

# Indicators of change

The adaption of the health trainer service in England

February 2015





**Tower Hamlets Health Trainer Service**

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**Sheffield Health Trainer Service** – visit to Peace Gardens

## Foreword – Shirley Cramer CBE



In 2011, the then Health Secretary, Andrew Lansley, made the prediction that the NHS would be unaffordable by 2030, costing an estimated £230 billion each year.<sup>1</sup>

A major contributing factor in the rising cost of healthcare services is the staggering level of avoidable illness in the UK. Medical conditions relating to overweight and obesity, for example, cost the NHS an estimated £6 to £8 billion a year, roughly 5% of the entire NHS budget. By 2030, this figure is expected to rise to between £10 and £12 billion.<sup>2</sup>

Any health improvement initiative seeking to reduce the level of avoidable illness must recognise that these conditions and their associated lifestyle choices are not distributed evenly throughout society. Instead, the UK continues to face stark health inequalities with the poorest in society experiencing the poorest health outcomes and consequently, lower healthy and actual life expectancy.<sup>3</sup>

Faced with such challenges, the health trainer service is a valuable resource for commissioners. Commissioning for health improvement is about much more than introducing services to meet targets on specific issues, such as smoking; it is about getting to the root of the fundamental health needs of a community and building a community's capacity to tackle the public health issues. The health trainer service is ideally placed to do this.

Previous Data Collection and Reporting System (DCRS) reports have demonstrated the success of the service in supporting healthy lifestyle changes in areas such as smoking, diet and physical activity; this new report seeks to go one step further by looking in greater depth at the different approaches being taken by services and highlighting the breadth of health trainer work. Through the use of qualitative research, alongside the DCRS data, this report has given a voice to individual services highlighting their extensive work to target the wider determinants of health through, for example, the development of community assets and their work on a vast array of issues from debt and housing to social isolation.

To tackle the major public health challenges, it is vital that commissioners recognise the importance of embedding healthy lifestyles within communities, and our research demonstrates that when commissioned effectively, the health trainer service could be instrumental in achieving this.

**Shirley Cramer CBE**

Chief Executive, RSPH

February 2015

## References

<sup>1</sup> Lansley A. *Why the health service needs surgery*. Available online at: <http://www.telegraph.co.uk/comment/personal-view/8551239/Why-the-health-service-needs-surgery.html> (2011, last accessed 13th February 2015)

<sup>2</sup> McKinsey Global Institute. *Overcoming obesity: an initial economic analysis*. London: McKinsey and Company, 2014

<sup>3</sup> Marmot M. *Fair society, healthy lives. The Marmot review, executive summary*. London: The Institute of Health Equity, 2010





## Foreword – Duncan Selbie



Communities are the key to achieving good public health. A community, characterised by a range of local organisations, community groups and social networks, provides a foundation upon which individuals are supported to make positive lifestyle choices.

The report published earlier this month jointly by Public Health England and NHS England, *A guide to community-centred approaches for health and wellbeing*, recognises the importance of communities for improving the health of the public and crucially, reducing avoidable illness and health inequalities.<sup>1</sup> The health trainer service, in seeking to empower communities through the recruitment of local individuals, the development of community assets and the provision of a bridge into other services, is an excellent example of this approach.

All communities are different, however and this must be reflected in health improvement initiatives. Developing local solutions is key to the success of any programme; a fact which underpins the design of the health trainer service. The new Data Collection and Reporting System report demonstrates the ability of the service to adapt to local needs at both an organisational level with services offering a range of intervention types, and also at an individual level with health trainers offering client-led, flexible support.

To tackle the major public health challenges, it is crucial that commissioners look to embed community-centred approaches in their health and wellbeing plans,<sup>1</sup> and as this report demonstrates, the health trainer service could be a vital part of this. The health trainer service has developed considerably since it was first introduced, branching out into new areas of work, but at the same time, continuing to achieve considerable success in supporting behaviour change and reaching the most deprived.

