Health Trainers in the North West
Summary of Key Points

Both local and national evaluations report:

※ Positive views of the service from clients, stakeholders and Health Trainers, who particularly value the personal and individually tailored service.
※ High levels of job satisfaction reported by Health Trainers.
※ The need for absolute clarity regarding the role of the Health Trainer to ensure appropriate referral to the service.
※ The need for Health Trainers to receive training in counselling skills and dealing with people with mental health issues, such as anxiety and depression.
※ Key features of the Health Trainers’ skills which helped clients move towards achieving higher levels of confidence and self-belief were motivation, support and encouragement.

Findings from the Data Collection and Reporting System (DCRS) database showed:

※ Twenty-one out of twenty-four PCTs in the North West now have Health Trainers, with service models varying, to reflect the flexibility of the service in targeting local needs.
※ Over 41,000 clients have been recorded on the Data Collection and Reporting System (DCRS) database up to August 2010, although figures vary enormously between the 18 North West organisations who subscribe to the DCRS.
※ Nearly twice as many clients are female than male, and the majority are white British. Two-thirds of clients come from the most deprived areas.
※ Half of the clients wanted assistance with their diet, and a third with physical exercise. Few required assistance with alcohol consumption.
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1. Introduction

This synthesis report was commissioned by the North West Health Trainer Partnership.

The report brings together evidence from a range of sources, utilising quantitative and qualitative methods and includes local and national evaluations and reports, journal articles, media reports, personal communication with Health Trainer leads and staff as well as drawing from Data Collection and Reporting System (DCRS) data from North West Health Trainer services.

The report will describe the conception of the Health Trainer service, outlining the relevant legacy documents and provide indications of the way forward in light of recent government policy. Brief discussion of the limited evidence around the cost-effectiveness of the service will be made. The current Health Trainer service provision across the North West will be outlined to illustrate the different ways of working across the region, with specific examples and case studies presented. Findings from local reports and evaluations will be documented, and discussed in the context of regional evaluations. Data from the DCRS will be presented in the context of the four target outcomes set for the service by the Department of Health (DH). Finally, conclusions from the evidence presented will be drawn, alongside a series of recommendations.

The Health Trainer service was set up in 2005 to tackle health inequalities. Health Trainers are recruited from local communities and work to support health related lifestyle change. Key to their role is the work they do on a one-to-one basis with those populations least likely to choose and maintain healthy lifestyles. They offer practical support to change their behaviour to achieve their own choices and goals. Recent national figures show that over 167,000 clients have accessed the Health Trainer service since its inception, whilst there are over 1,750 Health Trainers currently working in the service.¹

Policy

The concept of Health Trainers was first introduced in the public health White Paper Choosing Health: making healthier choices easier (2004)² in response to the health inequalities evident throughout the country. These showed that despite free healthcare, wide mortality and morbidity differentials were experienced between social classes. As part of a national health promotion initiative, Health Trainers were proposed to offer personalised support to help people make healthier choices. Choosing Health² describes the Health Trainer role as follows:

"Offering practical advice and good connections into the services and support available locally, they will become an essential common-sense resource in the community to help out on health choices. A guide for those who want help, not an instructor for those who do not, they will provide valuable support for people to make informed lifestyle choices."²[p106]

Choosing Health² proposed that much illness and disease could be prevented if specific changes to lifestyle were introduced. The five reducible risk factors targeted are tobacco, alcohol, blood pressure, cholesterol and obesity. Hence, stopping smoking, exercising, losing weight and eating healthily are key objectives for the Health Trainer scheme. Box 1 provides an overview of key policies which have lead to the implementation of the Health Trainer Service.
Box 1: Historical national policy and strategy

- **The Health Divide** (1987) (also called the Whitehead report) revealed that the gap between health standards and social class had widened since the publication of the Black Report and restated the direct link between health and social class.

- **The Acheson Report** (1998) mirrored findings of the Black report. The root cause of inequalities in health was poverty and many of the inequalities are 'remediable'.

- **Tackling Health Inequalities: A programme for action** (DH 2003) established the foundations required to achieve the challenging national target for 2010 to raise life expectancy in the most disadvantaged areas faster than elsewhere.

- **Choosing Health** (DH 2004) identified Health Trainers as a key workforce resource for helping deliver the ambitious and practical approach to tackling health inequalities.

- **Securing Good Health for the Whole Population** (Wanless 2004) recognised that although individuals are ultimately responsible for their own and their children’s health, they need to be supported to help them engage in making better decisions about their own health and welfare.

Box 2 provides an overview of key relevant policies since inception of the Health Trainer programme.

Box 2: Recent national policy and strategy

- **Our Health, our care, our say** (2006) allowed the public to speak directly to ministers, health professionals, and each other on how improvements could be made to their local services. It demonstrated a need to change the way services are provided in communities and make them as flexible as possible, and provide a more personal service that is tailored to the specific health or social care needs of individuals.

- **Health Inequalities: Progress and Next Steps** (DH 2008) described the need to empower individuals using Health Trainers to facilitate behaviour change, as well as building community capacity for health through Health Trainers.

- **High Quality Care For All** (2008) (Lord Darzi report) highlighted variations in the quality of care provided by the NHS. The system therefore needs to be flexible to respond to the needs of local communities, tackle the variations in quality of care and give patients more information and choice.

- **Ambitions for Health** (DH 2008), ‘a strategic framework for maximising the potential of social marketing and health related behaviour’, included the need for Health Trainers to put social marketing principles into action at a local level with the aim of lasting behavioural change.

- **Fairer Society Healthier Lives: Strategic Review of Health Inequalities Post 2010** (The Marmot Review) highlights the premature illness and death that affects all but the very higher socioeconomic groups in society. It emphasises the need to address inequality through joint effort between NHS, central and local government, private sector and local communities. The importance of local delivery is stressed along with empowerment of the individual and local communities. Specifically, Health Trainers are cited as having a contribution to reducing health inequalities.

- **Healthy Lives, Healthy People: Our strategy for Public Health in England** (2010) stresses the need for continued efforts to tackle inequalities by changing adults’ health behaviour through self-care, recognising that adults are responsible for their choices, but can be assisted through approaches that focus on enabling, guiding and supporting these choices. Emphasis is placed on community leadership with local communities at the heart of health improvements, shaping their own environments and tackling local issues.

Health Trainer services were established following the publication of **Choosing Health** in 2004. Twelve early adopter sites began to trial the service in 2005. The idea was to develop and test elements of the recruitment, training and employment package for Health Trainers and local models of service provision. Three of the trials ran in the North West: Tameside and Glossop Health Trainer Service run by the primary care trust (PCT); Cheshire and Merseyside; and a Manchester based service run jointly by the three PCTs and Manchester Public Health Development Service. Following the early adopter scheme, funding allocations for 88 PCTs was provided in 2006/07. These PCTs were identified as being in the bottom 20% for three or more of five indicators of health. There is a clear concentration of Spearhead trusts in the North West, with 14 in the region.

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a The five indicators are life expectancy (male and female), < 75 cancer mortality rate, < 75 cardiovascular disease mortality rate, Index of Multiple Deprivation average score.
With additional funding provided by DH, the scheme was then rolled out nationally in 2007. As well as PCT / local authority adoption, an impact assessment showed that Health Trainers can be successful in assisting prisoners and those on probation. Since then, Health Trainers have been employed to work with third party organisations across private, voluntary and public sectors. These include such diverse collaborations as The Royal Mail, The Football Foundation and The British Army.

The Health Trainer service supports adults who want to make a change toward healthier lifestyle but need assistance to achieve and maintain this. The service is underpinned by the principle of informed choice. That is, rather than statutory agencies instructing the population in how they need to change their health behaviour, Health Trainers are seen as guides, supporting individuals, predominantly in the socially disadvantaged and ‘hard to reach’ groups, by helping them to set achievable goals, and to meet these goals by giving practical support and identifying potential barriers to achieving them. The idea behind this is a personalised care approach which focuses on self-care and empowers individuals to make decisions about their health and behaviour by providing information and support. The approach is that of partnership and collaboration. Furthermore, the emphasis is on working with individuals, specifically those who do not usually access health services or are excluded from services, rather than targeting groups. Broadly, the objectives of the Health Trainer Service are to:

- Identify and engage with individuals from deprived groups or communities.
- Enable individuals to change their behaviour to positively impact on their health and wellbeing.
- Support individuals to make more effective use of health and wellbeing services.
- Increase capacity and capability, building a workforce from the communities and groups within which they work with the right skills to tackle health inequalities.

The foundations of the Health Trainer service are based on theoretical models of the determinants of health behaviour change which provides the evidence base on which the work of Health Trainers is based. Box 3 details the four targeted outcomes that have been set for the Health Trainer Services:

**Box 3: Targeted outcomes**

1. Building the workforce with the right skills to tackle health inequalities.
2. Reaching the hard to reach.
3. Delivering sustained improvement to the health of the people of England through behaviour change.
4. Providing access to and encouraging the appropriate use and take-up of NHS and other local services.
Health Trainers as the workforce

Health Trainers themselves are intended to be recruited from the locality in which they will serve. The aim is to provide ‘support from next door’ rather than ‘advice from on high’. Coming from the community they support, it is intended this will provide jobs for local people, who have the advantage of being familiar with community sources of advice and support. The expectation is that “their diversity, including age, ethnicity, race and gender, reflects the local area”. Furthermore, having a similar background to those they are working with, these Health Trainer ‘role models’ are thought likely to have more influence on those they are working with. The posts were also seen as an entry route into employment in the NHS for marginalised groups, who may otherwise not have found employment in the health sector.

The training of Health Trainers is based upon a small number of basic or fundamental ‘competencies’. These are:

- Make relationships with communities.
- Communicate with individuals about promoting their health and wellbeing.
- Enable individuals to change their behaviour to improve their own health and wellbeing.
- Manage and organise your own time and activities.

