RSPH
ROYAL SOCIETY FOR PUBLIC HEALTH
VISION, VOICE AND PRACTICE

Health Trainers Half Year Review 1st April – 30th September 2013

A critical assessment of Health Trainer activity, with particular reference to the most deprived social groupings, so as to assess the effectiveness and efficiency of the service in positively contributing to reducing health inequalities.

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DCRS Data Collection & Reporting Service

A Report Utilising Data Collection & Reporting Service Data
www.experiencecounts.org.uk

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1 SUMMARY OF KEY FINDINGS

This half year review was written by the Royal Society for Public Health (RSPH). The aim of this review has been to critically assess Health Trainer Service (HTS) activity, with particular reference to the most deprived social grouping (quintile 1), so as to assess the effectiveness and efficiency of the Health Trainer Service to positively contribute to reducing health inequalities.

1.1 KEY FINDINGS

This review has identified the following as key findings in respect to Health Trainer Services.

1. The data supports the notion that the methodology and deployment of HT is well suited to the challenge of improving the health behaviours of those in greatest need of assistance.

2. These services are an important strategic and tactical asset in reducing health inequalities.

3. Besides immediate, tangible gains, this workforce has an almost unique ability to leave a legacy with their clients in terms of improved health awareness and understanding which has longer term benefits.

4. Recruitment continues from Quintile 1 indicating that the service is holding true to its original concepts.

5. Results demonstrate an excellent capacity to engage with clients in the lowest socio-economic Quintile 1. Many in this quintile being the most difficult to engage with in respect of health issues.

6. Services have a strong track record in demonstrating an ability to positively improve clients' health behaviour and are actively engaging with some of the most important modifiable determinants' of health such as: food, diet, eating, alcohol, mental health and resilience.

7. The role of the Data Collection and Reporting Service (DCRS) in collecting and making Public Health data available is a valuable asset that should be more fully exploited.

2 INTRODUCTION

2.1 ABOUT THIS REVIEW

This half year review of Health Trainer Services (HTS) is being conducted under the auspices of the RSPH[1]. This report will differ in many ways in content and format from previous editions which tended to focus primarily on quantitative reporting. This departure in format and content is deliberate.

2.2 REVIEW RATIONALE

The value of this approach is to help commissioners and other interested parties evaluate and assess Health Trainers not simply by reference to HT recorded activity but to locate Health Trainer activity as part of the spectrum of health improvement. We believe this approach will help explore and explain the particular attributes of the HTS and subsequently give a clear understanding of the outcomes to be expected from use of HTS to best allow focused and rational commissioning and deployment.

2.3 THE ROLE OF THE DCRS

This review's ability to reflect on the performance of HTS is only possible because of the wealth of data available through the DCRS. Without the DCRS functioning as central data-warehouse for the bulk of HTS activity and of the HTS committing to record this data, it would not be possible to report on impact and effectiveness with the degree of confidence currently possible.

It has been a criticism of Public Health in the UK in general that although data on targets and populations measures is well established, e.g. smoking prevalence, teenage pregnancy and obesity rates to name a few are routinely gathered, measures of attainment of health improvement process activity are not so well documented. As a result robust assessment of health improvement impact and effectiveness has been limited. The continued operation of the DCRS does mean that in this important aspect of health improvement, the activity of HTSs, is available for scrutiny.

2.4 THE COMMISSIONING CHALLENGE

It is also important to flag up early how important it is to be successful in health improvement. The shift of disease from acute to chronic conditions and a rapidly ageing society means that the cost of providing health and social care services is escalating. It is argued by Wanless[2] that unless we are more effective in preventing ill health or at least delaying the onset of chronic conditions, the financial cost of the NHS, will become unaffordable within the next generation. The data reported here will be a good indication as to whether the HTS has an important strategic and tactical role in ensuring those most in need have a better chance of good health and controlling health costs.

This review aims to contain clear narrative as well as qualitative data. This format will enable reflection on the theory and practice of Health Trainer (HT) operation. It is important commissioners know what they are purchasing in terms of the theory of process, of application

[1] RSPH – Royal Society for Public Health - https://www.rsph.org.uk/
[2] Wanless D. (2002, Securing our Future Health – Taking a Long Term View) http://si.easp.es/derechosciudadania/wp-content/uploads/2009/10/4.informe-wanless.pdf

and of outcomes. Commissioning, especially for health improvement, is about much more than simple target attainment. Effective Commissioning for Health Improvement is about generating an end product certainly, but it is also about generating a legacy that empowers, endures, enables and facilities individuals, families and communities to use new skills in solving everyday health problems. It has been demonstrated that this building of social and personal capital does lessen the total burden on the health and social care[3] sectors. This process is what is known as positively impacting on the modifiable determinants of health. Quoting Rahman & Wills[4], the premise of the health trainer programme is that support from "next door" rather than "advice on high" is more likely to be effective.

[3] Shircore R, Shaw S. Commissioning for values is as important as commissioning for outcomes. Perspectives in Public Health. 2013, 133(1):26 – 27

[4] Rahman E, Wills J. The career journeys of health trainers in two health trainer services in England. Perspectives in Public Health. 2013, 133(4):207 – 212

3 HEALTH TRAINERS – THEIR METHODOLOGICAL BASIS AND WHY THEY SHOULD BE EFFECTIVE

3.1 THEIR METHODOLOGICAL BASIS

The Health Trainer Programme is now eight years old[5] with a principal aim of reducing health inequalities. It is therefore worth reminding ourselves of the methodological basis to Health Trainer activity so as to appreciate how they should be impacting upon this challenging issue.

The bulk of traditional health care delivery is by staff operating to a medical (deficit) model. Health workers respond to a patient who presents health/medical problems or symptoms and they use their professional knowledge to make a diagnosis from the symptoms and to recommend specific prescriptions/actions to resolve the diagnosis. This model of working fits the challenge of responding to physical conditions which require external intervention. The role of the recipient is to be compliant.

Health Improvement in general and Behaviour Change in particular, does not operate to the above model. Health Improvement through Behaviour Change requires the individual to be an active participant in the process if a positive outcome is to be attained. Therefore the methodology of HT operation is radically different from the actions of traditional health service staff.

3.2 THE HEALTH TRAINER MODEL

Health Trainers operate to a psycho social model of practice[6]. Working within a health improvement context they are proactive in seeking not health problems per se but with people who may have actual or nascent health issues and assisting them to improve their health behaviours and habits by helping them theme redefine the issue and to put change into actual practice.

HTs are trained in specific psychological techniques of engagement and support. Important aspects being Social Learning Theory, Bandura[7] and the Process of Change (Transtheoretical) Model Prochaska et al[8]. This training coupled with the organisational emphasis of recruitment of staff from the areas of deprivation they will be working in is an important aspect of their deployment[9].