### Duncan Selbie

Chief Executive, Public Health England  
February 2015

### References

- <sup>1</sup>. Public Health England, NHS England. *A guide to community-centred approaches for health and wellbeing*. London: Public Health England, 2015



**Cornwall Health Trainer Service**

## Executive summary

- The health trainer service was introduced in 2004 with the core goals of preventing avoidable illness and reducing health inequalities. At the start of 2015, these goals have lost none of their relevancy. It is estimated that a staggering one in four of deaths in England and Wales could potentially be avoided, amounting to more than 100,000 deaths per year.<sup>1</sup>
- Previous reports produced using the Data Collection and Reporting System (DCRS), the data repository established by the Department of Health, have demonstrated the considerable success of health trainer services in targeting the most deprived groups, supporting positive behaviour change and improving the mental wellbeing of clients.
- This DCRS report, the first in a series of six reports to be produced by the Royal Society for Public Health, seeks to build on these findings; using both the DCRS data and qualitative research, this report looks in greater depth at how services are being utilised across England and examines the extent to which they have moved away from the 'original' service design.
- Our research found considerable diversity between health trainer services, with many services moving into a range of new settings and new areas of work.
- There is a growing polarisation of services, between on the one hand, services adopting more clinical work and on the other, services consciously resisting this move and instead, placing a far greater focus on the wider determinants of health and community development.
- The diversity between services is driven by a number of factors; one strong theme emerging from the research is the uncertainty felt by services around funding and the use of short-term contracts. This is leading to increased pressure to operate more efficiently and more clearly demonstrate the effectiveness of services.
- Many services have also adapted in order to more effectively meet the complex mental health and emotional needs of clients.
- This report, alongside the previous DCRS publications, provides a strong evidence base for the effectiveness of the health trainer service. Services are increasingly operating under a wide range of organisational structures and contractual arrangements, but are nevertheless continuing to achieve considerable success in supporting individuals to lead healthier lifestyles and when commissioned effectively, are instrumental in embedding healthy lifestyles within communities.
- Many services, however, have voiced concerns over an increasing focus on meeting specific targets. It is vital that as services develop, commissioners do not lose sight of the original 'ethos' of the service and that its potential to tackle the wider determinants of health is recognised in commissioning.

## References

<sup>1</sup>. Office of National Statistics. *Avoidable mortality in England and Wales, 2012*. Available online at: [http://www.ons.gov.uk/ons/dcp171778\\_362295.pdf](http://www.ons.gov.uk/ons/dcp171778_362295.pdf) (2014, last accessed 14th February 2015)



## Introduction

Over the past century, public health in the UK has undergone vast changes. The 'big killers' of the early 20th century, namely infectious diseases like tuberculosis, have largely been defeated through the rise in living standards, greater access to healthcare and the advent of the 'antibiotic age'.<sup>1</sup> However, at the same time, we have seen the rise of new, more intractable public health issues. The 'big killers' of today, namely heart disease, stroke, cancer, lung and liver disease, are not the result of poor hygiene or the transmission of pathogens, but instead are, to a large extent, the result of unhealthy lifestyle choices. It is estimated that a staggering two-thirds of all deaths for under 75s could have been avoided through the adoption of healthier lifestyles, such as eating more healthily, tackling the wider determinants of health or healthcare interventions, such as earlier diagnosis.<sup>2</sup>

As the major threats to public health change, so too must our response to defeat them. In 2004, the White Paper, *Choosing Health: Making Healthy Choices Easier*, recognised that we 'need a new approach to the health of the public, reflecting the rapid and radical transformation of English society in the latter half of the twentieth century'.<sup>3</sup> An integral part of this 'new approach' was the introduction of the health trainer service. This marked a significant shift in public health, moving away from an approach in which the patient is a passive recipient of advice and services, to one in which the patient or 'client' is an active partner, empowered to make healthier lifestyle choices.<sup>3</sup> Rolled out across England from 2006, the health trainer service has already provided support to over half a million people.<sup>4</sup>

The efficacy of the health trainer service is supported by a strong evidence base in the form of the Data Collection and Reporting System (DCRS), the data repository established by the