Health Trainers are supported by Health Trainer Champions who provide clients with health information and signpost them to the NHS and other community services, as well as to Health Trainers. The aim, as with Health Trainers, is to assist the local population in helping them to live healthier lifestyles and access the support they need. This is achieved by helping them to develop their knowledge and skills in relation to health and wellbeing, as well as helping them to identify how their lifestyle might affect their health and wellbeing.

The way forward

The Department of Health considers that the national Health Trainer programme has made a “positive contribution to health improvement and has the potential to have a significant impact on health outcomes, particularly in deprived areas”. As such, the strategic aim for 2009-11 states that:

“The Health Trainer programme will actively contribute to DH priorities 2009-11, by embedding Health Trainer services as an integral part of the regional and local work on tackling health inequalities, lifestyle challenges and health improvement”.

The Marmot Review stated that “initiatives using local Health Trainers, community health champions and community development work show encouraging signs of empowering individuals to participate and take control of their health and well-being. The impact of such innovations on health inequalities has yet to be determined”.

The recent White Paper Healthy Lives, Healthy People: our strategy for public health in England continues to build on the principles underpinning the Health Trainer service. These include the need for continued efforts to tackle inequalities in premature death and illness, and positively promote healthier behaviours and lifestyles by changing adults’ health behaviour. This will be achieved by recognising that adults are responsible for their choices, but can be assisted through approaches that focus on enabling, guiding and supporting these choices. In addition, emphasis is placed on finding local solutions that are tailored to people’s different needs. This will be tackled by putting local government and local communities at the heart of health improvements through administration of new resources, rights and powers to shape their environments and tackle local problems.

The Department of Health considers that the national Health Trainer programme has “already made a positive contribution to health improvement and has the potential to have a significant impact on health outcomes, particularly in deprived areas”.
Currently the Health Trainer scheme is largely implemented through primary care trusts (PCTs), although strategic health authorities will be abolished by 2012/13, with PCTs being phased out from April 2013. This report does, however, illustrate that within the North West many Health Trainer schemes are already being run either in partnership, or solely by local authorities, the wider NHS or voluntary organisations and it may be that this is the way forward for the service.

**Value for money**

It is widely acknowledged that there is no simple means of measuring the cost-effectiveness of the Health Trainer service. The DH National Implementation Team for Health Trainers recently funded an assessment of the value for money of Health Trainer services. The method used for assessing value for money starts by analysing the objectives of each service and the evidence available on the impact it has had on the people involved. A set of indicators is proposed by which the performance of the Health Trainers can be measured and compared to financial cost. Although many assumptions have been made, these can be revised in order to take into account local perspectives and values. The report, including five case studies which were used to test the method, found that Health Trainer services “can achieve high levels of value for money… but it also highlighted the variability between services, the problems of data collecting and the difficulty of capturing some aspects of the value of the Health Trainer Service”.18 (p2)

**Service delivery across the North West**

According to the NHS North West Health Trainer Partnership, 21 of 24 PCTs in the North West now have Health Trainers, with investment in the service from NHS and local authorities totalling £9 million for the year 2009/10. The three PCTs without a Health Trainer scheme are Central and Eastern Cheshire PCT, Western Cheshire PCT and Trafford PCT. Across the North West, the service models used vary considerably, appearing to reflect the flexibility of the service in targeting local needs. This works from the top down, so the service is run jointly or individually by the most appropriate organisation, with in some cases, health services devolving responsibility to local authority or social enterprise. For example, the Health Trainer service in Salford is run by a social enterprise group (Unlimited Potential) and Liverpool’s service is delivered by a voluntary sector partnership of Liverpool Personal Services Society (PSS) and Age Concern Liverpool, whereas Bolton’s service is currently delivered by the PCT.

Across the region, the different services are located within diverse settings. Some are centrally based from one location (e.g. Halton and St Helens operate from Bold Miners Centre). Others are based in small teams (for example, Wirral Health Trainers are based in Health Action Area Teams but located in non-NHS premises including a school, YMCA and two community centres). Some work in pairs (such as Liverpool Health Trainers who work in pairs across seven neighbourhood areas that cover the whole city). Similarly, the client base that Health Trainers target varies according to the health needs of the population. Whilst some services target the general population (including the Liverpool service, which has no specific emphasis), others target specific clients (e.g. Bolton PCT has an emphasis on those with high risk of cardiovascular disease (CVD)). Separate to these are services provided in specific locations targeting clients from those locations (for example, community Health Trainers based at pharmacies in East Lancashire, and clients within HMP Hindley for Ashton, Leigh and Wigan PCT). Further details of the Health Trainer programmes across the North West can be found in Table 1.
Table 1 Overview of current Health Trainer service provision in the North West

<table>
<thead>
<tr>
<th>PCT</th>
<th>Date commenced (with clients)</th>
<th>How organised / run</th>
<th>No. of Health Trainers (current)</th>
<th>No. of clients (current)</th>
<th>Emphasis</th>
<th>Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cheshire and Merseyside</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Central and Eastern Cheshire</td>
<td>N/A</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Halton and St Helens</td>
<td>2007</td>
<td>Jointly between PCT and council</td>
<td>10 HT + 2 HT champions</td>
<td>1,600 clients seen 2009/10</td>
<td>Priority those in deprived areas with poor health</td>
<td>16+</td>
</tr>
<tr>
<td>Knowsley</td>
<td>March 2007</td>
<td>Knowsley Integrated Provider Service (partnership with NHS Knowsley)</td>
<td>4 Lifestyle Advisers + 1 vacant post, 1 LA assistant, 1 Administrator</td>
<td>1,410 clients seen 2009/10</td>
<td>Support CVD health checks</td>
<td>19+ All Knowsley residents, priority more deprived areas</td>
</tr>
<tr>
<td>Liverpool</td>
<td>2007</td>
<td>Liverpool PCT</td>
<td>9 WTE* (+ 4 vacancies)</td>
<td>1,154 clients assessed 2009/10</td>
<td>No specific emphasis</td>
<td>18+; 80% referrals from primary care, 20% community</td>
</tr>
<tr>
<td>Sefton</td>
<td>August 2010</td>
<td>PCT and 3rd sector</td>
<td>1 WTE</td>
<td>None to date</td>
<td>Worklessness organisations</td>
<td>18+ unemployed</td>
</tr>
<tr>
<td>Wirral</td>
<td>January 2009</td>
<td>NHS Wirral</td>
<td>8 WTE</td>
<td>2,135 clients with a health plan, 2009/10</td>
<td>Men over 40, people with mild to moderate depression, families who are obese. Long term conditions, People in aftercare following substance misuse.</td>
<td>16+ target clients in areas deprivation</td>
</tr>
<tr>
<td>Wirral</td>
<td></td>
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<tr>
<td>Cumbria and Lancashire</td>
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<tr>
<td>Blackburn with Darwen</td>
<td>March 2008</td>
<td>Joint PCT and Borough Council</td>
<td>5 WTE</td>
<td>376</td>
<td>Deliver health checks Launching ‘health and wellbeing in the workplace’ initiative. Partnership with Blackburn Rovers FC.</td>
<td>18+ anyone who lives, works, is educated or has GP in borough</td>
</tr>
<tr>
<td>Blackpool</td>
<td>2007</td>
<td>PCT commissioned in collaboration with Wellbeing Service</td>
<td>4 WTE</td>
<td>472</td>
<td>Priority to clients in deprived areas</td>
<td>16+</td>
</tr>
<tr>
<td>Central Lancashire</td>
<td>October 2008</td>
<td>NHS Central Lancashire commission 6 host organisations</td>
<td>6 WTE</td>
<td>560 clients seen 2009/10</td>
<td>BME, older people, men, children and families and rural communities</td>
<td>18+ living East Lancashire</td>
</tr>
<tr>
<td>East Lancashire</td>
<td>Not yet established due to budget constraints - however pilot studies are ongoing</td>
<td>Worklessness Pilot Scheme</td>
<td>None although personnel trained to Level 2 and 3</td>
<td>3 Age concern</td>
<td></td>
<td></td>
</tr>
<tr>
<td>North Lancashire</td>
<td>Information unavailable</td>
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<tr>
<td>Greater Manchester</td>
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<tr>
<td>Ashton, Leigh and Wigan</td>
<td>January 2007</td>
<td>Ashton, Leigh and Wigan Community Healthcare (commissioned by PCT since September 2009)</td>
<td>28 WTE + 7 vacancies (5.8 WTE band 4 and 29 WTE band 3)</td>
<td>468</td>
<td>Health trainers deliver services from 2 fire stations, 1 HT delivers services from HMP Hindley</td>
<td>16+; 52% drawn from 20% most deprived areas</td>
</tr>
<tr>
<td>Bolton</td>
<td>January 2008</td>
<td>PCT run - located across GP practices</td>
<td>22</td>
<td>1845</td>
<td>High risk CVD Patients with IGT</td>
<td>16+ anyone who wants to change lifestyle risk factor</td>
</tr>
<tr>
<td>Heywood, Middleton and Rochdale</td>
<td>January 2008</td>
<td>PCT</td>
<td>17</td>
<td>741</td>
<td>General, and breastfeeding / stopping smoking</td>
<td>18+ unless breastfeeding and stop smoking topic areas. Registered with Bury GP or resident in the area.</td>
</tr>
<tr>
<td>Heywood, Middleton and Rochdale</td>
<td>January 2008</td>
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</tr>
</tbody>
</table>

* Whole Time Equivalent (WTE)
Case studies of Health Trainer models of delivery within the North West

The following are examples to illustrate the different models of service delivery that are employed across the North West. From a wide variety of services we have included examples of care for those with mental health issues, physical exercise / diet needs, ex-offenders, the workless and the homeless, as well as care through the local pharmacy.

