressure to support the PCT's efforts to achieve smoking cessation targets, potentially restricting their ability to undertake the whole HT role. There was also speculation that the payments system applied to General Practice might sometimes discourage referrals (if in effect the system rewards GPs for helping the smoker then there can be an incentive to keep patients on a GP waiting list rather than making a referral)

3.3 Torbay NHS Care Trust

Torbay has 3 staff appointed at AfC Level 4 (appeal pending for regrading to Level 5) who work as ½ time HTs and ½ time 'lifestyle support' workers, specialising in mental health (stress control and depression issues etc), smoking cessation and physical activity. (These 'lifestyle support' roles are linked to Torbay's LAA targets).

The HTs cautioned against false expectations for the service. They can be asked to do '*everything*'. Corporate strategies can also assume that an effective inequalities intervention is simply the provision of extra services (eg smoking cessation) in disadvantaged neighbourhoods.

'*You can't simply expect the poor of Watcombe to come out and make use of stop smoking and alcohol advisory services; people like smoking and going down the pub, they're no more likely to leave the comfort of the TV and the internet'* than residents in any other area or socio-economic class. There should not be the presumption that people want to change; a lot of outreach is required to encourage change. HTs can make a vital contribution by supporting people to make lifestyle changes.

Torbay's HT's are trained (unlike most Level 3 HTs) to do rapid *health MoT* checks (e.g. blood pressure, cholesterol) in community settings and then to refer people onto services as appropriate. GP referrals to HTs are described as *good* in Torbay (although it is necessary to keep reminding surgeries of the HT option). They also receive referrals from the NHS lifestyles support team and from other sources such as Torbay's street wardens.

HTs have had over 150 clients to date (not including MoTs or 1-off meetings with clients). Key issues have been related to mental health (isolation) and weight – but there's always more than one issue that people present. Clients do include an element of the '*worried well'*. A University of the West of England evaluation showed good feedback from clients who valued the personal time they received from HTs. The HTs believe that they are helping to diverting to prevent some clients from falling into '*clinical depression'*. Their local knowledge is key for gaining and referring clients.

Torbay has a '*co-creating mental health'* scheme whereby some clients/service users and HTs work with clinicians who benefit from gaining knowledge about motivational behaviour change and how to ask their patients '*open-ended'* questions.

The HT service is now planning to be more focused, targeting new geographical areas and groups such as men aged 35+ (eg via Torquay Football Club and the Stagecoach bus company staff). There will be more promotion of HTs in workplaces and community centres and even siderooms in selected pubs. They will also work with the Jobcentre plus service. They are also considering setting up a post-HT service 'support' group which would provide social contact and help keep clients in touch with health services. From this group they might be able to recruit volunteers and offer training equivalent to the AfC Grade 2 KSF etc. The HT service is currently agreeing a suitable '*volunteers contract'* with the Torbay Trust HR department.

Torbay suggested that community organisations could be good hosts for HTs if line-management and NHS relationships can be put on a good footing. There is a need to be aware of how the voluntary sector agenda (e.g. needing to raise income) might affect the HTs They offered Plymouth the advice of '*keep it focused, don't spread HTs too thin'* and stressed the benefits of linking HTs priorities to LAA targets.

3.4 Bristol PCT

Bristol was an early adopter for HTs and now has 10 HTs (fte = 6) with plans to have 20 HTs in place in the next year. The service has been through a less productive phase and has now appointed a (Grade 6) HT co-ordinator who is new to the NHS but who has a specific expertise in community development and '*neighbourhood management'*. The service appears to be benefiting from a dynamic cordination and an experienced and supportive Public Health Specialist with overall responsibility for the service.

The new cordinator inherited a large and disparate team and needed to prioritise '*selling*' the programme to partners and clients alike and increasing the referrals. From a starting point of only 7 clients there are now 60, which is expected to rise to over 100 soon. The Coordinator even uses her regular show on local community radio (which is partly sponsored by the PCT) to help promote referrals. The general focus is on the deprived (ex Neighbourhood Renewal) areas.

The Coordinator has presented the HT 'vision' to physiotherapists (who tend to refer older people), occupational therapists, community nurses and non NHS groups such as Second Step (who works with ex-offenders, the homeless and the long-term sick) and the Red Cross. The Red Cross have a large number of volunteers who work with people leaving hospital who live alone.