[5] Stanwell-Smith R. Ripple Effects and making a lifestyle change forever (Editorial). Perspectives in Public Health. 2013, 133(4):182
[6] DoH, Improving Health: Changing Behaviour (NHS Health Trainer Handbook) 2004, pp63-70
[7] Bandura A, (1997) Self –efficacy: The exercise of control. New York: Freeman
[8] Prochaska J.O. et al, (1994) Changing for good. New York: Avon Books
[9] Durantini, M.R. e al, (2006) Conceptualising the influence of social agents of behaviour change: A meta-analysis of the effectiveness of HIV-prevention interventionists for different groups. Psychological Bulletin 132(2). 212-248

3.3 THE ROLE OF A HEALTH TRAINER

For reference purposes only, the definition of the Health Trainer role appointed to an HTS is stated below;

> *It involves training people in the skills to actively set their own behavioural goals and manage their own behaviour and more broadly events and circumstances…….*
>
> *In targeting those people who would like to change behaviours relevant to their health…….the Health Trainer has the potential to reduce health inequalities.*
>
> Improving Health: Changing Behaviour[10] (2009), The Department of Health (DoH)

Excerpt 1 – Definition of the HT role taken from Improving Health, Changing Behaviour.

It should also be clearly stated that some HTS employ personnel in equivalent and complementary roles (such as Health Trainer Champions, Health Ambassadors, Health Check Advisors etc) some or all of whom contribute to the overall HTS activity that is covered herein.

3.4 HOW HEALTH TRAINERS OPERATE

Their recruitment and deployment is a clear example of trying to tackle health inequalities by the development of a new community-based workforce, with an explicit aim of building local capacity and pathways to volunteering and employment[11.]

Health Trainers are trained to engage with local people and support them in engaging with a specific Personal Health Plan (PHP) which they tailor make for the client. A key operational element of the HTS is seeking to engage a client on a PHP and supporting that client to a successful outcome. However there are other legitimate exit options. Following an initial assessment the client may just receive a Health Check or Mini-MOT. Other clients may just want information or decide not to engage or be sign-posted to other sources of dedicated specialist help.

Of those that start a PHP, not all complete for a variety of reasons. This should not be seen as wholly negative. The Process of Change Model recognises that not all behaviour change will be successful at the first attempt, however even to start to consider change should be seen in a positive light.

[10] Improving Health: Changing Behaviour – NHS Health Trainer Handbook, (DoH), 2008
[11] Visram S, South J. Building and evidence base for health trainers. Perspectives in Public Health. 2013, 133(4):193 – 194

4.1 ASSESSMENT CRITERIA

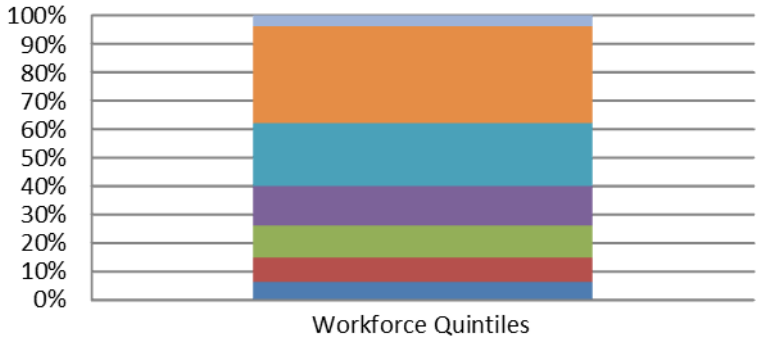
As well as reviewing the basic numeric data of Health Trainer Service (HTS) activity, it is important that it is linked into the broader school of public health methodology. This review shall reflect on to two key public health perspectives: the first being Maslow[12] and the related concept of "self-efficacy". The second is the Ottawa Charter[13] these two elements have been chosen as they reflect a consensus of the particular challenge of those living in difficult financial and social circumstances. In this respect Maslow's model reflecting the particular needs of people to be addressed before they can take positive action in pursuit of their own health.

4.1.1 Core Data (1st April - 30th Sept 2013)[14]

For those new to the work of the DCRS attention is drawn to the substantial body of performance data that can be accessed by its clients. The author of this review was both surprised and impressed by the quality and depth of the reporting forms and ease of access to such a substantial data base of activity. In particular the ability to cross tabulate a range of variables related to both topic and client domains. For this review particular focus has been on Quintile 1 – Most Deprived, as this group experiences the highest levels of morbidity and mortality and is a population identified for particular support (see Appendix A – The Public Health Outcomes framework).

4.2 FOCUS ON HEALTH TRAINERS:

4.2.1 Health Trainer Origins[15] by Deprivation Quintiles



Not recognised	37
Q1 - Most Deprived	334
Q2	217
Q3	135
Q4	111
Q5 - Least Deprived	84
Unknown	62

Figure 2 - Workforce deprivation quintile status.

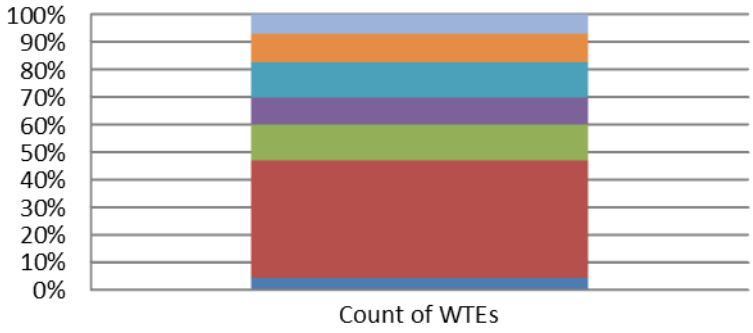
[12] John M. Last (Ed.) 2012, A Dictionary of Public Health , OUP
[13] Ottawa Charter: http://www.who.int/healthpromotion/conferences/previous/ottawa/en/ Key policy planks: Build Public Policy, Creative Supportive Environments, Strengthen Community Action, Develop Personal Skills, Reorientate Health Services,
[14] To simplify reporting of data the figures in the narrative are rounded up or down in accordance with accepted practice.
[15] Based upon currently employed HTs whose services utilise the DCRS.

As was stated earlier a key methodological basis of the HTS is based on them being drawn from the populations they serve. This table clearly shows that this essential methodological goal is being achieved in good measure. From a record of 980 Trainers:

- 34% are drawn from the most deprived quintile of the population.
- A further 22% being drawn from the second most deprived quintile.

These two figures indicate that those administering the service are holding true to the original operational and process requirements. This is to be welcomed as it is an essential element of the total process.

4.2.2 Health Trainers Working Time Equivalent (WTE)[16]



Count of WTEs	
0.1-0.2	70
0.3-0.4	101
0.5	125
0.6-0.7	96
0.8-0.9	128
1.0	417
WTE unknown	43

Figure 3 - Workforce working time equivalent breakdown.