Clients who have mental health issues: Unlimited Potential Salford

The Salford based Health Trainer service run by Unlimited Potential have recognised that many of their clients have needs around improving their mental health. Whilst they are unable to offer specific services for those with acute problems, they provide support for those with issues such as depression, anxiety, low self-esteem, and so on. Figures from the service show that the most common primary issue recorded for clients accessing the service between April 2009 and August 2010 was exercise. However, depression, social isolation, stress and anxiety were also very important reasons for referral, the latter two slightly more so than diet, and all noticeably more so than alcohol and smoking. All of these clients appeared to progress with a majority of clients achieving their personal health plan (PHP) goal.

The Health Trainer service both refers to and take referrals from the Increasing Access to Psychological Therapies (IAPT) services which includes Salford’s primary care Mental Health Team and Salford’s primary care psychology service. Additionally, they have received a substantial number of referrals from: Carers Support service, private and NHS counsellors, drug / alcohol services, Gateway Centre, Jobcentre Plus, Learning Disabilities Team, REACH project, Salvation Army and Social Services, amongst others, although GP referrals remain the most important source. The Health Trainers work is primarily low intensity and with clients who have mild to moderate psychological difficulties, such as anxiety. Although trained counsellors, the Health Trainers have received Applied Suicide Intervention Skills Training (ASIST) which was set up in response to local need. By focusing not on the individual’s needs but positively on their strengths, this helps them to achieve their goals. The service has been well received locally, anecdotal feedback is positive, suggesting that it makes a real difference to people’s lives, as the following case study illustrates.
Case Study

Client B is a 24 year old single mother who self-referred to the service as she had been suffering from depression and low self-esteem. She had recently had a baby and had been prescribed anti-depressants. Initially Client B expressed that she just wanted support in obtaining a healthier lifestyle, but then it became evident that she had more complex issues that she needed support with. Client B disclosed that she was feeling suicidal and was taking more than the prescribed dose of drugs every night as a means to block out the anxiety she was experiencing. She broke down saying she was frightened about the future of her baby because her baby had mixed heritage and she was already experiencing racial abuse about her baby which was causing her great stress. Although she had been seeing a counsellor she was not happy with the counsellor’s approach. The Health Trainer role was to find out what services were supporting the client and what support network she had. The Health Trainer provided contact details of agencies and encouraged her to attend the mothers and toddlers group as means of social support. Client B disclosed to the Health Trainer that just being able to talk to somebody who was willing to listen and not judge her has probably stopped her from seriously hurting herself. She is currently being supported by social services, she attends the mother and toddlers group weekly and says it just gets her out of the house, is a form of release and has allowed her to meet and socialise with other parents.

Manchester Success Through Sport Programme (Manchester City Football Club)

Manchester City Football Club (MCFC) was the first professional football club in the country to have a NHS Health Trainer based with it beginning in June 2007. When the Health Trainer service began it linked into ongoing projects and activities such as the ‘Getting Manchester Moving’ Campaign, and the CITC T-dances, as well as outreach work in the local East Manchester area. Other referrals to the Health Trainer service were created through the MCFC media channels e.g. mcfc.co.uk, the MCFC match day programme, the MCFC magazine and match day events. Currently there are three Health Trainers (two WTE) working at CITC, supporting a project called Success Through Sports. The project aims to work with young men aged 18-25 from the Ardwick and Moss Side areas of Manchester, which are particularly deprived areas of the city, to help them become more active, healthy, motivated and used to routine. It also aims to help them become more employable by providing training opportunities and employability skills workshops. The Health Trainer roles are to help with recruitment and the delivery of health workshops alongside their usual Health Trainer role with the participants. The club’s Health Trainer sees between 10 and 15 people a week.

Case Study

“We normally sit in the executive box and have a chat. It starts off with a bit of banter about football, I think that helps set them at ease, and then we get on to their lifestyle. Some people talk about diet or need help accessing physical activity. We draw up an action plan, which we then talk about on follow-up sessions. It is about giving people confidence. I can take them down to local leisure facilities and introduce them to staff there. Or I can refer them on to stop smoking services and other health services”.

The Probation Service – Tameside and Glossop PCT

Tameside and Glossop PCT ran a joint six month health improvement pilot scheme with Tameside Probation Service from November 2007 to April 2008, aimed to utilise the health trainer service (then known as Connect 4 Life) (C4L) to deliver health improvement advice to offenders that were subject to supervision by the probation service. This was aimed at offenders who were near to completing their period of supervision and also those who were subject to Drug Rehabilitation Requirement, or required to attend Substance Related Offending group work programme. The service offered participants a health and wellbeing assessment and the opportunity to devise a personalised six month health plan based on increasing physical activity, adopting healthy eating, encouraging stop smoking and sensible drinking and reducing stress. The C4L coach gave an introductory
session and each client was given an appointment for a one-to-one healthy lifestyle advice session, with dates set for each client to attend further advice sessions.

Altogether 25 clients were referred and 15 presented for their initial assessment. Of these, 10 engaged with the coach on a regular basis. These clients had multiple, often complex needs, that included all aspects of healthcare, the majority of clients having mental health issues ranging from lack of confidence and self esteem through to anxiety and depression. Social exclusion was also a problem in this group. Furthermore, all had very poor dental health and no access to a dentist, whilst many also had no GP having been struck off due to repeated failure to attend appointments. Levels of literacy and numeracy were low, which meant that some of the questions asked on the health and wellbeing assessment were too complex, leading to frustration and lack of willingness to further engage.

The initial assessment provided an opportunity for the coach to break down barriers and start to understand the clients’ complex lifestyle and needs. The clients appeared to appreciate having someone listen. Starting to build up an element of trust and rapport was particularly important, but took longer to achieve. Due to their challenging needs, however, a greater level of support was necessary in order to even make any minor lifestyle change such as introducing healthier eating patterns, or increasing water consumption. The clients therefore needed to be seen on a weekly basis rather than monthly as was the case for clients accessing the conventional Health Trainer model. Most fully engaged with the coach and welcomed the opportunity to ‘unpick’ some of the issues in their lives. Of the ten clients that remained with the programme, all were partly able to achieve the goals that were agreed as part of their personal health plan, predominantly eating healthier food. Some clients stated they were able to reduce their substance use and alcohol intake.

The Management Board for the Rochdale Local Delivery Unit Probation Health Trainer Pilot, and their partners recently obtained funding to roll out the Probation Health Trainer programme across the North East sector of Greater Manchester. Currently, ex-offenders are employed with Greater Manchester Probation Trust, on a fixed term contract. They are now fully qualified Health Trainers, working out of the Rochdale and Middleton Probation Offices to support healthy behaviour changes in offenders on probation caseload. The intention is, that by improving the health of offenders, there will be a reduction in re-offending and therefore fewer victims.

Recent figures from the Rochdale project show that between February, when the service began, and November of 2010, 506 appointments had been attended with the Health Trainers across the Rochdale district. This is 80.7% of all appointments that were made. The most common issues that people requested support with were smoking, diet, alcohol and exercise; whilst a number also requested support with sexual health and mental wellbeing issues.

**Health Trainer and Worklessness Agenda: Making the Links Project – Cumbria**

This 12 month pilot is being coordinated by HM Partnerships with regional Health Trainer money. In Cumbria there are two pilot sites, Workington and Barrow. The Workington pilot is being hosted by Routes to Work and focusing on clients who are long-term recipients of Incapacity Benefit/Employment Support Allowance within the three key geographical areas of Flimby, Northside and Siddick. The Barrow site is hosted by the Return to Work team based with Furness Enterprise.

The pilot has a number of broad objectives:

- To improve partnership working between health, Jobcentre Plus and other local agencies and to expand the links between health and workless partners.
- To have a measurable economic impact on the pilot area.
- To establish a Health Trainer service for the pilot.
- To impact on and improve the health of those utilising the services of workless partners.
- To reduce the incidence of poor health being a factor in long term worklessness and improve employability.
In Workington the Health Trainer has been in post since August 2010, and is based in a local community centre which is located in the heart of the target community. Barrow’s Health Trainer has been in post since November 2010, and she is currently shadowing members of the Return to Work team and undertaking training. After her induction period, the Health Trainer will meet clients at the Return to Work base at Waterside House and at a satellite Workshop in the town centre.

Case study

This client was referred to me via Cumbria Action for Social Support (CASS), who deal with the homeless and ex-offenders. The client suffers from severe depression, is a heroin user and had recently been through the judicial process. The first meeting took place with a CASS member of staff present due to the lack of confidence and self-esteem of the client. The initial meeting was an informal chat where I encouraged the client to go into a little bit more depth about his addictions, behaviours and feelings of depression. He explained to me that he had managed to come off drugs before, but after the recent court case, he’d began using again and got involved in the ‘wrong crowd’. He said he wanted help to boost his confidence and to stop using drugs. I asked him whether he’d heard of the Rising Sun Trust (as he was not registered with them) with a look to signposting him there. He said he had but he was not keen. He was apparently registered with CADAS, but hadn’t been in touch with them for a while. I encouraged him to get in touch with his drug and alcohol worker. We arranged a further meeting, looking at getting him out of the house.

The third time we met, we played snooker at the local hall. The client claimed he felt nervous about leaving the house usually, but appeared to enjoy our time playing snooker. He was even laughing and smiling at one point, something I had not seen him do since I met him. We talked a lot during the game, and he even agreed to start an exercise programme. I explained that I could get him involved at the local gym, perhaps even going with him the first few times as he gains confidence and get an instructor to put him on a good programme to slowly build his basic fitness, which would improve his self-esteem and confidence as well as his general health”.