Department of Health. The DCRS reports published to date have examined the health trainer service as a whole, providing almost a national picture of its success in targeting 'hard to reach' groups, supporting positive behaviour change and improving mental wellbeing. The report published in November 2013, by the Royal Society for Public Health (RSPH) in collaboration with the DCRS, focused on the potential of the health trainer service to tackle health inequalities. By focusing on clients from the most deprived quintile, this report demonstrated the success of the service in supporting them to make positive lifestyle changes across a wide range of health and wellbeing issues. Examples of this success include an average 57% increase in fruit and vegetable consumption, an average 53% decrease in fried, fatty and snack food consumption and an average 43% decrease in alcohol intake.<sup>5</sup>

As the first in a series of six DCRS reports to be produced by the RSPH, this report will seek to build on these findings by looking in greater depth at how the service is being utilised across England and its ability to adapt to local needs. This adaptability, combined with the major changes in public health over the past few years, namely the transition of public health to local authorities, has resulted in significant diversity between services in terms of organisational structure and contractual arrangements. Using both quantitative data from the DCRS and qualitative research, we will examine this diversity, seeking to understand how far services have moved away from the 'original' service model and where possible, highlight the impact of recent changes. It is hoped that in doing so, this report will prove to be a useful resource for commissioners in understanding how best to utilise the health trainer service and tackle local public health issues.





**North Tees and Hartlepool Health Trainer Service**

## Methodology

For this report, we utilised both quantitative data drawn from the DCRS and qualitative research. Using purposive sampling, we focused on a sample of 21 services drawn from DCRS users. Based on the premise that the extent to which a service has changed their use of the DCRS is indicative of a service's level of adaptation, we included a range of services from those whose data collection has largely remained the same to those who have significantly altered their use of the DCRS.

The qualitative research, conducted in November 2014, consisted of semi-structured telephone interviews with 17 service managers and a survey using open-ended questions sent to health trainers from the 21 services. We received 80 responses in total to this survey.



**Cornwall Health Trainer Service**  
Eat Well, Spend Less cooking group in Redruth





**Cornwall Health Trainer Service**  
Big Beach Day 2014 in Newquay

## Features of the 'original' health trainer service

### Features of the 'original' health trainer service:

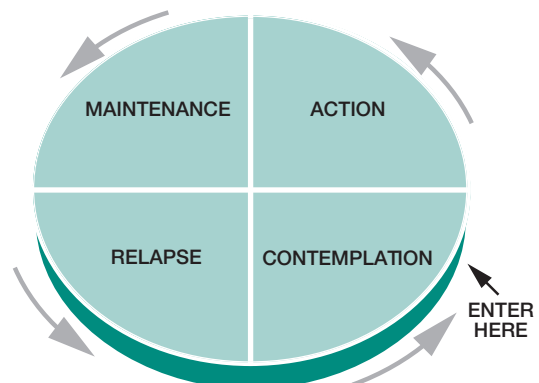
- Health trainers are drawn from local communities
- The service seeks to tackle health inequalities by targeting deprived groups
- Health trainers provide flexible, client-led support
- They focus on supporting lifestyle changes and preventing ill health

When the health trainer service was first introduced, its core goals included reaching out to the most deprived communities, supporting healthy lifestyle changes and ultimately, reducing avoidable illness and tackling health inequalities. For a service to be successful in achieving such goals, *Choosing Health* recognised that 'support had to be tailored to the realities of individual lives, with support personalised sensitively and provided flexibly and conveniently'.<sup>3</sup>

This recognition underpinned the 'original' design of the health trainer service. Drawn from within local communities, health trainers were to have an 'understanding [of] the day-to-day concerns and experiences of the people they are supporting',<sup>6</sup> enabling them to reach out to those most in need of health support and advice. Whereas previous public health initiatives had adopted a top-down approach, the health trainer service instead sought to be a 'resource' for communities. Through the use of goal setting in the form of the personal health plans (PHP), brief advice and signposting, health trainers were to act as a 'guide', offering client-led support over six to eight sessions and supporting behaviour change in areas such as healthy eating, physical activity, smoking and alcohol.<sup>7</sup>