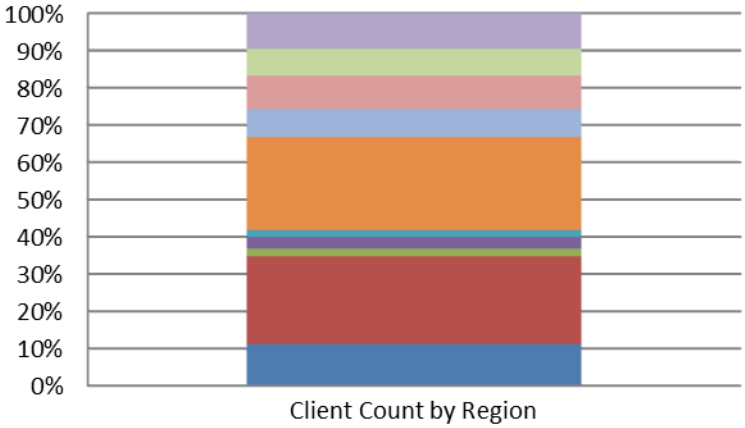
Whilst Figure 2 indicated that Health Trainers were being successfully recruited from the most deprived areas. Figure 3 shows the breakdown by WTE of the 980 recorded:

- 43% are 1.0 WTE
- 13% are 0.5 WTE
- The remaining 44% reflects a range of employment options.

Part of the reason for using local people is to boost local skills and the local economy to build local capacity. This table indicates the flexible nature of the employment being offered which helps maximise the numbers of Health Trainers benefitting from the employment opportunity as well as providing employment that caters for challenging personal and local circumstances.

[16] Based upon currently employed HTs whose services utilise the DCRS.

4.3.1 Total Health Trainer Clients Since Service Inception by Region[17]



Channel Islands	35
East Midlands	50313
East of England	37733
London	47856
North East	39268
North West	131329
South Central	10089
South East Coast	16343
South West	10604
West Midlands	124091
Yorkshire & the Humber	59148

Figure 4 - DCRS recorded clients since service inception (total 520809)

It is well documented that social inequalities are not uniformly spread across England. The above table indicates that those areas with the highest counts of deprivation have been effective in deploying the HTS. From a total record count of 500,000+
Highest percentage is:

1. North West ranks first with 25%
2. West Midland ranks second on 24%
3. Yorkshire & the Humber with 11%

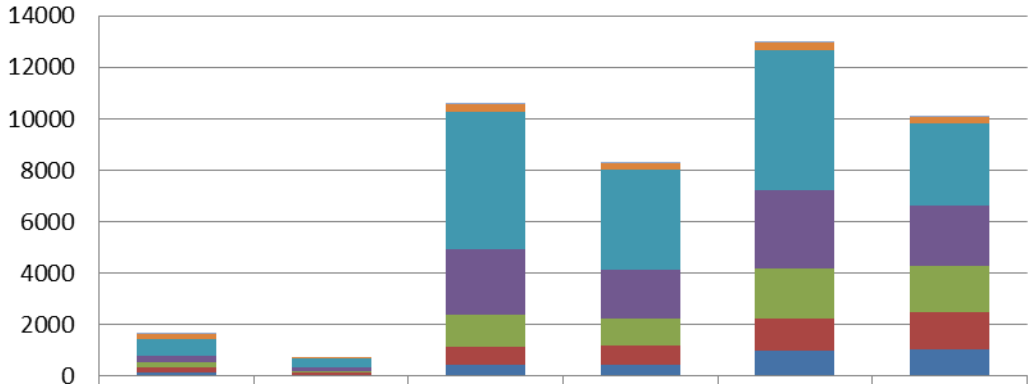
The surprising figure is London with 9%. The lower level of activity recorded in London maybe caused by a range of issues.

- HTS commissioning in London is of a lower level than anticipated.
- HTS may operate in London but branded differently and therefore not using DCRS for data recording.
- HTS may operate in London but may not be signed up to DCRS reporting and therefore the activity data would not be recorded.

Whatever the reason, the loss of possible data reflecting the London aspect is unfortunate. It would be helpful to know whether London was typical or not, in respect to HTS recruitment, addressed client issues and change outcomes.

[17] Based upon currently employed HTs whose services utilise the DCRS.

4.3.2 Age of Clients at Time of Engagement

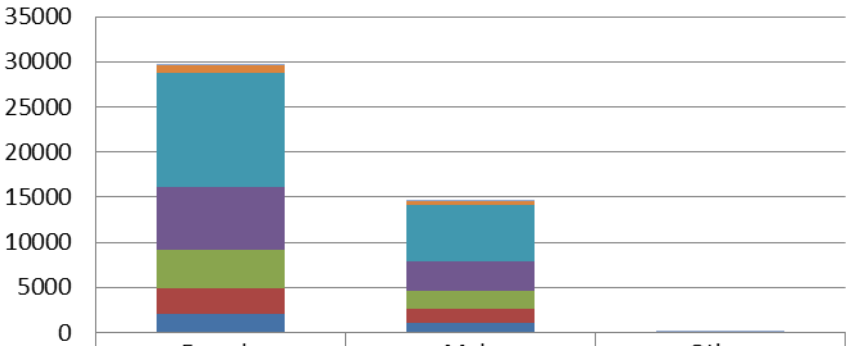


	Declined	Under 18	18 - 34	35 - 44	45 - 59	60 and over
No fixed abode	13		53	26	22	11
Not recognised	190	15	301	231	287	254
Q1 - Most deprived	650	380	5377	3898	5463	3214
Q2	274	127	2527	1883	3032	2335
Q3	200	89	1229	1046	1963	1816
Q4	152	51	716	725	1245	1450
Q5 - Least deprived	168	68	434	467	969	1020

Figure 5 - Breakdown of client ages and deprivation

Figure 5 above indicates *the spread of ages* with whom HTs engage. In keeping with our general focus of the most deprived quintiles it can be seen that for quintile 1 there are two peaks, the 18-34 age range at 5377 (28%) and the 45-59 age group – 5463 (29%). From a Health Improvement perspective these are encouraging returns, especially the 18-34 age groups where the potential for significant improvement in health behaviour patterns can have an enduring effect over the person's life time.

4.3.3 Gender and Quintile Deprivation



	Female	Male	Other
No fixed abode	57	67	1
Not recognised	868	390	7
Q1 - Most deprived	12619	6331	39
Q2	6899	3266	17
Q3	4309	2024	11
Q4	2861	1475	3
Q5 - Least deprived	2031	1090	5

Figure 6 - Breakdown of client gender and deprivation

Figure 6 records the gender breakdown by quintile. In quintile 1 approximately a third of the clients are male and two thirds female, this proportion carrying on into quintile 2. From an equity perspective, there is an argument for saying more men need to be recruited. However in respect to family and community health and well-being the proportion of females engaging with HTS may be an advantage. Women as partners and mothers in families tend to be the dominant force in controlling food purchase, family meals and other health related activities. Thus supporting change with this group is likely to positively impact on other household members.