Working Through Pharmacies – East Lancashire Health Trainer Service

A pilot scheme in East Lancashire currently employs dedicated Health Trainers at local pharmacies, to offer healthy lifestyle advice on issues ranging from weight loss, smoking cessation, diet, exercise to relaxation and mental health. The pilot has been funded by East Lancashire Primary Care Trust. Selected pharmacy staff have been trained to City and Guilds Level 3 as Health Trainers. The initiative, believed to be the first of its type in the country, aims to use a dedicated staff member at the pilot pharmacy sites as a Health Trainer operating in ‘the very heart of their local community’. The Health Trainers can also provide a valuable link into other pharmacy services such as chlamydia screening, early intervention advice about alcohol use or drugs misuse services. The initial 12 month pilot has been extended until March 2011 to a further five pharmacies. Each pharmacy aims to deliver motivation and one-to-one support to 50 clients per year, with a lifestyle behaviour change achievement rate of 80%. The service is seen as using community pharmacy and the staff team skills "to the best advantage as well as providing a one-to-one service for patients who do not need a GP appointment". Furthermore, it is seen as a shift of emphasis into self motivated prevention agenda or support for self care in a long term condition.
Case Study

Referral to our Health Trainer, particularly by our pharmacist, has produced some very positive results, for example, patients who have been newly prescribed statins can be linked into a pharmacy-based service which is accessible, close to home and at a convenient time.

Our Health Trainer also has good access to the pharmacist’s skills in support of their role e.g. referral to the pharmacist can be made for medicines use review. This linked working with appropriately trained staff forms an excellent platform on which to build services such as vascular checks. As a result of patient requests, the pharmacy now provides a blood pressure monitoring service.

Working with the Homeless – Liverpool Health Trainer Service

The Liverpool Health Trainer for City and North holds a surgery once a week with Addaction, an organisation which works with people with drug and alcohol issues. The following case study is an example of the work that the Health Trainer undertakes with homeless clients.

Case Study

The client, who was alcohol dependant and homeless met the Health Trainer at Addaction. He had been drinking for a couple of years and because of this, his wife had left him and he had lost his home. At this stage, he was ready to make a change in his life but didn’t know where to start. Addaction supported him around his alcohol dependence, whilst the Health Trainer supported him around his lifestyle and one of the first suggestions she made was to start exercising. He began exercising by attending the Walk for Health Scheme, which the Health Trainer supported him on and then arranged for him to have a free 3 month gym pass. The gentleman started going to the gym and once the three month gym pass ran out he joined a local gym so he could continue to exercise. The Health Trainer worked closely with him during this period and as he was progressing so well she even got him a voluntary job which he did one day a week. One year later the client now rents a flat, no longer drinks and is still attending the gym. He is also ready to get back to work and is going to go back to college to take his English and Maths. He has said on numerous occasions that he would not be where he is now if it was not for the support of the Health Trainer.

A synthesis of the evidence from North West evaluation reports

The following section is a summary of findings from evaluations of the Health Trainer service that have been carried out in the North West region. Altogether, ten reports19-28 were located and used for this part of the synthesis report.

The recruitment process and initial service provision

Obstacles to recruiting unemployed and unqualified Health Trainers were identified as: having a web-based recruitment strategy, applicants being required to have an NVQ level 3, and in some cases access to a car. Furthermore, the selection procedure was described as ‘daunting’ particularly for those not used to being interviewed, many of whom lacked confidence in addition to relevant skills.

Equitable shortlist and interview criteria meant that those who met the specified criteria and scored highest at interview had to be offered the position, even if the preference would be to give the position to local and / or the unemployed. Consequently, this results in lower employment of workless persons than might be required to fulfil the DH criteria of building the workforce from the communities. One suggestion put forward was to bring in local unemployed people specifically and train them up to the role of Health Trainer.

Where the workless were employed as Health Trainers they were identified as having a high level of support needs, possibly because they didn’t have ‘autonomy’.
Whilst some participants felt that a Band 3 grading should be a minimum requirement to show evidence of the ability to work with people, literacy and IT skills plus experience of managing a workload, others thought the position was about ‘development’ so no minimum criteria is needed.

The reports highlighted that focused recruitment was necessary with clarity about the Health Trainer role for applicants. Initial difficulties with a high level of turnover of staff were apparent in some cases, because the Health Trainers were not deemed to be adequately matched to the roles they had to perform and they consequently moved into better paid health related roles.

There was wide recognition that Health Trainers need ongoing training and support for development, as well as a plan for career development in order to retain staff and provide progression opportunities. There was also recognition that the salary was ‘low’; however, one report identified that the selection process was easier where staff were employed by the voluntary sector and therefore not subject to PCT pay bandings.

Two reports identified difficulties in recruiting male Health Trainers to the service.

One report identified initial difficulties finding placement agencies, although this was improving as the service gains recognition. The need to place Health Trainers from the outset with organisations who had strong links to local communities was identified. By not widely consulting with the PCT in development of the service, this led to some reluctance of GPs to engage with the service.

Health Trainer perspectives

Ten evaluation reports provided information on Health Trainer views. There were issues common to many, although other specific issues arose in the different reports. These might simply reflect that the views were pertinent to those specific services, or it might be that the nature of the data collection (i.e. the questions asked) meant the views of all services was not collected on a specific subject.

Notably, there was overwhelming opinion evident in all reports that Health Trainers enjoyed their job, deriving great satisfaction from it and developing a range of skills within their role. However, there was also full acknowledgement that the job could be stressful, and the wages received do not reflect the nature and expertise of the Health Trainer role, neither does the grading reflect the complexity of the work involved. As a result, the Health Trainer role was different in actuality than expectation.

Although the role of the Health Trainer was primarily seen as tackling the five risk factors (tobacco, alcohol, blood pressure, cholesterol and obesity), Health Trainers reflected on the complex needs of the clients.

"I can’t remember when I last had a smoker. Now it is depression and debt and stress"

As a result, there is need for support for Health Trainers to be able to work with complex cases, including training in counselling skills and dealing with people with mental health issues, especially depression, anxiety and suicidal thoughts.

"the training falls short generally of what is required for us to fulfil the role to the highest standard"

This led some Health Trainers to report lack of confidence working with clients with mental health needs, and being uncertain of their remit in this respect. Regular updates were also specified as necessary to ensure the Health Trainer knowledge and skills are kept up to date.

Health Trainers thought their role was particularly important for aspects such as having time to listen and support clients who do not get this from other services. Other strengths of the Health Trainer role were the accessibility and flexibility, similarly the personal and individually tailored service.
Some concerns of the Health Trainers were apparent across all reports. This included lack of understanding of the role of the Health Trainer amongst both health professionals and clients. Stronger marketing and communications were deemed necessary to raise the profile and clarify the role of the Health Trainer service. To some extent this was due to the fact that the name doesn’t reflect the job, which led in some cases to inappropriate referrals. Three reports also identified safety concerns for those Health Trainers working in placements alone, or visiting clients’ homes which needed addressing.

**Stakeholder views**

Six evaluation reports included the views of stakeholders. All reported positive views towards the Health Trainer service, indeed the Salford evaluation concluded that:

> "all stakeholders believed that the HT service was making a difference to people in Salford and was a good use of public money" ²⁷ (p25)

Specifically, the strength of the service was the individualised approach, which meant that Health Trainers could spend time listening to clients on a one-to-one basis in a way that other health care services could not provide. This was particularly useful to those stakeholders within services who had limited time or resources. There was also the view that the service bridged a gap in health care services. One report did, however, identify that some stakeholders felt there was a further need to break down barriers between community and health services whilst other reports noted the lack of clarity among both public and professionals about the Health Trainer role. Again, this was thought to be partly due to the name.

Stakeholders felt there was a specific risk of Health Trainers moving on to more permanent and skilled positions within the health sector because of the nature of the job, thus leaving a gap in the workforce. One suggested solution to this was the provision of opportunity for greater career progression within the Health Trainer service. Supervision was also seen as crucial for developing the competencies of the Health Trainers, monitoring their progress, and supporting them in their roles.

Stakeholders in one report debated whether it was more appropriate for Health Trainers to be based in GP surgeries, as they see many people who would benefit from the service, or whether a community based location would help allay any fear and anxieties in clients. No consensus of opinion was achieved.

Stakeholders in the Knowsley evaluation identified that one barrier to the use of the service was that:

> "local people sometimes appeared very disengaged with poor lifestyles which are not always perceived as an issue by them" ²⁶(p50)

As a consequence, the Health Trainer is limited in the assistance that can be provided. As this was not reported in any other evaluation, it might be a specific issue to the population in that area.

**Client perspectives**

Six evaluations reported on clients perspectives of the Health Trainer service. Most notably, as with the Health Trainers and stakeholders, there was considerable confusion over the role of the Health Trainer. Largely this was thought to be due to the name ‘Health Trainer’ which appeared to be synonymous with ‘personal trainer’. Clients in one evaluation reported that the referral process did not help them to understand what the service provided, it wasn’t until they met the Health Trainer and had it explained to them in person, that it became clear.
Most clients were positive about the Health Trainer service, indeed the Liverpool evaluation\(^{25}\) reported:

> “most clients stated that the service had met or exceeded their expectations”\(^{25}\) (p25)

Of the participants in the Manchester evaluation,\(^22\) 93% reported they would recommend the service to others, whilst in Oldham\(^{19}\) 88% would recommend it. The Knowsley evaluation\(^{26}\) found feedback to be ‘generally’ positive. Aspects that clients appreciated included just having someone to talk to, or listen to their problems, one-to-one support that was individually tailored allowing progression at the clients own pace and to meet their own needs. They also liked that the health trainers were able to talk to them without using ‘unnecessary jargon’. Clients felt that the Health Trainer was able to provide motivation, support and encouragement which in turn helped them by giving them ‘confidence’ and ‘self belief’. Health Trainers were seen as knowledgeable about the local areas, and around issues such as health diet and exercise. Positive feedback was also forthcoming in relation to the flexibility of the service such as time and location of meetings. Some clients would have preferred to have more contact with the service, as one client pointed out health behaviour habits are often picked up over a lifetime so that six visits may not be enough. Also important was that the service was available at no cost.

There was no consensus regarding goal setting whilst some clients found the goal setting useful, particularly as they were small and achievable goals, others felt that they were not appropriate, as they did not require them, or they were not ready to do them.

To conclude, whilst a number of clients in this evaluation reported that their lifestyles had not markedly changed as a result of the intervention, they were positive about using the service.