There is a plan to speed up the HT training (typically 3 months) as there can be a high turnover of HTs. They have applied for Grade 4 status for HTs to reflect their skills and to aid staff retention. They are considering training up some of the Red Cross volunteers to in effect establish a 'bank' of trained people who could be called upon when HTs leave the PCT.

Different HTs have different capacities, and they all have to be allowed to balance freedom to work in their communities along with the discipline of working to targets. The Coordinator now provides supervision as well as 1-2-1 management. The aim is for a maximum of 20 clients per HT at one time; each client does not have to be seen each week. It was suggested that flexible caseload training could be useful for HTs.

HTs need a good sense of initiative and community networking skills to gain referrals and to help clients. The HTs have now received some 'presentation skills' training which helps them to 'excite' people about the value and potential of the service. The aim is for HT's to '*proud*' of their accredited NHS-branded contribution.

The PCT itself has limited experience of working in the community and engaging with a wide range of non-clinicians. Practical issues include getting the HT infrastructure right: appropriate office space in community settings and personal access to PCT computers.

The HT service is also preparing a simple client info sheet which will easily capture the crucial client data; summary data could then be routinely sent to GPs which could improve relations, referrals and outcomes.

The HT Priority is 1-2-1 support but they all have (for instance) some stop smoking training and 'of course' they do some group work in different settings.
A Bristol HT of 3 years standing spoke of how she appreciated the flexibility of her ½ time post and enjoyed the diversity of the work and the opportunities for personal development.

'*We can help people make change happen… join new groups, get extra exercise… often people know about agencies but won't go there, we can help them, accompany them, give*

them a named contact etc….' Low-level mental health issues and isolation are often the biggest symptom, closely followed by weight and inactivity issues - '*people want to get out'*.

GPs are not very helpful, mostly. I'm helping one of my clients to change GP at the moment. If you are not well health professionals can be intimidating…'

Bristol has also taken the innovative step of appointing 4 HTs with learning disabilities. It took them a year (rather than 3 months) to train up but they are now able to work as HTs with their peers, to capture data, help prepare individual health action plans and to make presentations.

These HTs described the main health issues they encountered as diet, being overweight, suffering from bullying, sexual health and the accessibility of services and information. Special materials have been produced for both the HTs and their clients to use.Two other big areas of their HT work are working with learning-disabled people's support workers to improve health outcomes, and teaching health professionals about accessibility etc.

The HTs are based in their own office with at least weekly 'supervision' and direct support from the HT Coordinator. The HTs said they '*don't like being bored… and enjoy meeting new people and going places*'. In common with other HTs they have to break the desired lifestyle change down into mini steps. They take care to ask people their interests and make a good connection with their clients. Some of their interventions and activities (individually and in group settings) include producing a health DVD, using games to explore men's health issues, cooking classes, health walks and presenting sessions which explaining where your body organs are and what they do etc.

3.5 Portsmouth PCT

Portsmouth was selected for consideration because the city's health profile (Association of Public Health Observatories 2008) presents the closest match with Plymouth when compared with the health profiles for all the local authority areas in England. A telephone interview was subsequently conducted with the PCT 'Commissioner' of the HT service.

Portsmouth was an early adopter for HTs. The DH Choosing Health budgetary allocation to Portsmouth has been built into the multi-agency agreed Local Area Agreement targets which *'protects* ' this funding for a 3 year period.

For example, Portsmouth has an LAA target to reduce the recorded rates of alcohol-related violent crime. HTs are expected to concentrate on health problems related to alcohol and obesity and so HTs contribute to the LAA targets.

Now Portsmouth can be characterised as having an innovative approach. They have adopted the 'commissioning' model and the whole service is delivered under one contract with a regional social enterprise and educational charity, Learning Links.

Learning Links won this contract in open competition with a range of other bidders including the City Council and the 'provider' arm of the PCT itself. According to the commissioner, a Public Health Development Manager, this has led to some tensions with the Council and other departments of the PCT who subsequently may be less inclined to '*put their bit in'* to the HT programme.

With the contract value being in the region of £300k pa for 3 years the PCT can be regarded as (depending on the point of view) being highly innovative and/or having taken a risk in commissioning the HT service from such a partner. It appears that a key management issue for the commissioner has been to develop and support the '*health competency'* of Learning Links.

A particular bonus of commissioning the HT service in this way can be described as supporting the '*setting*' approach to public health promotion i.e. developing public health in a range of environments. Moving aspects of primary health care from a GP practice into (e.g.) the setting of a football club or the probation service can access hard to reach people and build sustainability into public health promotion across the city.