The introduction of the health trainer service was indicative of a wider movement away from a more paternalistic approach in public health to an approach focused on the empowerment of individuals and embedding health within communities. This new service sought to promote the holistic view of health; rather than seeing an individual as just a smoker or an overweight person, health trainers would instead seek to look at the person as a whole with a greater understanding of their context.<sup>6</sup>

The service was to be an integral 'part of a wider workforce geared towards prevention of ill health'.<sup>6</sup> As part of the wider workforce, which includes any individual who is not a professionally qualified public health specialist, but has the ability or opportunity to improve the public's health, health trainers were designed to bring individuals into the 'cycle of change' [Figure one], supporting them to move through the contemplation and preparation stages of the cycle and ultimately, providing clients with the skills and resources to achieve action and maintenance.<sup>8</sup>



**Figure one** – 'Stages of change', adapted from Prochaska J O, DiClemente C C. Toward a comprehensive model of change. In Miller W R, Heather N, editor. *Treating addictive behaviour*. New York: Plenum Publishing, 1986



**Cornwall Health Trainer Service** - Eat Well, Spend Less cooking group at Redruth

## Adaptation of the health trainer service

From its inception, it was recognised that the health trainer service could be adapted to meet the individual needs of local communities and that the skills of the health trainers could be utilised on a far wider range of health and wellbeing issues than diet, physical activity, smoking and alcohol. *Choosing health* states that 'different neighbourhoods will need different types of health trainers and in developing good practice we will learn from seeing which models work best for different communities and individuals'.<sup>6</sup>

Diversity within the health trainer service is driven by a number of factors, including the adaptation of the service to meet local needs and also, the unprecedented changes within public health over the past few years. The most significant of which was the Health and Social Care Act 2012, which from April 2013 transferred responsibility for public health to local authorities in England. This Act ushered in a new era in public health, with a new breed of commissioner, the potential of a wider variety of service providers, new budgetary arrangements and the opportunity to take a more holistic approach in the new local authority setting.

Services are now operating under a burgeoning array of organisational structures and contractual arrangements, with indications that this is likely to increase over the next year as many services undergo further reorganisation. The health trainer service is going through a period of transition, and this report provides an insight into the direction in which services are moving. Two main themes emerging from this research will be discussed below.

### 6.1 The polarisation of health trainer services

Overall, the 'original' model remains the core of health trainer services across England. However, our research has found that services are adopting a wide range of approaches to support their clients. A major theme to emerge from our research is the polarisation of services, with an increasing number adopting a more clinical approach. It is common for health trainers to be based within GP surgeries; however, some services are now also taking on more clinical work themselves. The extent to which this has occurred varies greatly between services. For many, this move has primarily been in terms of health trainers more routinely using, for example, cholesterol, blood pressure or blood sugar tests as part of their work. Whilst for others, this move has entailed the addition of new types of work, for example some health trainers are now delivering health checks and/or are increasingly supporting clients on specific medical conditions, such as supporting them to more effectively manage diabetes, chronic pain or issues around sleep.

At the other end of the spectrum, there are a number of services that have consciously resisted this move; instead, placing a far greater focus on the wider determinants of health and supporting sustainable community development, such as community groups and classes and in the case of one service, a voluntary 'buddy' system. Our qualitative research indicates that services provided by third sector organisations or social enterprises and services based in wider wellbeing/lifestyle services, in comparison with other types of service, generally have a greater focus on taking a holistic approach and promoting the emotional wellbeing of their clients.



## Walsall Health Trainer Service

This is possibly due to having more connections with local communities and for the wider wellbeing/lifestyle services, the ease with which they can refer into other services focused on emotional wellbeing.

Our research has also highlighted other ways in which services have adapted. One service, for example, has adopted a telephone-based approach. Within this service, clients are provided with support over the telephone, with face-to-face support reserved for clients with hearing difficulties or learning disabilities. Another service is operating under a payment-by-results contract, in which they receive payment from their commissioners when a client is referred into the service and then for supporting them to achieve their PHP and sign off. The payments vary according to whether clients are from more or less deprived groups.