**Overview of Evidence from regional evaluations and research studies**

This section comprises a summary of findings from evaluations and research studies that were carried out elsewhere in England.\(^{30-41}\) Many of the findings presented in the different North West evaluations are similarly reported across the multiple evaluations across the country and highlight the success of the Health Trainer initiative according to both clients, stakeholders and Health Trainers themselves. Like in the North West, the majority of Health Trainers appear to be very positive about their role, not just in terms of personal satisfaction, but also in the belief that their job benefits individuals. Clients as well as stakeholders have on the whole been very positive about the service across numerous evaluations and it seems there are unique benefits that the service provides. However, it is widely held that clients, stakeholders and partner or referral organisations have, at least initially, some lack of understanding of the role that Health Trainers have. Again, many reports describe the name ‘Health Trainer’ to be a misnomer. This lack of clarity has, according to Visram and Drinkwater,\(^{29}\) implications for the way the service is perceived by professionals and the public and consequently leads to inappropriate referrals.

Evaluations have reported on unique benefits that the service provides. This relates to the informal, flexible and person centred approach, consequently the Health Trainer is seen as,

> “easy to relate to and confide in”

and

> “establish a meaningful relationship with”.

This role is seen as distinct from other healthcare professionals, who (by implication) may be perceived to be less easy to confide in. Health Trainers are also perceived as different to other healthcare professionals in that they have time to spend with clients, and that they are non-judgemental and caring. A number of evaluations describe the service as ‘filling a gap’ or providing a bridge between local community and the health care system. The approach taken to assist the individual in taking responsibility and empowering clients rather than directing is also described in a positive manner, and is seen as a role distinct from the clinical professional.\(^{30}\)
Clients tend to find the service most effective when the Health Trainer takes a holistic approach through offering practical and emotional support. Those that have not achieved desired changes found interventions important in enabling them to make a start in positive changes i.e. laying the foundation for change. This is seen as different to the healthcare professional role which predominantly follows the medical model.

A number of evaluations reported on a ‘ripple effect’ within local communities. Not only do clients begin to change their behaviours, but their family and friends also start to change their lifestyle behaviours in tandem. One effect termed ‘value added’ was the confidence that came once people began to make changes in their lifestyle. As one participant stated:

\[quote\]
what comes across very strongly is that when they do make lifestyle changes, people also gain hugely in confidence and improved mental health.\[/quote\]

This can also act as a stepping stone to making bigger life changes such as going into training, or (re)joining the workforce.

In order to attract the workless as Health Trainers it seems that support in completing the application form would help those who have little experience of the job application process. Specifically, the procedure is seen as presenting a challenge when it is NHS based because applicants do not know how to present evidence, and need to consider the person specification and address each point.

As services have developed it seems that a better balance has been struck between recruiting both qualified and unqualified staff. However, new Health Trainers without formal qualifications or the workless were identified as having considerable support needs which takes considerably more time and effort.

Workforce retention has varied across the services. One report suggests there is anecdotal evidence that some Health Trainers have left because they have found the work too challenging and/or did not feel they were receiving adequate management support and guidance. However, generally there seems to have been some employment progression within the NHS, and some Health Trainers report the need for clarity on the potential for career development.

Further support and training was identified as necessary around issues such as domestic violence, suicide prevention, self harm and mental health, because of the complex needs of clients. However, it has also been highlighted that attention needs to be paid to the boundaries of service provision, especially in relation to working with people with complex psychosocial needs.

Tensions were reported when engaging with other community workers, who were often unclear about the precise role involved, or the existence of the service altogether. Many Health Trainers also experienced:

\[quote\]
a marked degree of conflict between themselves and existing community workers, particularly health and social care professionals, who were perceived as feeling threatened by the Health Trainers.\[/quote\]

Stakeholders identified a further tension around the pressure for Health Trainer programmes to have a national standardised profile versus the need to maintain a local focus, being flexible and responsive to neighbourhood needs.

Partnership working was identified as providing some tensions. The engagement of staff in one partner service can be restricted by the overwhelming pressure of securing the future of core services. Thus, whilst partnerships bring considerable benefits and enhancements to the programme, they can also increase the chances that circumstances beyond the control of the programme team destroy, or at least severely hamper, its likelihood of success.
Summary of evidence

There were reported difficulties in recruiting the workless to the position of Health Trainer, and where employed, their support needs were greater than Health Trainers who had previously been in work.

There was lack of clarity regarding the role of the Health Trainer, which led to a high turnover of staff, and inappropriate referrals to the service.

Despite realising high levels of job satisfaction, Health Trainers reported that it was stressful and the wages did not always match the skills required for the complex nature of the role. Stakeholders identified that there needs to be opportunities for career progression in order to retain staff.

Health Trainers identified the need for training in counselling skills and dealing with people with mental health issues such as anxiety and depression.

Clients, stakeholders and Health Trainers all reported positive views of the service, and particularly valued the personal and individually tailored service which meant that clients had one-to-one support which met their own specific needs and enabled them to progress at their own pace.

Motivation, support and encouragement were key features of the Health Trainers skills which helped clients move towards achieving higher levels of confidence and self belief.

Intelligence

The following section presents an overview of data collected by the Data Collection and Reporting System (DCRS). However, the system is not mandatory and not all PCTs utilise the system. To date, 18 of the 21 PCT’s with an operating Health Trainer service in the North West use this system and thus the analysis below is therefore representative of these 18 PCTs only. The PCTs not using this system and therefore not represented here are Cumbria PCT (now NHS Cumbria), Sefton PCT (now NHS Sefton) and Wirral PCT (now NHS Wirral).

Where relevant and possible, the North West data has been compared to the latest figures from the Health Trainers DCRS National Hub Report.1 It must be noted, however, that some of the fields have a large proportion of missing data, so care must be taken when interpreting these results.

Outcome 1 - Increasing capacity and capability through building the workforce with the right skills in place, to tackle health inequalities.

A total of 391 Health Trainers have been employed in the North West of England. Current figures (September 2010) show that 287 health trainers were in post in August 2010, 104 having left their position.

Table 2: Employment status of Health Trainers

<table>
<thead>
<tr>
<th>Employment status</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No longer employed</td>
<td>104</td>
<td>27</td>
</tr>
<tr>
<td>Still employed</td>
<td>287</td>
<td>73</td>
</tr>
<tr>
<td>Total</td>
<td>391</td>
<td>100</td>
</tr>
</tbody>
</table>
Figure 1 shows the variety in the number of Health Trainers ever employed by each of the organisations. This range reflects the different contexts of the service provision i.e. start date, model of delivery, allocation of funding, and so on.

**Figure 1: Number of Health Trainers ever employed, by organisation**

The majority of Health Trainers are in their mid-twenties to mid-forties (59%), and few are younger than 18 or older than 65 (Table 3). These figures are similar to those presented in the national report, with the exception of the 36-45 year group which represented 29% of the total number of Health Trainers in the North West.

**Table 3: Age of Health Trainers**

<table>
<thead>
<tr>
<th>Age</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 18</td>
<td>3</td>
<td>0.8</td>
</tr>
<tr>
<td>18 - 25</td>
<td>40</td>
<td>10</td>
</tr>
<tr>
<td>26 - 35</td>
<td>116</td>
<td>30</td>
</tr>
<tr>
<td>36 - 45</td>
<td>113</td>
<td>29</td>
</tr>
<tr>
<td>46 - 55</td>
<td>65</td>
<td>16</td>
</tr>
<tr>
<td>56 - 65</td>
<td>19</td>
<td>5</td>
</tr>
<tr>
<td>Over 65</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>Not recorded</td>
<td>27</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>391</td>
<td>100</td>
</tr>
</tbody>
</table>
Table 4 shows a predominantly female workforce with nearly three-quarters of Health Trainers being female (73%) and just 20% being male. This data was not reported nationally so comparisons cannot be made.

**Table 4: Gender of Health Trainers**

<table>
<thead>
<tr>
<th>Gender</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>284</td>
<td>73</td>
</tr>
<tr>
<td>Male</td>
<td>79</td>
<td>20</td>
</tr>
<tr>
<td>Not recorded</td>
<td>27</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>390</td>
<td>100</td>
</tr>
</tbody>
</table>

The majority of Health Trainers were white British (77%), and a further 5% Asian or Asian British – Pakistani (Table 5). The North West employs a higher proportion of white British Health Trainers than national data shows (68%).

**Table 5: Ethnicity of Health Trainers**

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>White – British</td>
<td>301</td>
<td>77</td>
</tr>
<tr>
<td>White – Irish</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Other White Background</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Mixed - White and Black Caribbean</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Asian or Asian British - Indian</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Asian or Asian British - Pakistani</td>
<td>19</td>
<td>5</td>
</tr>
<tr>
<td>Asian or Asian British - Bangladeshi</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Any Other Asian Background</td>
<td>2</td>
<td>0.5</td>
</tr>
<tr>
<td>Black or Black British</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>Chinese</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Not recorded</td>
<td>31</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>391</td>
<td>100</td>
</tr>
</tbody>
</table>

Just over half of the Health Trainers (57%) came from the two most deprived fifths of areas, with just 8% from the least deprived fifth of areas (Table 6). This was very similar to that national proportions (55% and 8% respectively).

**Table 6: Health Trainers by deprivation quintiles**

<table>
<thead>
<tr>
<th>Deprivation quintiles</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 - Most deprived</td>
<td>140</td>
<td>36</td>
</tr>
<tr>
<td>Q2</td>
<td>83</td>
<td>21</td>
</tr>
<tr>
<td>Q3</td>
<td>51</td>
<td>13</td>
</tr>
<tr>
<td>Q4</td>
<td>51</td>
<td>13</td>
</tr>
<tr>
<td>Q5 - Least deprived</td>
<td>30</td>
<td>8</td>
</tr>
<tr>
<td>Unknown</td>
<td>36</td>
<td>9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>391</td>
<td>100</td>
</tr>
</tbody>
</table>
Most Health Trainers were well educated, with nearly equal proportions having been to university (35%) or college (34%). Seventeen percent had reached GCSE level.