Learning Links already utilise a one to one support model to support education with disadvantaged groups - for example they utilise 'learning champions' to support this work – making an obvious comparison with the theory behind the HT service. Most significantly however, Learning Links were seen as being 'in touch' with and understanding different groups in the community, often beyond the 'reach' of the PCT. Learning Links already had relationships with those communities where HTs should be working. By focusing on organisations that *don't normally do health* it becomes much easier to (e.g.) access men

Learning Links adopted a 2-stage model for HTs and spent the first 6 months identifying partner organisations in different settings such as:

- a healthy living centre;
- the local professional football club (with extra football industry funding);
- the city disability forum;
- the Citizens Advice Bureau;
- the Salvation Army;
- Age Concern;;
- the Foyer (youth supported housing charity); and
- the Council for voluntary Services.

Learning Links have now sub-contracted the HT service into these settings. It would have been very time-consuming and expensive for the PCT itself to have directly and separately negotiated HT service-level agreements with at least 5 different organisations.

For the commissioner the main challenge and 'risk' appears to have been to support the development of the '*health competency'* of Learning Links and in turn the other organisations hosting HTs. However Learning Links were already a recognised centre for City and Guilds qualification and hence they were able to deliver the HT staff training in partnership with other organisations.

Learning Links have developed their health competencies and have delivered training in partnership with the PCT and Councuil etc. The suitable competencies for HT tutors have been agreed, such as producing a portfolio of evidence demonstrating competence. Depending on their background, public health specialists are also seen as suitable tutors.

Learning Links have a key staff member managing the HT service. 24 people are employed as HTs (10 FTE) and there are 10 HT volunteers. These are either people who already have a relevant role which the HT role can complement, or specific volunteer recruits, trained to the NHS KSF Level 2, and therefore Health Champions within the HT programme.

It has been possible to access football industry funds (Littlewooods Pools) for seconding a HT into the club structure. Several other possible workplace HT projects are currently under consideration.

Porstmouth was also the first PCT to work with the Probation service and appoint ex-offenders as HTs during the HT pilot phase. Post-pilot, it has been essential to persuade Probation to provided resources for the day to day management of this work . After the pilot the HT programme has been extended into the local prison, which has a relatively high number of men serving lengthy sentences.. It has proved more difficult to '*get real buy in'* but a service level agreement has been agreed.

Serving prisoners have been recruited as HTs, earning the standard £15 a week now. However these men will now have accreditation and will be have the opportunity to link with and even work for the established probation HT service when they leave prison. In the meantime a large number of prisoners have the opportunity to see HTs during their sentences. (A disadvantage however is that prisoners can get moved around from prison to prison and valuable relationships and experience can be lost).

February 2009 marks the end of the 1st year of the contract. Most of the year has been spent identifying host organisations, delivering training and building up structures. Some HTs are still not accredited and there has been little active marketing of the service to date, although many HTs are already seeing clients. A significant aspect of the training is helping HTs find out about existing services for the onward referral of clients. Client mental health issues are a prominent feature of HT work to date. Some HTs have expressed concerns about the appropriate response when engaging with potentially suicidal clients.

Objectives for year 2 include developing the evidence base and working to integrate HTs into existing services. There is a need to inform other healthcare services about possible increased or decreased demand as a consequence of HT interventions. HTs *do a bit of everything* and have to be prepared for a wide range of situations. It's also important not too expect too much from the HT service.

You've got to be very clear what you want with commissioning. The HT programme is delivering more health services into the community via organisations that are able to access vulnerable individuals who experience significant inequalities and can lead chaotic lives (eg visiting the dentist equals significant behaviour change). The commissioned HT process can have a big impact on other organisations (e.g. they can become health champions) and the wider community.

Commissioning the HT programme can be seen as capacity-building: *someone else takes responsibility so you (the Public Health team) can do something else.*

3.6 Summary produced by CIOSPCT for their HT winning entry for the Sustainable Community Awards 2008:

"Duncan said he felt able to trust you and was confident that his life was going to change. He told me he had never met anyone so conscientious as you. He was thrilled with the support that you have given and continue to give. He tells me that he hopes to be off benefit by next July and self sufficient." are words from a client which epitomises the work of the Health Trainers Service in Cornwall. An area of high deprivation and health poverty, we are tackling health inequalities through the Health Trainer

Service (HTS). We have taken a two-layered approach to the development of the HTS in Cornwall whereby a Community Health Development Worker (CHDW) line-manages and supports the Health Trainers to provide a more holistic approach. The CHDW works via a community development approach with local community groups supporting them, thus empowering members of our community. This forms the initial support structure to our local communities as a foundation level of support while the Health Trainers provide one-to-one support to individuals who wish to make positive changes to their lifestyle. The project is delivered through a partnership approach with the third sector overseen by the Healthy Neighbourhoods Partnership.