Using data from the DCRS, we compared the behaviour change success of all the services in our sample (see sample average statistics in tables below). We then sought to separate

the services into discrete categories based on their types of adaptation. However, it became clear early on that because of the unique nature of services and the number of overlapping characteristics, this was not going to be possible without adopting an overly simplistic approach and failing to capture the complexity of the services. Instead, to highlight the range of services included in the overall analysis, tables one, two and three provide the data for seven individual services, each representing a different 'type' of service, compared with the overall sample average. We have focused on data relating to diet as this is the most common primary issue chosen by clients. Our findings indicate that the health trainer service is highly adaptable and is able to achieve considerable success in supporting behaviour change and improving mental wellbeing whilst operating to a range of approaches. The results from the telephone-based service, in particular, are an encouraging finding given the widespread use of telephone support for clients in rural locations.

**Table one** – percentage of clients achieving their personal health plans in 2014:

Service type	Achievement of PHP	Part achievement of PHP
Sample average (21)	51.1%	24.4%
Telephone-based service (1)	54%	30%
Payment-by-results (1)	69%	7%
Non-clinical, greater focus on holistic approach, third sector provider (1)	51%	24%
Non-clinical, greater focus on holistic approach (1)	58%	22%
Greater focus on clinical approach, third sector provider (1)	49%	45%
Greater focus on clinical approach (1)	55%	25%
Based in a wider lifestyle service (1)	49%	23%





**Cornwall Health Trainer Service** - A group at Gwithian

**Table two** – average change in client intake of fruit and vegetables and fried, fatty and snack foods in 2014:

Service type	5-a-day	Fried, fatty and snack foods
Sample average	+ 67.8% (20)	-58.5% (19)
Telephone-based service (1)	+ 39%	-52%
Payment by results (1)	+ 95%	-74%
Non-clinical, greater focus on holistic approach, third sector provider (1)	+ 38%	-56%
Non-clinical, greater focus on holistic approach (1)	+ 35%	-54%
Greater focus on clinical approach, third sector provider (1)	+ 41%	-63%
Greater focus on clinical approach (1)	+ 82%	-69%
Based in a wider lifestyle service (1)	+ 52%	-56%

## 6.2 Drivers of polarisation

Due to the complexity of the different approaches being taken, it was felt that qualitative research would be better placed than quantitative analysis to explore the realities of the health trainer services in England. The adaptation of these services, our research has found, is driven by a number of factors. For some of those moving towards more clinical work, one contributing factor seems to be the increasing pressure to meet specific targets. Budgetary constraints and the need to demonstrate the ‘value for money’ of services are universal concerns for public health teams in local authorities. Our research indicates, however, that in some local authorities these pressures are resulting in a greater focus on commissioning for outputs rather than outcomes. Faced with uncertainty around funding and short term contracts, health trainer services are under growing pressure to more clearly demonstrate the effectiveness of their service.

This is illustrated by the following quote from a service manager;

*“I think probably all health trainers were asked to report on whether people achieved or part achieved or that sort of thing, but obviously commissioners want more now. You know they want to see that the interventions that you are doing have health benefits really.”*

Adopting more clinical work, for some services, offers a clearer way of demonstrating the effectiveness of their service and increases the likelihood that they will be re-commissioned. One service manager stated that;

*“[the service] might not be how we originally wanted it, but we need to be able to still offer the service and try to make it as effective as possible really so if that means we’ve got to change some things then perhaps do things that are a bit more clinical that could be the way we’re going really.”*





Speaking specifically in relation to the delivery of health checks, another service manager states that;

*“they’re pieces of work that public health and local authorities have to deliver on, they’ve got certain targets they have to meet, so if health trainers are doing that work then they’re more likely to continue being commissioned....they have to deliver those things, it’s making their jobs, their position stronger.”*

Similarly, with regard to the telephone-based service, the move to this approach was based on the need to support a greater number of clients, whilst achieving greater cost-effectiveness. Many services have expressed concern about understaffing due to lack of funding, with several services stating that their health trainers now have waiting lists. The data for all DCRS services in 2010 demonstrates that each full time equivalent health trainer was supporting on average 132 clients; in 2014, this has risen to 152 clients. For services based in rural locations or those who are only commissioned to serve part of a particular area, telephone support is already widely used to meet client demand.