104 Health Trainers have left their position since being employed, which constitutes 26% of the total workforce employed as Health Trainers since 2005. Of those that had left their position, 35% found alternative NHS employment, 28% were employed outside of the NHS, and 4% went on to further training or education (Figure 2).

**Figure 2: Reason for leaving position as Health Trainer**

There are no discernible demographic patterns with regard to the type of Health Trainers that left their position. Indeed, these tend to mirror the proportions employed as Health Trainers i.e. 74% were female, 36% were aged between 26 and 35, and 79% were white British.

**Outcome 2 - Reaching the ‘hard to reach’**

Some 41,365 clients from the North West have been included on the DCRS database up to August 2010. Figure 3 shows that the total number of clients varies across the 18 services, largely determined by the length of time that the service has been in operation, the model of care that is followed, and the number of Health Trainers in post.

**Figure 3: Number of clients per organisation**
The two main ways through which clients heard about the services were through a promotional event (40%), and via a referral (34%) (Table 7). However, word of mouth (9%) was important to a lesser extent. In comparison, the national report found that just 31% heard about the service via a promotional event, 38% through referral and 14% via word of mouth.

Table 7: How clients heard about the service

<table>
<thead>
<tr>
<th>Method</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity</td>
<td>21</td>
<td>0.05</td>
</tr>
<tr>
<td>At work</td>
<td>483</td>
<td>1</td>
</tr>
<tr>
<td>By being referred</td>
<td>13,867</td>
<td>34</td>
</tr>
<tr>
<td>Community services</td>
<td>388</td>
<td>1</td>
</tr>
<tr>
<td>Local media</td>
<td>694</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>2,123</td>
<td>5</td>
</tr>
<tr>
<td>Other care services</td>
<td>933</td>
<td>2</td>
</tr>
<tr>
<td>Poster / leaflet</td>
<td>2,315</td>
<td>6</td>
</tr>
<tr>
<td>Promotional event</td>
<td>16,584</td>
<td>40</td>
</tr>
<tr>
<td>Website</td>
<td>1</td>
<td>0.0</td>
</tr>
<tr>
<td>Word of mouth</td>
<td>3,927</td>
<td>9</td>
</tr>
<tr>
<td>Not recorded</td>
<td>29</td>
<td>0.1</td>
</tr>
<tr>
<td></td>
<td>41,365</td>
<td>100</td>
</tr>
</tbody>
</table>

Although client numbers peaked in the 36-45 and 46-55 years age bands (18% in each), there was a fairly even spread across the older age bands, with 13% of clients in the over 65 group (Figure 4). However, fewer clients were in the younger groups (8% were aged 18-25 and 1% were under 18 years of age). These figures are comparable to the age breakdown reported in the national dataset.

Figure 4: Age of clients
Nearly twice as many females as males used the Health Trainer scheme (65% compared with 33%). The majority of clients were white British (78%), with a further 6% Asian / Asian British, Pakistani. However, the proportions varied according to the different services, and were proportionate to the local population. Within the North West there are slightly higher proportions of white British compared to the national DCRS data which listed 71% as white British, and 5% Asian / Asian British, Pakistani. No other ethnic groups were particularly well represented either in the North West, or nationally, although there were a range of clients from all listed ethnic groups.

Sixty-eight percent of clients came from the two most deprived quintiles, with decreasing numbers of clients as the deprivation level reduces (Table 8). Thus, only 4% of clients were from the least deprived areas.

Table 8: Clients by deprivation quintiles

<table>
<thead>
<tr>
<th>Deprivation quintiles</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No fixed abode</td>
<td>75</td>
<td>0.2</td>
</tr>
<tr>
<td>Q1 - Most deprived</td>
<td>20,170</td>
<td>49</td>
</tr>
<tr>
<td>Q2</td>
<td>7,854</td>
<td>19</td>
</tr>
<tr>
<td>Q3</td>
<td>4,837</td>
<td>12</td>
</tr>
<tr>
<td>Q4</td>
<td>3,481</td>
<td>8</td>
</tr>
<tr>
<td>Q5 - Least deprived</td>
<td>1,621</td>
<td>4</td>
</tr>
<tr>
<td>Unknown / Not recognised</td>
<td>3,327</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>41,365</td>
<td>100</td>
</tr>
</tbody>
</table>

It is not possible to compare this with the national report which only lists the most deprived / least deprived, not recognised and unknown.

A higher percentage were not registered with a GP in the North West (6%) than the national figure (0.4%).

Outcome 3 - Deliver sustained improvement to the health of the people of England through behaviour change.

Diet was the most important issue that clients wanted to address, with over half of all clients (54%) naming this as a priority. Almost a third of clients (29%) wanted to address the issue of exercise. Equal numbers wanted to cover smoking or a ‘local issue’ (7%). Just 3% gave alcohol consumption as their primary issue to be addressed (Table 9). These proportions are similar to those given in the national report.

Table 9: Primary issue

<table>
<thead>
<tr>
<th>Primary Issue</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>484</td>
<td>3</td>
</tr>
<tr>
<td>Diet</td>
<td>10,397</td>
<td>54</td>
</tr>
<tr>
<td>Exercise</td>
<td>5,517</td>
<td>29</td>
</tr>
<tr>
<td>Local issue</td>
<td>1,415</td>
<td>7</td>
</tr>
<tr>
<td>Smoking</td>
<td>1,413</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>19,228</td>
<td>100</td>
</tr>
</tbody>
</table>

Deprivation is measured by postcode deprivation scores, an overall average across indicators of income, employment, health deprivation and disability, education, skills and training, barriers to housing and services, crime, living environment (http://www.communities.gov.uk/communities/neighborhoodrenewal/deprivation/)
Nearly half of the sample did not require a personal health plan (48%), whilst for 24% information was unavailable. However, of those who had a plan, 48% achieved it, 26% part achieved it, whilst 15% did not achieve it. These proportions are similar to the national figures of 47%, 27% and 16% respectively. Half of all clients who had a personal health plan in relation to smoking achieved it, whilst 17% part achieved it. One-third (33%) did not achieve their personal health plan.

Table 10 shows of those clients that were signed off at the assessment stage, most had completed (45%) or part completed a personal health plan (PHP) (12%), information was not recorded for 23%, whilst in 7% of cases the client assessment was recorded as ‘did not attend’.

**Table 10: Reason for signing off from the service**

<table>
<thead>
<tr>
<th>Sign-off reason</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chose an alternative service</td>
<td>150</td>
<td>1</td>
</tr>
<tr>
<td>Client DNAs (did not attend)</td>
<td>1,541</td>
<td>7</td>
</tr>
<tr>
<td>Could not afford desired activities</td>
<td>28</td>
<td>0.1</td>
</tr>
<tr>
<td>Could not contact client</td>
<td>783</td>
<td>4</td>
</tr>
<tr>
<td>Did not follow plan</td>
<td>326</td>
<td>2</td>
</tr>
<tr>
<td>Did not realise commitment required</td>
<td>237</td>
<td>1</td>
</tr>
<tr>
<td>Disappointed with rate of progress</td>
<td>99</td>
<td>1</td>
</tr>
<tr>
<td>Insufficient support from significant others</td>
<td>28</td>
<td>0.1</td>
</tr>
<tr>
<td>Not ready to make changes</td>
<td>260</td>
<td>1</td>
</tr>
<tr>
<td>Only wanted some information</td>
<td>79</td>
<td>0.4</td>
</tr>
<tr>
<td>Other</td>
<td>700</td>
<td>3</td>
</tr>
<tr>
<td>PHP completed</td>
<td>9,554</td>
<td>45</td>
</tr>
<tr>
<td>PHP part completed</td>
<td>2,650</td>
<td>12</td>
</tr>
<tr>
<td>Recommended to primary care</td>
<td>63</td>
<td>0.3</td>
</tr>
<tr>
<td>Signpost only</td>
<td>1</td>
<td>0.0</td>
</tr>
<tr>
<td>Not recorded</td>
<td>4,960</td>
<td>23</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>21,459</td>
<td>100</td>
</tr>
</tbody>
</table>

Unfortunately there is no scope within the dataset to break down wellbeing indicators to client characteristics, thus only the overall picture is presented below. General health was recorded for just 2,168 clients (Table 11). The majority of clients recorded a positive change (77%) compared with 8% who reported a negative change. No change was reported for 15% of clients.

**Table 11: Change in general health score**

<table>
<thead>
<tr>
<th>Change</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative change</td>
<td>163</td>
<td>8</td>
</tr>
<tr>
<td>No change</td>
<td>336</td>
<td>15</td>
</tr>
<tr>
<td>Positive change</td>
<td>1,669</td>
<td>76</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2,168</td>
<td>100</td>
</tr>
</tbody>
</table>
According to the World Health Organization five item wellbeing scale, the majority of clients who provided before and after data reported a positive change (68%) whilst 13% reported a negative change (Table 12). Nineteen percent of clients reported no change. Again, it must be noted that data was only available for 1,868 cases, 5% of the total number of clients.

**Table 12: Change in wellbeing score**

<table>
<thead>
<tr>
<th>Change</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative change</td>
<td>245</td>
<td>13</td>
</tr>
<tr>
<td>No change</td>
<td>353</td>
<td>19</td>
</tr>
<tr>
<td>Positive change</td>
<td>1,270</td>
<td>68</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,868</td>
<td>100</td>
</tr>
</tbody>
</table>

Self-efficacy showed the least positive change of the wellbeing measures (Table 13). 55% reported positive change, 11% a negative change whilst one-third (34%) reported no change. As with the other wellbeing measures data was only obtained for 2,244 clients, just 5% of all clients.