Main Submission

The Healthy Neighbourhoods Partnership (HNP) has developed and grown over the last three years and is a collaboration of public and voluntary organisations with the aim of reducing health inequalities in the most deprived areas in Cornwall using a community health development approach. The HNP is the lead body for the delivery of our Health Trainer Service (HTS) in Cornwall and the lead for the Health Inequalities target of our Local Area Agreement (LAA). The strength of the HNP has brought us diverse and innovative points of view that have been instrumental in developing a programme that truly reflects the needs of our differing communities.

The aim of the project is to work with local communities to reduce health inequalities, ensuring access to appropriate services to those disadvantaged throughout Cornwall. The county suffers from high health poverty and deprivation and residents have a high need for accessible services to support positive lifestyle changes. This project addresses those needs through a people centered approach, working with a strategic network of providers from statutory and voluntary sectors.

In 2004 with the publication of the Choosing Health White Paper, the Government set out its plans to develop a new public health work force in the form of Health Trainers (HTs); helping people to help themselves through support from 'next door'. It was the HNP that took on the mantle to develop and deliver the HTS in Cornwall.

There is a general understanding of the need to be able to develop people in terms of self esteem and personal confidence and to empower people to take their own health and well being as a personal responsibility and desire to change. Therefore we have taken a two-layered approach to the development of the HTS in Cornwall whereby a Community Health Development Worker (CHDW) line manages and supports the HTs to provide a more holistic approach. The CHDW works on a community development approach with local community groups supporting them through development, thus empowering members of our community. The CHDW forms the initial support structure to our local communities as a foundation level of support. This role assists in providing the HTs with ready participants to begin to make changes to their lifestyles. The HTs provide one-to-one support to people who wish to make positive changes to their lifestyle.

We delivered a year pilot phase with seven Health Trainers (HT) working in areas of most disadvantage and where we were able to add value to current delivery, bearing in mind the restrictions of the timescale. We gained funding through Neighbourhood Renewal Fund and Cornwall Works (lead for worklessness for the LAA) together with NHS funding to deliver the pilot. Recognising the value and importance of delivery through partnership with the third sector we tendered out the delivery of the project for four of the HTs. Two HTs based in the most deprived areas in Cornwall were delivered through BTCV in west Cornwall, while a local charity providing support for residents of social housing Cornwall Neighbourhoods for Change (CN4C) won the tender to deliver in Bodmin and Truro. The Health Promotion Service itself employed and line managed the HTs in the Clay Area, Newquay and Saltash.

When we recruit HTs it is important to us that they are passionate about helping communities and people to make positive changes to their lives. We are not necessarily looking for people with a high level of education or previous work experience. We certainly value contributions people make through community work and volunteering. Where possible we try and recruit from the local area so the HT has a greater understanding of the issues that people face locally. All HTs go through the City & Guilds III

Health Trainers Certificate and additional training as required. An additional benefit to the project has been the empowerment and personal development of our HTs themselves. Some of our HTs have had long periods out of work; have no formal qualifications or recent work experience. However, all our HTs are united in their passion and commitment to helping people achieve their aims successfully. We have found this approach to recruitment has been extremely valuable in terms of HTs being well versed in the issues many people face in their daily lives. The HTs themselves are models of how, with support, people can make changes for themselves, step by small step.

There are many reasons why people, especially those from hard to reach groups, do not access services including limited knowledge on what is available, 'that's not for people like me', lack of confidence, poor previous experience, etc. By centering our service within local communities we are able to ensure that the HTS is seen as accessible and approachable.

This project has been able to provide a unique structure in supplying support to people on their own terms and in their own locality. The project workers work specifically in the identified geographical areas; not expecting clients to come to them, but physically going and seek clients out. Although referrals are received from partners ranging from the CAB, housing associations and GPs, many clients are now self referring after word of mouth from colleagues, family and friends. Historically this has proved one of the most important ways of reaching hard to reach groups.