The move to adopt more clinical work has garnered a mixed response. For some, it has been welcomed as a natural progression of the service. One service manager felt that it was necessary to take on more clinical work to more effectively support clients. Health trainers are working with clients from the most deprived communities, who suffer disproportionately from poor health and are, therefore, more likely to present with and require support on conditions such as diabetes and COPD. Another service manager also welcomed the new role of health trainers in delivering health checks as the service is ideally placed to reach out to the individuals most in need of such support, but who have little

contact with primary care services. The DCRS data demonstrates that the majority of clients receiving health checks are indeed from the most deprived quintiles. In 2014, for the 11 services within our sample collecting data on health checks and health MOTs, on average 51.5% of clients were from quintile one, the most deprived quintile and just 6.3% were from quintile five, the least deprived quintile.

There are concerns, however, that these developments, particularly the move to more clinical work, may result in the service losing its core purpose. These concerns are illustrated by the following quote from a health trainer;

*“I have seen this service grow from its original remit and have concerns that we will ever more move away from its core principles. We are not clinical staff and based on the original ethos of the service, we were not set up to be clinical or badged as clinical. My fear is that as we move forward this will be lost.”*

The research indicates that in some services there is a tension between pressure to meet specific targets and the desire of some service managers to take a more holistic approach. Whilst some services have successfully combined a community-based, holistic approach with the addition of more clinical work, service managers from other services have expressed concern that their work is becoming less about effecting real, long term change in the lives of their clients and more about achieving, for example, a particular number of ‘quits’ or particular amount of weight lost.

It is arguable that this move towards a more clinical approach is indeed a divergence from the ‘original’ service model. Health trainers were intended to be a ‘common-sense resource’, acting as a bridge between communities and medical services.<sup>3</sup> As health trainers increasingly



**Cornwall Health Trainer Service** – Wheal Martin walking group

deliver more clinical support, particularly on specific conditions, the service may become less about bringing people into the 'cycle of change'<sup>8</sup> and may increasingly be viewed as more medical themselves, thus losing the 'support from next door'<sup>6</sup> aspect that is so key to the service. These were concerns shared by service managers who have resisted the move to more clinical work. One service manager, for example, when discussing clinical work and smoking cessation stated that;

*“if we start using health trainers for these roles, then we are lost in the health trainer role and I guess for me it's about preserving that role and the benefits that role has.”*

Similarly, another service manager has avoided even basing health trainers within GP surgeries due to concerns that this may 'medicalise' the service.

Whilst the DCRS data overall demonstrates the success of the different types of service in supporting behaviour change. The DCRS data does, however, indicate that some contractual arrangements can impact the extent to which services reach out to the most deprived communities, a core goal of the service. For the sample as a whole, the average percentage of clients from quintile one is 44.9% and from quintile five, the average is just 6.3%. However, for the service operating under payment-by-results contract, the percentage for quintile one drops to 14.1% and for quintile five rises to 20.9%, possibly due to the comparative ease with which individuals from this group can be recruited. Similarly, of the individuals receiving health checks from the payment-by-results service, just 13% are from quintile one and 22% are from quintile five. This is a concerning finding and is likely to have a significant impact on the extent to which such services are able to tackle health inequalities.

Whilst the primary purpose of health trainers is to support positive behaviour change, there is significant 'added value' from the health trainer service that commissioning for outputs does not recognise. As a resource drawn from within local communities, health trainers have the potential to positively impact a wide range of issues, from improving mental wellbeing, reducing social isolation to developing community assets and tackling the wider determinants of health. In this sense, the health trainer service builds on a long tradition of health promotion, which recognises the importance of viewing health in a holistic way. The 1986 WHO Ottawa Charter, for example, states that 'health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being'.<sup>9</sup>

Our research has demonstrated that health trainers are able to support greater community cohesion by bringing people together through, for example, organising local groups and classes. Moreover, health trainers are able to provide support and advice on a wide range of issues impacting health such as housing and debt. A clear example of the service's ability to tackle the wider determinants of health is the work one service is doing with the Jobcentre. The manager of this service states that their health trainers are;