**Table 13: Change in self efficacy score**

<table>
<thead>
<tr>
<th>Change</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative change</td>
<td>258</td>
<td>11</td>
</tr>
<tr>
<td>No change</td>
<td>758</td>
<td>34</td>
</tr>
<tr>
<td>Positive change</td>
<td>1228</td>
<td>55</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2244</td>
<td>100</td>
</tr>
</tbody>
</table>

**Outcome 4 - Providing access to, and encouraging the appropriate use and uptake of NHS and other local services.**

There are very few indicators that measure progress with regards to Outcome 4. However, Table 14 shows that whilst a large number are self-referrals, there does appear to be considerable integration with other services, notably the GP or primary care services (18%) and lifestyle risk management services (17%) who have referred clients to the Health Trainer service.

**Table 14: Referral to Health Trainer service**

<table>
<thead>
<tr>
<th>Client referred by</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advice and guidance</td>
<td>291</td>
<td>1</td>
</tr>
<tr>
<td>Community / voluntary services</td>
<td>7,302</td>
<td>17</td>
</tr>
<tr>
<td>Disability services</td>
<td>11</td>
<td>0.03</td>
</tr>
<tr>
<td>Emotional wellbeing services</td>
<td>282</td>
<td>1</td>
</tr>
<tr>
<td>GP or other primary care services</td>
<td>7,706</td>
<td>18</td>
</tr>
<tr>
<td>Health Trainer services</td>
<td>651</td>
<td>2</td>
</tr>
<tr>
<td>Hospital services</td>
<td>436</td>
<td>1</td>
</tr>
<tr>
<td>Lifestyle risk management services</td>
<td>7,371</td>
<td>17</td>
</tr>
<tr>
<td>Local authority services</td>
<td>1,121</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>1,335</td>
<td>3</td>
</tr>
<tr>
<td>Self</td>
<td>15,566</td>
<td>37</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>42,072</td>
<td>100</td>
</tr>
</tbody>
</table>
Summary of intelligence data

Whilst over 390 Health Trainers have been employed in the North West, the number per organisation varies considerably between the 18 PCTs who subscribe to the DCRS.

Over 41,000 clients have been recorded on the DCRS database up to August 2010, although figures vary enormously between the different organisations.

Most Health Trainers are aged between 25-45, female, white British and well educated. However, they are more likely to come from deprived areas.

Clients, however, have a range of ages, although nearly twice as many are female than male, and the majority are white British. Two-thirds of clients come from the most deprived areas.

Half of the clients wanted assistance with their diet, and a third with physical exercise. Few wanted assistance with alcohol consumption.

Although a large proportion of clients did not require a personal health plan (or the information was unavailable) those that had a plan were likely to achieve or part achieve it.

The three health and wellbeing indicators showed that most clients had a positive change in outcome.

Two-thirds of clients came from the two most deprived quintiles, with decreasing numbers of clients as the deprivation level reduces. Thus, only 4% of clients were from the least deprived areas.

Conclusions and Recommendations

Current service provision across the North West is unequal and as such it would be inappropriate to compare services that are not alike. However, it is clear that there is flexibility within the service provision, which seems to ensure the services are delivered in the most appropriate way, and are targeted to meet the specific needs of the local population that they serve.

Many of the findings from the North West evaluation reports mirror those from around the country and largely demonstrate that the service is valued by clients, stakeholders and Health Trainers alike. The service is clearly valued for its unique one-to-one, down to earth approach which seems to foster a valuable relationship between client and Health Trainer. Unfortunately, this has a downside in that Health Trainers then become the focus for clients more complex, usually mental health needs, which was not the direction envisaged by the Department of Health when it set up the service. Health Trainers are thus left feeling unconfident about their abilities to help and require further training for a role that may or may not be part of their job.

There is recognition that whilst Health Trainers do gain considerable job satisfaction, the comprehensive nature of their job leads them to feel that their wages do not represent the actual work they do. Furthermore, there is agreement that lack of opportunities to progress within the service mean they have to step outside, to gain promotion.

Although the North West has the highest number of Health Trainers nationally the services in individual boroughs are relatively small. As Health Trainer services have a variety of priority populations and settings, there are, inevitably, some misconceptions and misunderstandings about the role of Health Trainers amongst those that have had little direct involvement with their local Health Trainer service. A key challenge resulting from this has been the need to appropriately promote local services without creating a demand that the service does not have the capacity to meet. This is also linked to perceptions of the title ‘Health Trainer’, which can be associated with ‘personal trainer’. As a new public health workforce, this can be overcome in time, working with both clients and referral agents.
Data from the North West DCRS show that although Health Trainers come from a wide ranging background, the most 'typical' Health Trainer would be aged around 35, female, white British, living in a deprived area but educated to college or university standard. The evidence from evaluation reports would suggest that this is partly due to the standard NHS recruitment process, which tends to favour those who are more capable, confident and able to complete a person specification form. As a result, suggestions have been made to bring in more local people who are unqualified or currently out of work and train them up for the role. This appears to have had some success where it has been adopted. However, the challenge of this is reportedly that these individuals do need considerably more support when in post.

The data also shows that the North West services appear to be reaching clients who live in the most deprived areas, and representative of all age groups including the over 65s. However, the majority of clients are female and relatively few are recorded as being in a vulnerable group according to the variable 'community of interest'.

With regard to delivering sustained improvement through behaviour change, it can be seen that most clients wanted assistance with diet and exercise, and that three-quarters achieved or partly achieved their PHP outcome. Similarly, there were positive changes with regard to the wellbeing indicators, although there were a minority of clients who reported negative changes in each individual category. This would suggest that, where relevant, the Health Trainer scheme had a positive effect on their clients’ health and wellbeing. Whilst the qualitative data suggests not all clients want to pursue a PHP goal, or achieved their goal, it is also clear that there were knock-on effects for those around them, who also altered their behaviour in tandem. Furthermore, with changes in health behaviour, clients report feeling more confident a point which is substantiated by over half the clients demonstrating a positive change in self-efficacy. This may act as a ‘kick-start’ to further health changes or to changes in personal circumstances such as seeking employment, promotion or training.

The DCRS dataset provides a wide variety of information on the Health Trainer service, both local and national data can be interrogated and displayed visually. However, there is a large amount of missing and/or unreported data in the DCRS dataset, which suggests that improvements are needed in ensuring that information is input in a timely and consistent manner in order to maximise its potential as a reliable tool.

A key benefit in promoting the impact of Health Trainer services is the Value for Money tool developed in 2010 which provides an easy to use calculator enabling local services to present commissioners with a tangible measure of the impact of the service. In the current economic climate and public sector financial position, this is an invaluable asset in presenting the impact and outcomes of this frontline public health service in relation to the potential health and social care costs of not prioritising early, health promoting interventions.

Recommendations

- The Health Trainer service will benefit from a refreshed communication strategy that reflects the move to empowering local communities to improve health and wellbeing that is described in the Public Health White Paper: Healthy Lives, Healthy People. In line with the White Paper, further publicity would seem to be necessary in order to promote the service to both clients and health professionals including new GP commissioning structures and local government.

- Targeted recruitment, particularly towards men, may help to address the gender imbalance both within the Health Trainers and the clients.

- In order to recruit a higher proportion of unqualified and workless Health Trainers in some services, the recruitment process may need to be less formal, or provide more assistance for those who have difficulty in filling in forms such as person specifications.

- Reaffirming the role of the Health Trainer is needed to reflect changes to the public health system through the Healthy Lives, Healthy People White Paper. This would appear to be necessary both for stakeholders and clients, and also for the Health Trainers themselves. This would benefit the referral process, workforce retention, and Health Trainers’ training needs.
• Recognition is needed amongst service commissioners and providers of the complex needs of clients, which may not become apparent until the client is comfortable with the Health Trainer. From this, decisions need to be taken about whether such clients can benefit from the Health Trainer service. If so, more appropriate training is needed for the Health Trainers, as well as greater recognition of the complexity of the role. If the service is not appropriate for such clients, then there needs to be appropriate services the Health Trainer can refer to immediately in order that the client is not left in a vulnerable position.

• The Health Trainer service is well placed to support local communities to tackle poor health and low aspiration and the service should continue to work with general practices to ensure that the emerging model for GP commissioning includes an understanding of the Health Trainer model and the support that it can provide to individuals to improve their health and wellbeing.

References


Appendix 1: Additional Case Studies

Impaired Glucose Tolerance (IGT) – NHS Bolton

NHS Bolton are delivering a pilot scheme around intensive lifestyle intervention for people with impaired glucose tolerance (IGT) through their Health Trainer services. The aim is to prevent or delay the onset of type 2 diabetes. Evidence from randomised controlled trials (Ratner 2006, Lindstrom et al 2006) have shown that intensive lifestyle interventions can reduce IGT risk by up to 58%. The idea behind the pilot is for the Health Trainers to help patients understand their condition better, acquire skills and knowledge to enable them to implement and sustain lifestyle changes. They will also assist them in engaging with local NHS and community services in a more effective way. They work using a mixture of face to face appointments as well as regular telephone support.

One of the tools they use is a risk score (an adapted version of the FINDRISC [Lindstrom and Tuomilhelto 2003]) which is used to identify people at risk of developing type 2 diabetes. All people with IGT will receive lifestyle advice through their allocated health trainer, their FINDRISC score will be recorded before and after the six month intervention in addition to a range of other cardiovascular risk factors.

The initial three month pilot in one practice was followed by a 10 month implementation phase across five practices which was due to be evaluated in December 2010.

Case Study

Following an oral glucose tolerance test (GTT), Patient A was found to have impaired glucose tolerance (IGT). At the initial appointment with the Health Trainer he was sceptical of being able to lower his risk of developing diabetes because he had a family history of diabetes and thought it inevitable that he would develop it.