The HTs are often seen as a 'Jack of all trades, master of none'. This is because most clients need one central point to gain support and access to knowledge and other partners who may be able to help. One of the most important skills of the HT is to be able to signpost clients to the specialist support, but to be there as a constant to offer support in often what can be very hectic lifestyles. Clients are supported by setting SMART goals and a process of review on the terms of the client. Although we have to be careful that clients do not become dependant on the support of a HT, often as the client's confidence grows with their success as will their aims and goals. It is therefore possible for some clients to see their HT on a fairly long term basis; this programme of support aims to react directly to the needs of the client and is not restricted through its own structure.

For many people from disadvantaged areas health can often be seen as a luxury; something they have no time or resources to be able to deal with. For many clients, basic needs such as housing and debt management are more pressing issues. Because our aim is to support people with their own aims and goals we are able to work on the issues that most affect them; all of which have an impact on health inequalities. Housing and debt management have been issues of high need specifically in the east of the county, whereas other areas see weight management as a high priority. Other support we provide through the work of the project includes employment, training, social interaction and volunteering as well as more traditional health support in losing/maintaining weight, healthy eating and accessing physical activity.

If clients are to engage with the Health Trainers successfully, we must ensure that the service we provide is appropriate for their needs. Therefore the method of support and service delivery needs to be flexible and individually tailored. Some clients feel more confident in a group environment, whereas others only feel comfortable in a one-to-one situation. Of course, as peoples' confidence grows they may take advantage of all manner of support that is available. The following are groups that are currently running:

- Drop In Health Groups
- Walking Groups
- Discussion Groups
- Swimming Groups
- Healthy Eating Groups
- Why Weight & Weight Management Groups
- Art & Craft for Mental Health Groups

To date we have supported 235 clients (this does not include 43 clients whom are supported through Level II HTs as we are awaiting additional information of support offered) of which 45% have been referred to other agencies and support services (152 referrals made) including Citizens Advice Bureau, Link into Learning, Young People and Family Services, Cornwall Drug and Alcohol Service and local

colleges. Over 30 clients have gained employment after working with a HT and many after a considerable amount of time unemployed. For example, one client has now gained employment after having been unemployed for 13 years.

In excess of 20 clients began volunteering as a result of their contact with a HT. For some this has acted as a gateway to future employment opportunities for example: For NQ01 voluntary work acted as a gateway to a paid position at the local children's centre. For others the act of volunteering is a means of socialising with others and contributing to their local community.

Health Trainers have assisted over 30 clients in access training courses, in some cases this has resulted in the client obtaining paid employment. In other cases training has been provided to clients who wish to become more involved in Volunteering.

Health Trainers have supported and offered advice to many clients (more than 26) regarding financial issues, the three main areas covered are:

- Help with accessing benefits
- Debt management advice (signposting, support and in some cases advocacy)
- Help to access funding re: training courses

In one instance a client was assisted in sourcing funding to pay for driving lessons in order that she may be able to travel to work.

Over the course of the project in excess of 55 clients have been on the Shape Up programme and successfully completed it. Notes: Clients tend to join up initially either to become more active, eat more healthily, or lose weight. It soon becomes apparent to the client through contact with the HT that these three issues are not mutually exclusive (Shape Up addresses all three in either an individual or a group setting. Clients are record their number of steps taken per day and are also signposted to various fitness groups.

Other issues for client – Health Trainer contact are: Smoking Cessation, housing issues, confidence building, and increasing social activity.

An example of the above issues that HTs commonly find themselves dealing with and how they interact can be found below:

TM 008: Referred to HT for help to source funding for Training. Client's application for funding was successful and he took lessons and tests to obtain his Taxi Driving License. Client is now a successful self employed Taxi Driver.

NQ 001: Client was referred to Health Trainer for help with stopping smoking. Client stopped smoking, embarked on a healthy eating/lifestyle regime (became more active, lost weight and ate healthier).
Client began volunteering and applied for a job as a manager at the Children's Centre which she got.

JW is a 27 year old morbidly obese man from the Clay Area who, at the time of referral was approximately 31stone. Due to his weight he was unable to walk or undertake any physical activity. Since contact with a HT he has begun accessing the gym four times a week and joined the St Stephens Healthy Walkers group and has now lost a total of 5 stone, 19 inches from his waist. He has recently been accepted onto the Heaven Sent Project and is now studying at Duchy College (Amenity Horticulture). JW has been instrumental in setting up a small steps walking group as a volunteer with his HT and has undertaken the Walk Leaders qualification. Previously JW never left his house and felt isolated and alone. As a result of working with the HT his confidence and self esteem have rocketed. His HT reports that JW is now never at home – mainly due to his new found social life and friends.