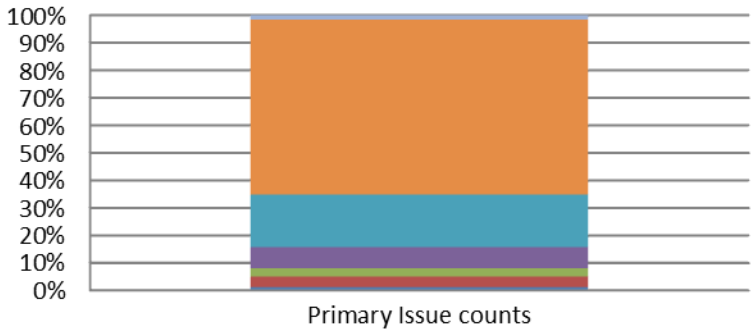
4.4 HEALTH TRAINER CLIENT INTERVENTIONS

4.4.1 Client Options for Change

Prior to the choice of change a benchmark health and wellbeing check will have been recorded. Based upon both those measurements and discussions[18] with the client a choice of targeted health interventions is often then offered. The principal HTS options are: alcohol, diet, exercise, smoking and local issue[19]. From this list diet is clearly the issue that most clients want to change – for the better. Once the option is selected a personal health plan is agreed upon and staggered mini-goals set and measured against.

Critically the DCRS provides an array of standardised benchmarking measures that local services simply enable and disable to tailor their data recording according to operational and commissioner reporting needs. It is worth reporting on a sample of these domains as they give insight into the needs and motivations of clients and thereafter an ability to measure the success of the HTS intervention.

4.4.2 Clients Primary Choice of Health Issue[20]



Alcohol	470
Diet	18174
Exercise	5488
Local issues	2196
Not recorded	861
Smoking	1100
Weight Management	344

Figure 7 - Breakdown of chosen primary issue.

[18] Multiple issues can often surface but HTS methodology recommends the identification and address of a single 'primary issue'.
[19] Local issue traditionally referred to areas of wellbeing need such as stress, isolation, sleep and anxiety. Localisation policy has meant this area has expanded in scope more recently however (e.g. pain management, financial/ housing issues, dementia).
[20] DCRS Note - Weight Management was newly added in 2013, only a handful of services have enabled this. Most services use Diet and potentially select exercise as a secondary issue (there is a primary issue multi-select option).

The data in Figure 7 is important in a number of respects: from total records of 28,633

- Diet (63%) is the most frequent area individuals wish to change and improve upon.
- Exercise on (19%) is next most popular.
- Local Issue (8%) was the third popular. Local issue refers to a mix of issues often surrounding emotional or psychological concerns.

Also of note is that whilst the HT is trained to isolate a single 'primary issue' to address, clear appreciation is given of the complex nature of client needs which can be represented through the recording of secondary (often related) issues.

4.5 CLIENT INTERVENTION CHANGE RESULTS

4.5.1 Diet Related Change Results

4.5.1.1 Daily Portion Intake Changes

As can be seen from Figure 8 below within quintile 1 there is a reported improvement of 57% in the intake of fruit and vegetables – a significant result. It should also be noted these change results are regardless of primary issue and include all clients regardless of ultimate PHP outcome.

Avg. portions / day			
Deprivation Quintiles	Pre-PHP	Post-PHP	% Improvement
Q1 - Most deprived	3.03	4.75	56.77%
Q2	2.99	4.68	56.52%
Q3	2.89	4.79	65.74%
Q4	3.22	4.95	53.73%
Q5 - Least deprived	3.26	4.95	51.84%

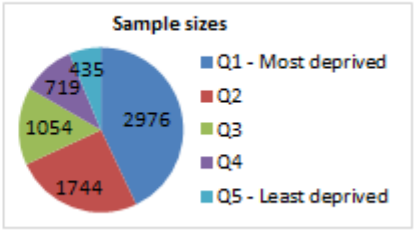


Figure 8 - Improvement in fruit & vegetable consumption (regardless of final client outcome) by deprivation quintile

Looking at another option of clients (Figure 9 below), reducing the amount of Fried Food in diet there are equally impressive figures of a 53% drop in fried, fatty and snack foods consumed for quintile 1 and again it should be noted these results are regardless of primary issue and PHP outcome

Avg. portions / day			
Deprivation Quintiles	Pre-PHP	Post-PHP	% Improvement
Q1 - Most deprived	5.62	2.64	-53.02%
Q2	4.47	2.1	-53.02%
Q3	4.46	1.81	-59.42%
Q4	4.13	2.02	-51.09%
Q5 - Least deprived	3.87	1.69	-56.33%

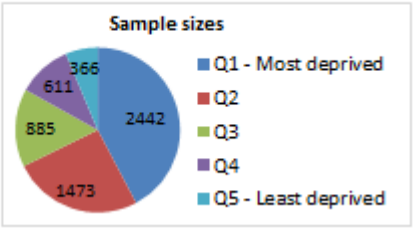


Figure 9 – Average reduction in fried, fatty & snack consumption (regardless of final client outcome) by deprivation quintile

4.5.1.2 Body Mass Index (BMI) Change Results

Figure 10 overleaf demonstrates BMI reduction of well over 4% for quintile 1 clients wanting to lose weight (NB: a reduction of over 4+% was actually also found for the wider quintile 1 population regardless of weight change aim)! This figure is significant and an important one to take note of if England's Public Health challenge of child and adult obesity is to be slowed and ultimately reversed. Obesity related to early onset of diabetes, asthma, heart disease and a range of orthopaedic conditions is too important to be ignored.

Averaged BMIs			
Deprivation Quintiles	Pre-PHP	Post-PHP	% Improvement
No fixed abode	42.09	38.8	-7.82%
Q1 - Most deprived	35.7	34.06	-4.59%
Q2	35.32	33.79	-4.33%
Q3	35.4	33.79	-4.55%
Q4	34.95	33.61	-3.83%
Q5 - Least deprived	34.46	33	-4.24%

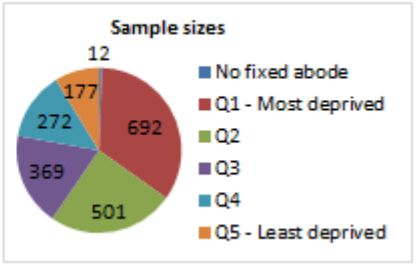


Figure 10 – Average BMI change for those clients flagged as wanting to lose weight.

Returning to Figure 7 - Breakdown of chosen primary issue. exercise (19%) is the second most popular choice. This is not surprising in that diet and exercise are linked in the public's mind.

Within a public health context the ranking of smoking at 4% and alcohol at 2% may appear a poor result. To view the data in this way is to confuse means and ends. The role of the HTS is to assist people to take control of their lives. In this context they also signposted 4466 clients to other specialist services during the period and also referred a further 17881 clients into additional specialist services during the course of their interventional work, significant numbers.

