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**INSTITUTE FOR HEALTH
AND WELLBEING**



Health Trainers End of Year Review 1st April 2013 – 31st March 2014

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A critical assessment of health trainer activity, with particular reference to the most deprived social groups, and a focus on mental health and wellbeing.

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A Report Utilising Data Collection &
Reporting Service Data
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1 SUMMARY OF KEY FINDINGS

This review has identified the key findings listed below in respect to Health Trainer Services.

1.1 KEY FINDINGS



1377 (= 919 full time equivalents) health trainers were recorded in the DCRS system as working with 97,248 clients in England in the financial year 2013-14 (for more information see pages 7 & 13).

Health trainers continue to reach out to those in the greatest need: 43% of clients were from areas of high deprivation (Quintile 1), with a further 24% in Quintile 2 (for more information see pages 9-10).



32% of health trainers were from the most deprived areas (Quintile 1) with a further 20% from Quintile 2. 40% of health trainers lived in the same area as their clients. Health trainers and their clients were also matched on some other characteristics (for more information see pages 13).

More than 59% of clients who had initial contact with a health trainer went on to develop a full personal health plan (PHP); 13% were signposted to other services and 8% were given advice and guidance (for more information see page 16).



49% of clients who completed a personal health plan achieved the goals they set as part of their PHP, and a further 23% part achieved them (for more information see page 17-18).

There was no substantial variation in achievement of personal health plan goals by client characteristics (for more information see page 18).



Self-efficacy, General Health and WHO-5 wellbeing scores all improved following development of a personal health plan (+10.82%, +25.88% and +30.88% respectively) (for more information see page 19-20).

Clients who achieved their personal health goals also had greater improvements in self-efficacy (+12.38% vs -6.01%), general health (+28.05% vs +6.71%) and WHO-5 wellbeing (+33.86% vs +4.11%) scores, compared to those who did not achieve their health goals (for more information see page 23).



This report summarises health trainer activity in the financial year 2013-2014, using data recorded on the Data Collection and Reporting Service (DCRS). Not all health trainer services use the DCRS to record their activity (some use other systems and some do not use electronic systems at all), so the figures in this report do not represent the whole picture of what health trainers are doing nationally. Nevertheless, with approximately 60% of health trainer services are still using the DCRS; it is a vital central resource for assessing the activity of health trainers in England.

Recent reports have focussed on aspects of the health trainer system such as behaviour change (UCL, 2013) and commissioning (RCPH, 2013). This report summarises health trainer activity in general, but has a particular focus on mental health and wellbeing, in relation to client demographics and achievement of personal health plan goals.

3.1 THE HEALTH TRAINER MODEL

The concept of health trainers was introduced into health policy in 2004, through the white paper *Choosing Health: making healthier choices easier* (Department of Health, 2004)¹. Utilising a community-based workforce model, it was intended that the introduction of health trainers would reduce health inequalities in England by working with disadvantaged groups (Durantini et al. 2006).

Health trainers offer personalised support to those considered socially disadvantaged or ‘at risk’ to make healthy lifestyle choices. Central to the health trainer model, it was intended that health trainers be recruited from disadvantaged groups, thus, focussing on providing ‘support from next door’ rather than ‘advice from on high’ (Department of Health, 2004). The Department of Health (2004) described health trainers as ‘guides’, with a role to assist individuals to actively set their own behavioural goals and self-manage their behaviour, through the provision of information and support. Core competencies of health trainers centre on “enabling individuals to change their behaviour so that they can improve their own health and well-being” (Department of Health, 2008:15). This is achieved through assisting clients to: identify how behaviours affect their health, develop PHPs and change and maintain their behaviour (Department of Health, 2008). Health trainer schemes do however adopt a range of different service models, operate in different settings and work with people with a variety of health needs. It should therefore be recognised that the role of health trainers is diverse and differs within and between sites.

3.2 FOCUS ON MENTAL HEALTH

Health trainers’ practice draws on a psycho-social model, where they are trained to draw on techniques to promote psychological wellbeing and behaviour change among clients. Such techniques may include motivational interviewing, goal setting, action planning, personal contracts, self-monitoring, self-efficacy development and reward systems (Department of Health, 2008).

Changes in psychological concepts, such as self-efficacy, mental wellbeing and perceived health, as well as impacting on lifestyle behaviours, are important outcomes in their own right, ultimately impacting on health inequalities. Notably, these outcomes are interrelated; with good mental health and wellbeing associated with improved physical health (Department of Health, 2011) and self-efficacy being linked to mental health (World Health Organisation, 2009), particularly self-esteem (Mann et al., 2004).