Due to the initial pilot phase of the project the PCT has now mainstreamed all the work of the HTS and we now have a total of 11 full time equivalent Health Trainers, 3 CHDWs and the ability to extend the service to 2 additional HTs in the future.

Feedback
Below is an extract from an email we received from a partner containing feedback from a client:

I phoned Duncan today to see how he was getting on and to thank him for returning his CW 9. I wanted you to know that he spoke very highly of you in particular and the idea of Health Trainers in general. He told me that because of your background you really understood his problems and issues that he had to deal with. He said as soon as he first met you he knew you would do something to help him move on. Duncan said he felt able to trust you and was confident that his life was going to change. He told me he had never met anyone so conscientious as you. He was thrilled with the support that you have given and continue to give. He tells me that he hopes to be off benefit by next July and self sufficient. Duncan said we need more people like you. I told him we thought you were a star too.

Case Study
Meet Brenda, a lady who was described by her GP as a morbidly obese diabetic and heavy smoker. It was suggested by her surgery nurse that I could help her manage her lifestyle by helping her to lose weight and give up smoking.

I made an appointment to meet Brenda at home, and during our first meeting, Brenda quite matter of fact, no holds barred told me that she didn't want to talk about her weight, and she didn't want to give up smoking, and wasn't sure why I was there. After a cup of tea and some time getting to know each other, Brenda agreed to look at the things in her life that she felt she could change for the better and be in control of. We spoke about Brenda's activity level and Brenda was very honest in saying that she walked from home to car and car to home. Brenda said that as she was so large her legs really hurt if she walked so eventually she stopped walking. Brenda wished she could go out walking without feeling breathless and in pain.

Brenda chose to use walking as her positive behaviour change. We looked at what was available in the area and discovered that the boating lake gardens was on a flat level and had benches positioned all the way along and were only yards away from each other, so Brenda could stop and rest if she wanted to. We met in the lay-by the following week, and a nervous Brenda appeared from her car. We managed to get to the first bench, then stopped and chatted for half an hour. Brenda found this quite hard going. The next week we managed three benches. The next week Brenda made a break through. Brenda discovered that if she didn't have a cigarette for at least 20 minutes before walking, she could walk further. So the next week Brenda didn't have a cigarette 20 minutes before walking (an amazing effort for a 40 a day smoker!), and she managed 7 benches. As the weeks went by, Brenda got further and further along, her confidence grew and it began to make a difference to her outlook.

Brenda then set a goal – Brenda wanted to participate in the 'healthy walkers' walking group. Brenda felt she was making great steps in achieving this goal. A few weeks later it happened! Brenda walked 40 minutes, with one five minute stop! During subsequent walks conversation turned to looking for work. Brenda was convinced that, as she put it was "too fat to work, who would employ me?" We spoke about Brenda applying for temporary work at a local supermarket; Brenda thought about it, then thought some more, till eventually she applied. Interview came and went, Brenda still convinced she wouldn't be hired, and then the bombshell…… she got the job!! And how her confidence grew again!

Since then Brenda has lost 1 ½ stone and cut down smoking from 40 cigarettes a day to 15. Brenda walks regularly and is a regular attendee of the 'healthy walkers' walking group. Her confidence and self esteem has grown, and she has been promoted to a permanent position at work.

Appendix 4:

Revisiting the previous proposed Plymouth Health Trainers Project Plan (2005)

4.1 Context:

The Plymouth HT plan of 2005 gives a brief description of the HT theory and prepares some generic objectives for the HT role, such as:

- Identifying and engaging with local people and target groups (as identified locally).

The 2005 Plymouth Project Plan refers to '*identifying', 'supporting, 'helping*' and '*signposting*' people and appears to prepare for delivering the service in a flexible way.

The last objective is perhaps less common in the context of HT service objectives, but very relevant for the current day and the findings of this 2009 Scoping paper:

- *Monitoring the work to enable patterns of need to be identified in a way that can influence local public policy*.

This valuable objective should be retained for any future Plymouth HT plans. Data gathered by HTs should not be restricted to informing local and national HT performance management and evaluation. HT data can help provide a grassroots view of people's needs and show if/how people perceive and access important services (not just primary healthcare services).