*“getting people to a stage where they believe in themselves sufficiently to do voluntary work and paid work...we can never take ownership of that journey, but can take ownership of part of that journey.”*



The health trainer service is a key strategic resource for commissioners. However, the increased focus on outputs indicates that commissioners may increasingly view the service as more of a tactical resource used to meet specific targets on individual issues, such as smoking or obesity levels. To tackle the burden of avoidable illness and damaging health inequalities, it is crucial that commissioners think strategically. This means identifying the fundamental health needs of a community and commissioning over the longer-term, seeking to develop sustainable resources and strengthen community capacity to deal with the major public health challenges.

Many of the benefits of the health trainer service cannot be quantified and this needs to be recognised by commissioners. Health trainers are able to offer time and support provided by no other service on a wide range of topic areas. With the ever-increasing demands on GPs and other NHS services, the importance of this 'added value' cannot be underestimated.

### 6.3 Adapting to the complex health needs of clients

Reflective practice is critical for any service to be successful, and the health trainer service is a clear example of this. Our research has found that some service adaptations are due to the 'original' service model no longer reflecting the realities of health trainer work, particularly with regard to the complexity of some clients. As a result, services have altered and/or added to their work in order to provide more effective support.

Whilst most clients enter the service for support in areas such as diet, a very high proportion of clients are also experiencing underlying mental health issues, which often do not manifest

themselves until later in the health trainer intervention. One service manager stated that;

*“approximately 80 to 90% [of clients] have some sort of mental health issue from low level to severe mental health problems.”*

Another service manager in discussing the 'original' model stated that;

*“what it doesn't acknowledge is that most clients who come to the service, their emotional wellbeing underpins quite a lot of the other behaviours, so that makes it really difficult to not engage with that aspect of their lives.”*

Several services have found it necessary, therefore, to extend the period over which they support clients. One service, for example, has extended the period from 6-8 sessions to an unlimited number of sessions over 12 months.

In addition, many services have found it necessary to provide their staff with additional mental health training. For most services, this training is on topics such as mental wellbeing, but for some services more in-depth mental health training has been required. One service manager, for example, stated that their health trainers now see clients with;

*“very intense mental health issues,”*

and as a result, now provide their health trainers with 'suicide prevention' training. Another service has introduced health trainers focused specifically on mental wellbeing in order to meet local need.





**Walsall Health Trainer Service**

**Table three** – average change in client self-efficacy and wellbeing scores in 2014:

Service type	Self-efficacy	WHO-5
Sample average	+ 10.5% (12)	+ 39.7% (16)
Telephone-based service (1)	-0.4%	+ 16.26%
Payment-by-results (1)	Not collected	Not collected
Non-clinical, greater focus on holistic approach, third sector provider (1)	+ 22.06%	+ 55.27%
Non-clinical, greater focus on holistic approach (1)	+ 13.79%	+ 21.98%
Greater focus on clinical approach, third sector provider (1)	+ 12.85%	+ 55.96%
Greater focus on clinical approach (1)	+ 16.09%	+ 53.75%
Based in a wider lifestyle service (1)	+ 7.16%	+ 24.03%

As shown in table three, health trainers are extremely effective at improving the mental wellbeing of their clients. Several services have, however, voiced concern that they are seeing an increasing number of clients with more severe mental health issues due to growing gaps in the services into which they would normally refer.

One service manager stated that;

***“mental health is one of the biggest issues with access to services, and we are seeing more and more people that aren’t able to get the support and advice they need from mental health...services.”***

This is certainly a concerning finding. Whilst there is clear evidence demonstrating the positive impact of health trainers on the mental and emotional wellbeing of clients, supporting clients with more severe mental health issues goes far beyond the boundaries of their role.

As this demonstrates, the role of health trainer is a hugely diverse one. Health trainers work on a wide range of topics, from different health issues to problems around housing or emotional wellbeing. Our research has found, however, that there is widespread dissatisfaction amongst health trainers that the breadth of their work is not being fully recognised and is not reflected in their salary or career progression opportunities. A key aim of the health trainer service was that, by recruiting individuals from within local communities, the service could provide individuals from more deprived groups with skills and employment.<sup>6</sup> This research, however, indicates that for many health trainers there are limited opportunities to advance.