The consequence of HTS intervention is not just that 64% of people discussed their diet, but that the HT methodology of building a positive relationship with a client. This leaves a legacy of capacity of independent action with the client which can then be used for a variety of health and personal issues in the future. Discussing diet is not the end of the process but an indication of where the individual wishes to start.

It might be speculated that food related issues are more frequently selected as it is now easier to admit to wanting to change. Food and meals are now impacting on public perception. Reports on diet, health and life-style are now common. Some reports regarding food are negative such as the references to obesity. Other influences are positive – such as the popularity of TV cooking and cookery classes. These developments should not be under estimated in making it easier to admit to wanting to change this aspect of life. It could be argued that such programme popularity is acting in a social marketing capacity.

4.5.2 Wellbeing Related Change Results

4.5.2.1 Self-efficacy Scores [21]

Listed below are pre and post results for self-efficacy measured as averaged percentage scores.

Averaged % score			
Deprivation Quintiles	Pre-PHP	Post-PHP	% Improvement
Q1 - Most deprived	59.54	67.14	12.76%
Q2	59.51	69.72	17.16%
Q3	60.83	69.95	14.99%
Q4	67.08	71.84	7.10%
Q5 - Least deprived	64.78	70.48	8.80%

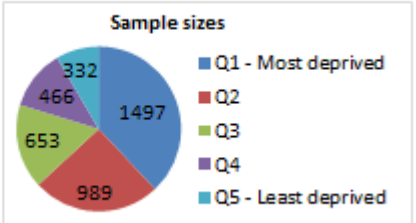


Figure 11 – Improvements in self-efficacy score by deprivation quintile.

Self-efficacy is a key psychological attribute comprising of:

[21] Self-efficacy "refers to individuals' judgements about whether they have the capacity to perform a particular activity". See Self efficacy guidance for Health Trainer Services, Smith, J. et al UCL (24.3.2010)

- Thinking – the level of motivation to accomplish a task goal and to overcome setbacks.
- Feeling – the level of self-esteem. Low levels of self-efficacy is often associated with depression.
- Acting – the level of effort individuals are willing to commit to goal attainment.

The data records an interesting mix:

- Quintile 1 the most deprived moved from 60% to 67% a 13% improvement.
- Quintiles 2 and 3 show the strongest gains.

4.5.2.2 Self Confidence

Averaged % score

Deprivation Quintiles	Pre-PHP	Post-PHP	% Improvement
Q1 - Most deprived	51.56	64.22	24.55%
Q2	47.51	66.86	40.73%
Q3	58.75	69.17	17.74%
Q4	56.74	73.48	29.50%
Q5 - Least deprived	59.8	75.33	25.97%

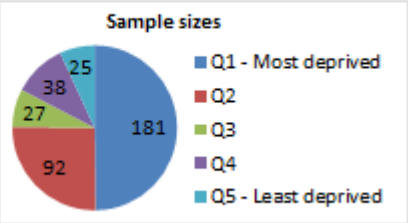


Figure 12 – Improvements in self-confidence score by deprivation quintile.

Self-confidence as a reporting measure is relatively new, starting in early 2013. Therefore the total sample size is relatively modest. This measure will become more robust as more returns are submitted. However it does require reporting agencies to make use of this option in reporting.

Self-confidence along with Self Efficacy is an important quality in being able to manage life and its challenges. The above table reports on shifts in self-reported confidence scores:

- The greatest increase is recorded in quintile 2 – up a significant 41%.
- Quintile 1 up a respectable 25%.

Some caution needs to be exercised over these figures in that the total records for Self Confidence are only 363 from a possible 11978. However, the records for Self Efficacy are a respectable 3937 out of 11978. In assessing effectiveness of service provision these two returns reflect important process measures of effectiveness.

What remains significant is that Self Efficacy along with Self-Confidence are crucial psychological requirements for the attainment of short term goals and for longer term legacy benefit.

4.5.2.3 General Health Measure

A valuable measure of a person's overall health state is their reporting of well-being.

Averaged % score

Deprivation Quintiles	Pre-PHP	Post-PHP	% Improvement
Q1 - Most deprived	46.9	56.3	20.04%
Q2	44.94	58.74	30.71%
Q3	44.63	60.98	36.63%
Q4	46.28	60.13	29.93%
Q5 - Least deprived	48.03	62.12	29.34%

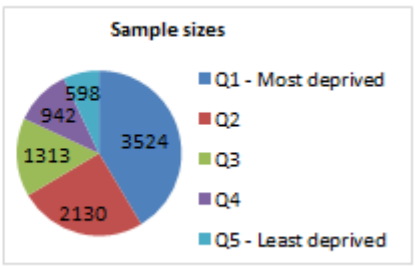


Figure 13 – Client reported general health by deprivation quintile

Whilst the impact of the Hawthorne effect[22] must be taken into consideration the picture building from the data table above suggests a significant capacity of HTS to positively impact on personal health states. The above table reports on General Health state. For those with good heath this measure is usually positive and taken for granted. For deprived communities this is not so. Taking our usual Quintile 1 the report is a pre PHP score of 47% with a post PHP score of 56%, a 20% improvement.

4.5.3 A Specific Change Result: Alcohol[23]

Listed below are pre and post results for Alcohol measured in units per week.

Averaged units per week			
Deprivation Quintiles	Pre-PHP	Post-PHP	% Improvement
No fixed abode	33.3	20.8	-37.54%
Q1 - Most deprived	30.68	17.45	-43.12%
Q2	25.64	13.92	-45.71%
Q3	24.84	12.38	-50.16%
Q4	21.92	13.04	-40.51%
Q5 - Least deprived	22.83	14.03	-38.55%

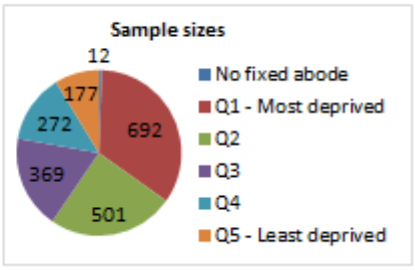


Figure 14 – Reductions in alcohol consumption by deprivation quintile.

The alcohol intake guidelines are stated in the footnote. For men this equates to 28 units per week and 21 units for women but during the week there needs to be days when no alcohol is ingested.

The Quintile 1 'pre-PHP' consumption is reported as 31 units per week which is above 28 unit limit recommendation. The after score being 17 units, equates to a 43% consumption drop.

Similarly impressive figures are reported for the other Quintiles. An interesting observation is the impact on those described as having "No Fixed Abode" where the rates of reduction seem equally impressive. Advice from DCRS regarding this indicator is that the sample size for this and other "No Fixed Abode" categories are too small to have confidence in reports. However as those who are homeless are a major deprived health group – further research on this group and the role of the HT might well prove of significant value.