There is also an important 'context note' at the end of the proposal which adds:

'HT's provide practical health promotion support for lifestyle change. It needs to be seen in the context of the wider work on 'determinants of health' and the encouragement of public policies that promote health. However, the important difference between this initiative and previous public health policy for lifestyle change is the focus on communities and groups who currently experience the worst health. Reducing the current gap in health experience between these groups and the population as a whole is the key strategic aim'.

The 2005 proposal is clear that the HT service will be focused on inequalities and will contribute to (and not distract from) wider work on the determinants of health and health inequalities.

4.2 Proposed operational features:

The 2005 proposal had the following key features:

- '*to place Health Trainers to work alongside existing PCT Community Public Health Practitioners within neighbourhood renewal priority areas. The PCT's Public Health Development Unit is committed to supporting the Neighbourhood Renewal Strategy as a policy for reducing health inequalities and for this to steer the health trainer programme at least initially for the first year;*
- *to start with up to 7 part-time posts in the first year, and expecting to expand;*
- *overall lead through a newly established project manager post (full time) probably based within Public Health. ..This post would provide leadership for the work, arrange appropriate training, recruit and place Health Trainers and provide supervision and support.*

- *..Community Public Health Practitioners would support and mentor trainers on a day-to-day basis and connect them directly with particular families and individuals. This close linking of current public health staff with the new health trainers will ensure more effective working and the provision of a local structure for referrals and support that includes clinicians, local neighbourhood organisations and community development workers.*
- *Employment arrangements would be discussed with each neighbourhood as HTs do not necessarily have to be employed by the NHS and it will be important to decide on the best arrangement available;*
- *one Health Trainer post dedicated to cross neighbourhood health promotion initiatives and work with communities of interest;*
- *HTs are expected to be recruited from the communities in which they live and possibly as a development of, or progression on from an existing role such as a community worker or Sure Start volunteer etc;.*
- *accredited training ,,,. expected to be delivered through a new National Vocational Qualification (NVQ) programme locally*.

4.3 Key points for a proposal in 2009?

The 2005 proposal gives a useful starting point for 2009 HT programme in Plymouth although some circumstances have changed/developed:

- the Neighbourhood Renewal (NR) strategy has now been superseded by the Plymouth Health Strategy, endorsed by the Local Strategic Partnership, which in theory embeds reducing health inequalities into the key strategies and work programmes of leading organisations in the city (although arguably lacking the specific focus of the NR strategy/plan);
- the Community Public Health practitioners programme has been enhanced via an extra post and the inclusion of more neighbourhoods and communities of interest;
- the Community Public Health practitioners programme has been evaluated by external researchers; and
- health promotion in Plymouth has been reviewed with the preparation of restructuring and developmental proposals.

These recent contextual developments are reviewed and considered in the light of the HT scoping and incorporated into the findings and conclusions (see section 5).

The 2005 proposals were drawn up with some consultation with community sector partners and a great deal of interest being expressed in hosting HT posts. There were even individual activists and volunteers interested in becoming HTs, and there was a great deal of disappointment when Plymouth's HT funding was redirected by the Strategic Health Authority.

Because of these sensitivities this scoping has only involved one meeting with a community stakeholder. Nonetheless it is reasonable to assume that several community organisations might welcome the opportunity to engage with and help deliver a Plymouth HT programme.

Appendix 5: Stakeholder engagement for this study

Main stakeholder engagement activities undertaken for this scoping paper:

December: • Initial meeting with CHP team & PH Consultant
- Meeting of (westcountry) hub re training & development
January - Set up with PH Consultant - Meeting with CHP team - Meeting of westcountry hub - RSPH Health Promotion Level 2 Train the Trainers training - Meeting Plymouth Deputy DPH & Consultant - meeting Torpoint/Saltash health trainer & local Manager
February • meeting voluntary sector stakeholder • Meeting of SW Hub, Taunton • Trainers and Manager, Redruth • Meeting Vocational Services Manager & Social Inclusion Lead, Adult Mental Health Services Plymouth PCT • Telephone interview with HT Commissioner, Portsmouth PCT • Trainers & Manager, Newton Abbot and Cullompton • Trainers & manager, Torbay • Trainers & manager Bristol
March • Plymouth Community Public Health Practitioners meeting • PCT Director of Primary Care
April • Meeting with PCT Mental Health Commissioning: CANCELLED