# 8



**Manchester Community Health Trainers**

## Conclusion

The health trainer service was established with the ambitious goals of reaching the most deprived groups in society and reducing health inequalities. Ten years after the service was first introduced, these goals are as important as ever. With projected rises in obesity and at the same time, the ever-increasing workload of healthcare services, the availability of a service focused on prevention that is able to offer time and flexible support is invaluable.

The DCRS reports published to date provide an evidence base which strongly supports investment in the health trainer service, demonstrating the utility of the health trainer 'model' for supporting behaviour change and improving mental wellbeing. This report builds on these findings, further strengthening the evidence base, by highlighting the adaptability of the service. Operating to a range of organisational structures and contractual arrangements, services can still be relied upon to achieve positive results.

Our research has also found that the health trainer service is undergoing significant changes. Many areas are seeing their lifestyle services being wholly or partly decommissioned and are facing growing pressure to more clearly demonstrate the effectiveness of their service. At the same time, services are developing considerably, moving into new areas of work and supporting clients with a complex range of needs. A strong theme emerging from almost all the interviews was the concern over funding and the uncertainty resulting from short-term contracts. Whilst all public health teams are facing severe budgetary constraints, services must be provided with the

resources and training necessary to support their clients effectively and safely. The results from the telephone-based service are an encouraging finding, indicating that this approach may be an effective method for services to reach individuals, for example, based in rural communities.

Our research also indicates that, whilst the 'original' model remains the core of the health trainer service, services have adopted a range of approaches to support their clients, with some moving down a more clinical route. It is important, however, that commissioners do not lose sight of the 'original' model.

Some services have been successful in combining a community-focused, holistic approach with the addition of more clinical work; however, other services have voiced concerns that they are becoming more target-focused and less focused on taking a holistic approach to support behaviour change. To tackle the wider determinants of health and unhealthy lifestyle choices, as well as resulting health inequalities, the health trainer service as originally designed is a valuable strategic resource. It is vital that this is recognised in commissioning and that, as the service develops, we do not lose sight of its 'original' ethos.



**Manchester Community Health Trainers**

## Appendix

Behaviour change data for all DCRS services in 2014 –

Change measures	Average change	Sample size
30 minutes of moderate exercise per week	+ 67.45%	8765
Weekly alcohol intake	– 12.59%	3739
Consumption of fruit and vegetables per day	+ 151.51%	18310
BMI	– 3.08%	19153
Weight in kg	– 3.00	17256
WHO-5 Score	+ 80.08%	11898
Self-efficacy	+ 21.77%	6271

PHP achievement data for all DCRS service in 2014\* –

\* This compares only achieved, part achieved, not achieved and outcome unknown numbers, no other recorded outcomes.

PHP outcome	Average	Sample size
Percentage achieved	52.14%	52545
Percentage achieved and part achieved	75.10%	52545

Clients by deprivation quintile for all DCRS services in 2014 –

Deprivation quintile	Average percentage from quintile	Total number from quintile
Q1	42.3%	36625
Q2	24.0%	20775
Q3	13.5%	11674
Q4	10.1%	8739
Q5	7.0%	6035
Total	100%	86681


PHP primary issue for all DCRS services in 2014 –

PHP primary issue	Percentage of PHP with primary issue	Total number with primary issue
Alcohol	1.75%	928
Diet	63.71%	33837
Exercise	18.05%	9586
Smoking	4.29%	2279
Weight management	2.49%	1320
Local issue	9.71%	5157
Sample size		53107



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The background of the page features a repeating pattern of light teal icons on a white background. These icons represent various aspects of health and wellness, including fruits like apples and strawberries, vegetables like carrots and broccoli, sports equipment like tennis rackets, bicycles, a football, a basketball, a tennis ball, a badminton racket, a dumbbell, a water bottle, a measuring tape, a heart with a pulse line, a scale, a stroller, and a leaf. The top of the page has a solid teal header.

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