4.5.4 Other DCRS Measures Available

As stated in section 2.1, the intention of this review is not to be highly quantitative. However regardless of a clinical or more non-clinical data interest, commissioners will be encouraged that the DCRS contains a range of change measures which, in support of the Governments Localisation Act 2011[24], individual service leads can select from and activate immediately (or subsequently deactivate again!) upon demand.

The current set of measures[25] range across all the key Public Health areas. Here are just some examples; Diet (various food group intake measure, BMI, Hip-Waist), Exercise (various session measures, GPPAQ), Smoking (cigarettes per day/week, CO^2 reading), Alcohol (units per week,

[22] A term referring to the tendency of some people to work harder and perform better when they are participants in an experiment. Individuals may change their behavior due to the attention they are receiving from researchers rather than because of any manipulation of independent variables.
http://psychology.about.com/od/hindex/g/def_hawthorn.htm

[23] Recommended Alcohol Intake (DoH) recommends: Men should not regularly drink more than 3-4 units of alcohol a day. Women should not regularly drink more than 2-3 units a day. If you've had a heavy drinking session, avoid alcohol for 48 hours. http://www.nhs.uk/Livewell/alcohol/Pages/alcohol-units.aspx#comments

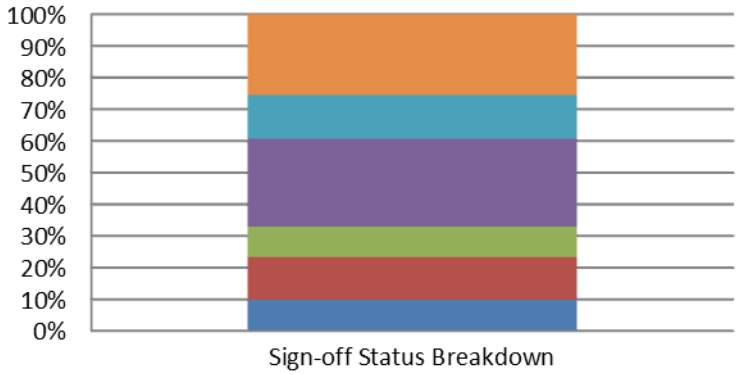
[24] UK Localisation Act & Policy see https://www.gov.uk/government/publications/localism-act-2011-overview.

[25] RSPH are informed that additional measures are gradually being loaded and made available for use.

Audit C), Wellbeing (WHO5, Self-confidence, WEMWBS) as well as more clinical areas (CVD, HBA1c, Blood Pressure/ Pulse, Cholesterol, Body Fat %, Heart rate).

4.6 CLIENT INTERVENTION OUTCOMES

4.6.1 Breakdown of Client Assessment Type Outcomes



Signed-off (DNA/No contact)	12280
Signed-off (Early)	6640
Signed-off (Full PHP)	13356
Signed-off (Information only)	4658
Signed-off (Premature PHP)	6509
Signed-off (Signposted)	4730

Figure 15 - Breakdown of sign-off statuses

As stated earlier the value of HTS is not only in its immediate impact but also because of the on-going support HT give to clients in helping them make the changes.

The above table records the pathways of over 48000 clients and their engagement with PHPs. Encouragingly;

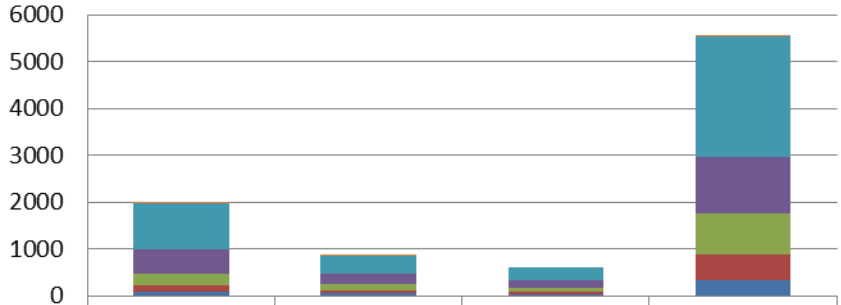
- 13356 (28% of total) were signed off after completing the full plan
- 4658 (10% of total) were signed off after being given information only. This is still seen as a good outcome as it means full PHP engagement was not required/ appropriate.
- 4730 (10% of total) were signed off after being signposted to other services. This should also be viewed as a positive outcome.
- Of the 6640 early sign-offs, 3082 (6% of total) were found to be after Mini-Health MOTs or Health Checks which again are formal outcomes designed to benefit clients.

The more challenging aspect:

- Whilst upon evaluation; 5199 (31%) PHP mini-goals had been achieved and 2442 (15%) part achieved prior to the unplanned termination (meaning some significant benefit was still attained), nevertheless 12,280 (25%) ultimately failed to fully attend (DNA'd) or were lost at some point upon follow-up contact.

Whilst the figure of 25% (DNA'd) is fairly high, in the context that the HTS strategically target clients from the most deprived areas this is perhaps not surprising. Individuals and families are more likely to lack domestic infrastructure and organisational skills. Alternatively they may simply not yet be fully ready, or indeed able, to undertake a fuller behaviour change for a variety of reasons. Nevertheless this is a critical area all Health Trainer Services must continually challenge and act upon in order to maximise the beneficial impact of their services.

4.6.2 Maintaining Change by Deprivation Status



	Client not contactable	No, not maintained	Not applicable	Yes, maintained
No fixed abode	9	1	0	17
Q1 - Most deprived	998	369	284	2558
Q2	518	234	162	1206
Q3	254	124	81	899
Q4	131	64	50	524
Q5 - Least deprived	83	58	27	343

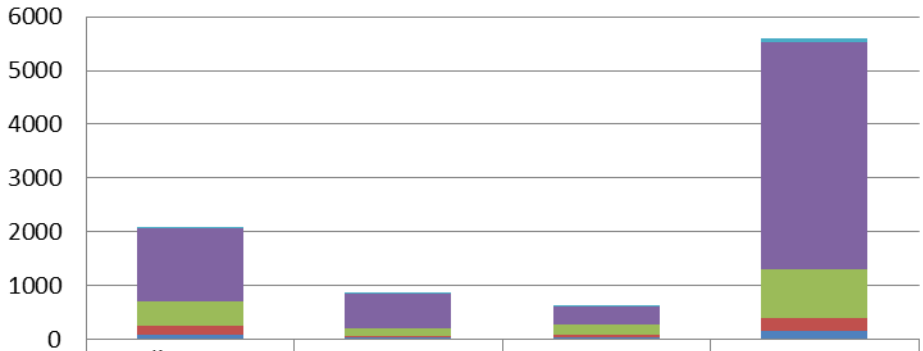
Figure 16 - Change maintained results by deprivation quintile.