The Health Trainer used the FINDRISC to show the patient his risk score (18, this being high risk of developing diabetes). She supported Patient A to undertake a full lifestyle assessment. Discussions took place about his daily intake of fruit and vegetables, physical activity levels, blood pressure, glucose readings and family history. Patient A developed a personal health plan supported by the Health Trainer. He identified the need to increase his physical activity levels and make small changes to his diet. They talked at some length about being ‘at risk’ and how he could reduce his risk of developing diabetes, by his own actions, particularly those in relation to his body shape. He took away some evidenced-based literature about effective weight loss, through eating well. He was also interested in looking at the local ‘Get Active’ website for ideas of how to exercise without damaging his knee further. The Health Trainer explained to him the concept of how to set himself SMART goals, which he took on board easily.

When the Health Trainer telephoned Patient A several weeks later, he was delighted with his own progress and keen to share the story of his success. At the three month review Patient A was no longer eating any sugary snacks or fried food during the working week and was making a large fruit salad, some of which he took to work to eat between meals, the remainder he finished during the evening. He also spent 30-40 minutes per day on his daughter’s cross trainer, whilst watching the evening news. He had reduced his BMI to 24.8 and his waist circumference by 10cm to 88cm. These changes had brought his FINDRISC score to 12. At the six month review a repeat GTT was undertaken with blood glucose levels reduced to 4.4. Patient A was amazed by the reduction in his glucose levels and extremely pleased with his progress.
Working with clients who are in a recovery programme – Wirral PCT

Wirral PCT employ a Health Trainer who works with clients in the drugs and alcohol action (DAAT) recovery programme. The Health Trainer works with the individual to assist them in making individual changes and signposts them to community services. The position is jointly funded and the full-time Health Trainer works alongside a Health Advisor. Within the recovery programme there are a number of supporting interventions and programmes for clients. These include ARCH Aftercare which prepares clients for employment, training and education using a combination of support services and activities including art and crafts; Spider Project, which provides a range of activities including creative writing, photography football coaching and Outward Bound activities; SHARP, a programme providing 48 days of treatment full-time and part-time with one-to-one counselling, group workshops, relapse prevention and life skills; and Phoenix Conservation, which enables recovering users to help rebuild and restore environmental projects, whilst providing skills and training for work beyond detox. The Health Trainer scheme within the recovery programme has proved to be successful with high demand for the service, which has led to the creation of a second post to be started shortly in the Treatment Tier of the programme. In the three months between September and November 2010, 42 DAAT referrals were seen by Health Trainers.

The Breastfeeding Initiative – Bury PCT

On initiation of the scheme staff received Le Leche peer support training and some also attended the three day UNICEF baby friendly course. The service is growing due to the targeted promotion of this service at health visitor and midwifery forums as well as local children’s centres.

Between January and November 2010 Health Trainers visited 40 different clients in their own homes, with the remit to support normal breastfeeding in liaison with the client’s midwife or health visitor. Health Trainers mentorship is provided by the Infant Feeding Coordinator for Bury and the service is represented at the local breastfeeding working party. The Health Trainers offer support and encouragement to breastfeeding mums and can offer information on latch and positioning, feeding patterns, sucking patterns, feeding on demand, mastitis, thrush, nipple shields, self-care and expressing and storing breast milk.

Depending on the nature of the support needs, the aim is to conduct a home visit (if needed) within 48 hours of the initial referral. A one-off visit to provide general information may be offered or more intensive support where there is client contact many times with a combination of home visits and telephone support over a short period of time. When the issue is resolved, then Health Trainer then works with the client to boost confidence and reduce contact. Although the Health Trainer keeps record of visits on the bespoke Health Trainer electronic database, they are also required to record the details of the visit in the client’s hand held records, the ‘Red Book’.

When it is recognised that a breastfeeding issue falls outside of what would be considered ‘normal’ the client is signposted to their local healthcare professional and the client’s health visitor/midwife informed.
Case study

The Health Visitor requested that we offer support to her client who was experiencing difficulties breastfeeding. The five week old baby was receiving one formula feed a day and was sleeping through the night. Baby was reported to be very fractious at the breast and weight gain was becoming a concern. An initial home visit was arranged for the next day.

On assessment, I found the following support needs: baby was extremely agitated during breastfeeding and struggled to stay latched at the breast; baby’s positioning at the breast would need some work and he was exhibiting behavioural cues that he was hungry following a breastfeed; client was giving the baby a dummy as she perceived that baby was ‘using’ her for ‘comfort’ and would take the baby off the breast when she perceived that baby was no longer actively feeding (this was usually five to ten minutes into a feed).

Action taken/intervention: explanation of normal/usual feeding behaviour in newborn babies and the importance of feeding on demand; explanation of cluster feeding and importance of night feeding; emphasis on the need to feed every two to three hours to ensure and increase milk supply to meet demand; explanation of sucking and swallowing patterns and the importance of allowing baby to end the feed; how to recognise baby’s feeding cues and to feed on demand; importance of good latch and attachment in effective transfer of milk; demonstration of principles of correct latch; demonstration of hand expression of milk; information on how to increase milk supply by expressing.

At a visit two days later, the client was very upset and tearful, unable to express any milk (one ounce), the baby was constantly hungry and rooting, with wind and colic, and had not had a bowel movement for four days. I recommended that client see her GP regarding possible lactose intolerance and reflux ‘diagnosis’ and also to discuss nipple symptoms should these prove to be ongoing. The client’s health visitor was informed of issues and I recommended client go to bed and rest with the baby and feed on demand. At a visit three days later the baby had been diagnosed with reflux; however, I provided support and reassurance. The client felt that breastfeeding was going well, that she felt much more confident latch and positioning were much improved. I observed a feed, all looked correct and arranged a telephone appointment. The client reported that without the support from the Health Trainer service, she would not have continued to breastfeed.

Sleep Deprivation – Bury PCT

All Health Trainers who work in the topic area of sleep are provided two full days of training (with regular updates) which was delivered in-house by either the mental health team or by senior staff working in this topic area. Fifty-five clients have been seen since the service started in January 2010 (up to November 22 2010).

Many clients self-refer into this service, but there are some who have been signposted by their GP whom they have often approached for medication. Some clients have experienced insomnia for many years, even decades, and can, on occasion, present as low in mood with either a history of sickness absence from work or with low level mental health issues such as stress, depression and anxiety. Principally, the service tends not to work with people who are actively misusing non-prescription drugs and medications or who are drinking alcohol at a level that would indicate dependency. At a first appointment, the Health Trainer conducts a sleep assessment/history which is designed to identify what particular issues are impacting on the client’s sleep, issues such as: lifestyle, beliefs about sleep, sleep hygiene, thoughts and behaviour related to sleep, routines, health and wellbeing and responsibilities. Clients are asked to complete sleep diaries which helps to identify whether a particular action or inaction is impacting on the client’s sleep. They also give the Health Trainer a ‘baseline’ from which to build on as clients are asked to give their sleep a score based on perceived quality. Clients would usually receive six sessions with a Health Trainer. During the sessions, the Health Trainer will seek to identify changes the client can make to their current routines, choices and thought patterns. Clients are also taught various distraction and relaxation techniques, including deep breathing and muscle relaxation. If it becomes clear that a client’s physical or mental health is having an impact on their ability to sleep or to action
the interventions agreed, then with the client’s agreement, a referral will be made to IAPT or the client signposted to the appropriate health professional. The success of this service is based upon a ‘before and after’ comparison of the client’s perceived quality of sleep, quantity of sleep and the merit of the interventions made.

Case study

The client worked shifts and was experiencing work-related stress and anxiety. The client is a carer who works shifts and says she is unable to relax or ‘switch off’. She did not have a regular bedtime routine, and consequently is exhausted. She was advised to switch to decaffeinated drinks after 16:00, stop watching TV when in bed, and only go to bed when tired. She was taught relaxation techniques, and also signposted to Bury Carers Service.

At a follow up the client reported significant improvement in her sleep pattern. Her stress levels were better controlled and she felt calmer and more able to deal with stressful situations.

The health and wellbeing of the client has improved immensely. She had learnt to identify stress triggers and put into place relaxation techniques before the stress got out of hand. In addition, with the changes the client had made as part of her bedtime routine, her sleep had improved too.

The Vascular Health Check Programme – Blackburn with Darwen

Blackburn with Darwen has CVD mortality rates significantly higher than the national average, with a prevalence that is not homogeneous, but disproportionately represented among the lower socioeconomic groups. In response to this, the Health Trainer service delivers a vascular Health Check programme in partnership with Blackburn with Darwen NHS. In addition to the GPs providing the CVD health checks, Blackburn with Darwen provide CVD checks in the community as well to reach the hard to reach groups.

The community nurse provides the health checks and there are five Health Trainers that each attend the venue where the health checks are taking place once a week to provide the information, support and guidance for behaviour change.

Case Study - Male CVD Clients

“Following an invitation for all staff to attend a health check up, and considering at that time I did consider that I was in the ‘risk’ category, I attended the consultation. I did have some knowledge of how to live a healthy balanced lifestyle, but sadly did not apply it, using excuses to avoid addressing the real problems I had. The health check confirmed my own feelings that, I was overweight, not getting enough exercise and simply not eating a healthy diet. Indicators such as BMI and waist measurements were simply too high. On being offered the opportunity to see a Health Trainer, I readily agreed and began to see her every three to four weeks. Initially, although the advice was good, accurate and valuable, I did not take heed and still used excuses to explain my still less than healthy lifestyle. These early meeting did actually highlight that I wasn’t that far away and that a few subtle changes would be of considerable benefit.

Eventually, I did make the changes, with the constant support of the Health Trainer, I have now managed to sustain a full month of this, what I now call the ‘new me’, my diet is good and well balanced, I have introduced more physical activity, for example I attend a weekly yoga class and have joined a rambling club, a weekly squash game and regular ballroom dance classes. I now feel there is a balance to my life, my weight has started to reduce, 3.5 kgs in the four week period. I do feel that without this service I would still be putting off addressing these issues, it has been her support that has enabled me to address the issues which I do believe will change my life for the better. The help this service has given me has been invaluable and is greatly appreciated.”
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