If the purpose of the service is to encourage, facilitate and support positive behaviour change the above table is of particular interest. Keeping to our theme of focusing on the most deprived communities the data shows that:

- In the most deprived quintile 2558 clients had maintained their behaviour change out of 4209 surveyed. This equates to a success rate of at least 61%, rising to 87% if we only consider those against the directly comparable 369 not maintained results.
- In the second most deprived quartile the success rate is 57%, rising to 84%.

It is also worth reminding ourselves that the methodology used by the HTS is one which accepts clients will not always be successful at the first, second or even third attempts at change. The methodology is predicated that the process of trying to change is itself a beneficial and positive experience, the experience itself leading to greater personal insight and resourcefulness.

4.6.3 Maintaining Change by Primary Issue



	Client not contactable	No, not maintained	Not applicable	Yes, maintained
Alcohol	16	10	7	69
Diet	1345	635	333	4223
Exercise	459	143	187	906
Local issues	169	22	63	254
Smoking	85	43	32	144

Figure 17 - Change maintained results by primary issue.

Figure 17 shows the numbers of all clients and their maintenance of change by primary issue. The table is important as it confirms and supports data reported elsewhere.

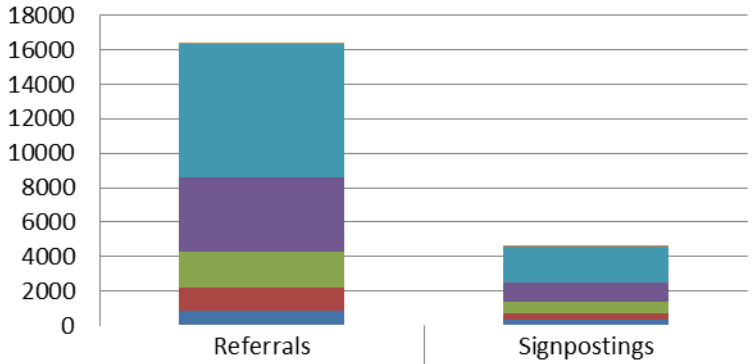
- For diet 65% of those surveyed maintained change in line with their PHP, rising higher (87%) if we only consider the 4223 maintained versus the 635 not maintained results.
- For exercise 53%, rising to 86% for maintained versus not maintained.
- For local issue 50%, rising to 92% for maintained versus not maintained.

These figures tally with earlier reports, a more challenging aspect being the non-contact at time of survey element standing at 22%. Of note is that there is no information about the number of contact attempts (i.e. this could be being recorded after only a single contact attempt), but as stated earlier we also know those in the more deprived quintiles often experience greater personal and family restrictions and opportunities to act in their own best interests. Thus the non-contact issue is more likely occurrence in those communities.

4.7 ONWARD REFERRALS

4.7.1 Supportive Referrals and Signposting by Deprivation Quintile

Please note our definition of a supportive referral is where the HT will still see the client as part of a Personal Health Plan, but it is also utilising a secondary specialist support service to enhance outcome or support an out of service scope need, whereas a signpost is where a client is guided / supported into another specialist service.



	Referrals	Signpostings
No fixed abode	45	30
Q1 - Most deprived	7767	2081
Q2	4328	1116
Q3	2070	694
Q4	1302	396
Q5- Least deprived	872	306

Figure 18 - Supportive Referrals & Signposting totals

The HTS is not a service that functions in isolation. An important aspect of the HT role is to refer on clients where appropriate. It is well established that the most deprived are often the least likely to seek advice or treatment. Therefore the ability of HTs to refer on is very important. Focusing on Quartile 1, when all PHP referral opportunities were reviewed it was found that 22% were referred on. Looking at Quartile 2 the figure was 23%.

These returns indicate that the HTS is functioning appropriately by pro-actively assisting the hard to reach to access help and assistance from other sources e.g. smoking cessation. We do not know the specifics for which they were referred unfortunately without running more detailed DCRS reports beyond the scope of this review. However the importance of early

diagnostic and treatment for many conditions cannot be overstated, not only in respect to treatment outcomes but also in respect of long term treatment costs.

Taking a basket of measures related to diet, and psychological measures these figures are wholly congruent and give added confidence that Health Trainer Services do make a significant and enduring positive impact on the people with whom they work.

This reviews' aim has been to critically assess Health Trainer activity in its context, with particular reference to the most deprived social groupings in order to assess HTS effectiveness and efficiency in positively contributing to reducing health inequalities. This focus on Quintile 1 was therefore deliberate as it reflects a major requirement of public health commissioning - that of reducing health inequalities[26] (see Appendix 1). Reviewing the data available it is heartening to see the impact of the HTS on this population group.

5.1 DEVELOPING THE LOCAL ECONOMY

A major determinant of health is the economic situation of a given population. Increased income is reflected in a higher health state. A poor level of income is associated with higher levels of mortality and morbidity. Countering poverty is a key principle of the Ottawa Charter, as is the development of sustainable and economically active communities. In this respect there are nearly 1000 active HTs which we have reported on[27], developing skills both in themselves and their clients. Of the HTs 56% are recruited from the most deprived Quintile 1 of the population. This suggests that we can and should continue to look towards people in deprived areas to be part of the "public health solution", rather than just to see them as people with needs. With the appropriate training and support, people can change and become positive health assets within their community.

5.2 HEALTH TRAINERS ACROSS ENGLAND

The data suggests an uneven spread of Health Trainer usage across England. Services are spread with some uniformity across England with the exception of London. The North West operates 25% of all HTs and the West Midlands 24%, London deploys only 9%. Bearing in mind the health inequalities gap in London this imbalance would be worth further investigation.

5.3 DOES THE HT SERVICE WORK?

A key commissioning question in relation to any health improvement project is simply -"Does it work and will it continue to work in the future?" Different tables, looking at successful Health Plans, Diet, Weight/BMI, Blood Pressure, Alcohol, Exercise and other measures all indicate positive and sustained change. In respect to enabling clients to make and sustain positive health behaviours this is a major success story.

This half year review also demonstrates that the HTS is continuing to operate to its original specifications of using local people in deprived areas to be a primary change agent. For those commissioners concerned with reducing health inequalities the way HTS operate is much more likely to be effective than simple campaigns focusing on topics.

The big story however behind Health Trainers is the importance of engaging with people on their own terms, in their own communities and focusing on personal skills development. To cite but one measure from this review is fraught with danger, but attention is drawn to Figure 13 – Client reported general health by deprivation quintile, where quintile 1 showed a 20% improvement in their reported health state.

[26] Public Health Outcomes Framework 2013 (PHE) https://www.gov.uk/government/collections/public-health-outcomes-framework

[27] DCRS captures around 65-70% of Health Trainer activity nationwide.

To reiterate, this review of the impact and change data across a raft of measures relating to the engagement gives confidence that significant and profound improvement has taken place. This needs to be continued.

5.4 COMMISSIONING PRACTICE RECOMMENDATIONS

If Commissioners are to fund Health Improvement Programmes then they must have confidence in both the provider and in the practice and methodology that will underpin their practice and service delivery. Health Trainer Service results are based on an embedded methodology and sound working practices. They are not based on the novelty or enthusiasm of practitioners over a short run pilot project. The methodology of the HTS is therefore proven and as the data shows it is increasing its track record of effectiveness. Applied correctly the HTS will have both an immediate and long term effect on the client population.

The solid level of performance of HTs shown in this half year review is based on the quality of their initial and subsequent training and supervision. It is essential to maintain the level of training both in quality and quantity if HTS effectiveness is to be maintained.

Key benefits of Health Trainer Services being:

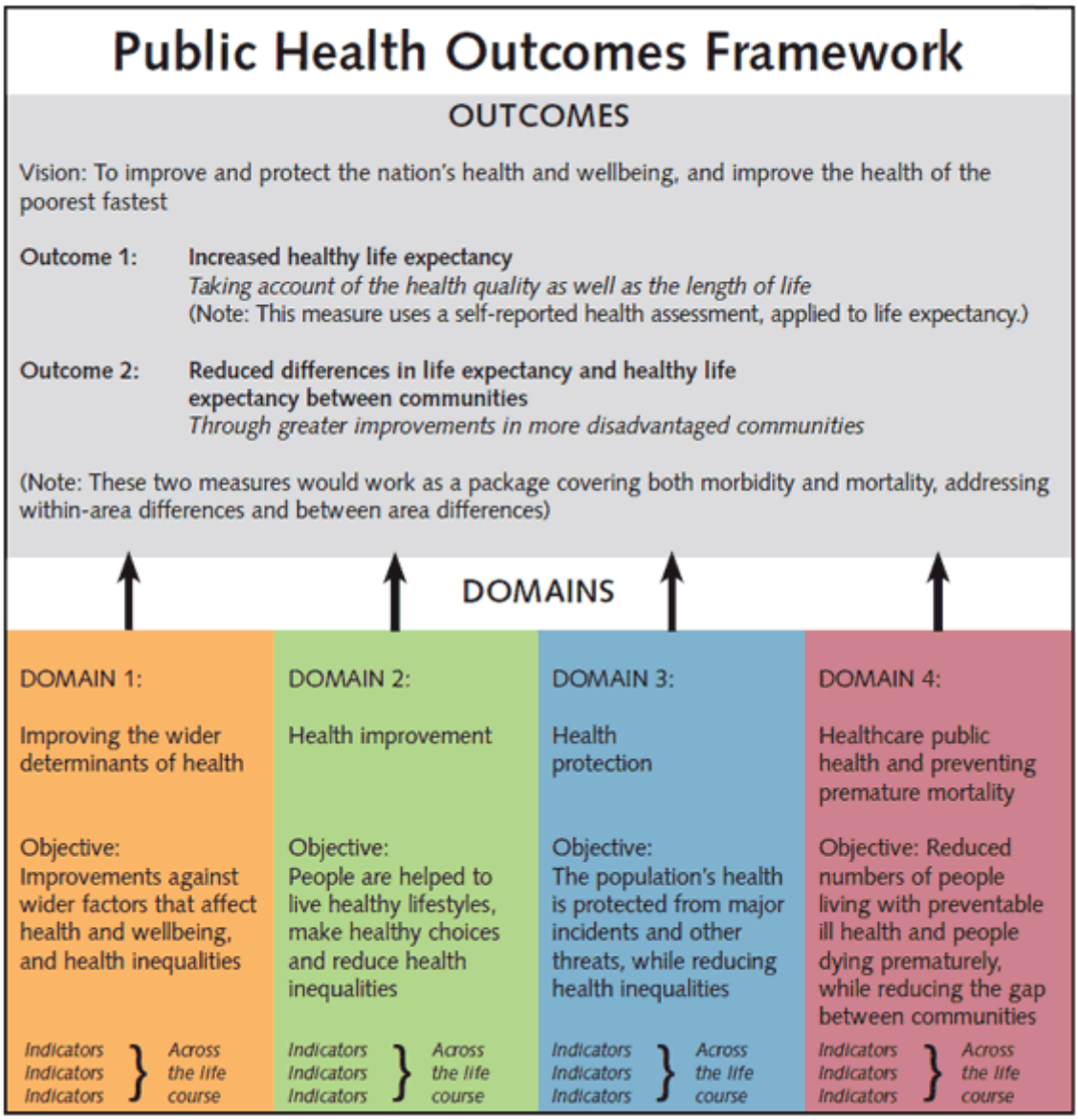
- Recruitment from within the more deprived communities . This practice must be continued to ensure service effectiveness and methodological consistency.
- Actively assisting the wider health economy meet the goals of the Ottawa Charter (see section 4.1), by supporting those with specific needs from more deprived communities.
- Empowering local people to become active in pursuing their own health goals as opposed to being passive recipients of health services

Areas where further review might be helpful:

- Development and practical assessment of the legacy value of the HTS intervention – both on staff and clients.
- Alcohol is a major public health issue[28]. HTS sample sizes are relatively small but results are positive, this presents an opportunity that should be reviewed locally.
- Whilst understanding HTS's are intentionally engaging difficult client groups, continually challenging DNA rates (see section 4.6.1) through working practice review, refinement and innovation is vital to maximise service value.
- Specific contextual features of a community or population should be reviewed, in line with UK Government Localisation Policy[29], to highlight and address service aspects which assist or detract from more efficient or effective operation (e.g. population demographics, existing community capital or assets).
- Clinical Commission Groups[30] and other public bodies also have statutory responsibility to reduce health inequalities. Duplicative commissioning with Public Health services must be avoided but CCG commissioning/ collaborative commissioning of HTS's may well be appropriate.

[28] Argued by the Faculty of Public Health to have become a serious and worsening public health problem in the UK. It is also suggested 'opportunistic screening' will help address this, see http://www.fph.org.uk/uploads/ps_alcohol.pdf.
[29] UK Localisation Act & Policy see https://www.gov.uk/government/publications/localism-act-2011-overview.
[30] Functions of CCGs (NHS England) http://www.england.nhs.uk/wp-content/uploads/2013/03/a-functions-ccgs.pdf

APPENDIX A – THE PUBLIC HEALTH OUTCOMES FRAMEWORK



APPENDIX B - GLOSSARY OF TERMS

- CCGs - Clinical Commission Groups
- DCRS – Data Collection Reporting Service, used to collect and report upon Public Health Service activity.
- DoH – The Department of Health
- HT - Health Trainer
- HTC - Health Trainer Champion
- HTS - Health Trainer Service
- PHP - Personal Health Plan, the health intervention plan agree with clients
- PHOF - Public Health Outcomes Framework

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Copies are freely available via the RSPH website www.rsph.org.uk / 020 7265 7334 or the DCRS Support Team dcrs.support@nhs.net / 0845 548 3277.