Psychological concepts are also important for behaviour change. For example, self-efficacy can be defined as belief in one’s ability to undertake a given behaviour and belief that that behaviour will lead to a given outcome. According to Bandura’s Social Learning Theory (1977), self-efficacy is therefore considered a predictor of success in behaviour change and maintenance. Moreover, self-efficacy is associated with perceived behavioural control and mental wellbeing (World Health Organisation, 2003). This complex interaction between

¹http://dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_133489.pdf

psychological concepts and behaviour change highlights their importance as outcomes for health trainer clients. Therefore, multiple strategies may be employed by a health trainer to increase a client's self-efficacy including, emphasising previous successes, role modelling, encouragement and increasing positive mood, as outlined in the health trainer handbook (Department of Health, 2008).

This report will add to the evidence base surrounding mental health and behaviour change in the context of health trainer services by focussing on these aspects and their interrelationship.

This section describes who is currently accessing those health trainer services in England that are using DCRS.

1. At least 97,248 people used health trainer services in 2013-14, with nearly a third based in the North West (Figure 1).
2. The age group using health trainer services the most, are people aged 46-55 years; however there is a good spread across all age groups (Figure 2).
3. More than two in three clients (68%) were female.
4. Two thirds (66%) were of white ethnicity (Figure 3), with almost 10% being of South Asian (Indian, Pakistani or Bangladeshi) ethnicity, and almost 4% Black African or Black Caribbean. The proportion of individuals from different ethnic backgrounds varied across regions.
5. Nearly half (43%) of clients were from areas of high deprivation (Quintile 1)² with a further 24% in Quintile 2 (Figure 4). This shows that health trainers are still reaching and targeting those they were intended to work with.
6. Whilst the proportion of clients from areas of high deprivation has decreased since 2011-2012, over two thirds of clients are from most deprived quintiles one and two (Figure 5).
7. The vast majority (96%) of clients were already registered with a GP.
8. 9% of those 55% of clients who answered the question about disability stated that they were disabled.
9. 1226 clients (1.5%) were in the prison or probation service.

The following figures illustrate the spread of clients by region (Figure 1), age (Figure 2), ethnicity (Figure 3) and deprivation quintiles (Figure 4).

² <https://www.gov.uk/government/publications/english-indices-of-deprivation-2010>

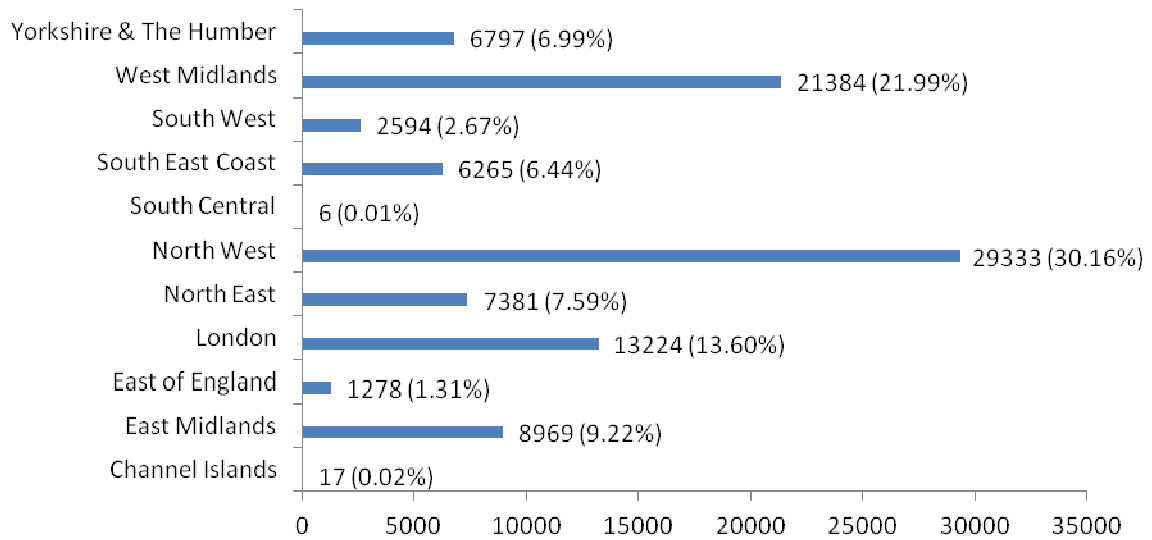


Figure 1: Number of clients per region

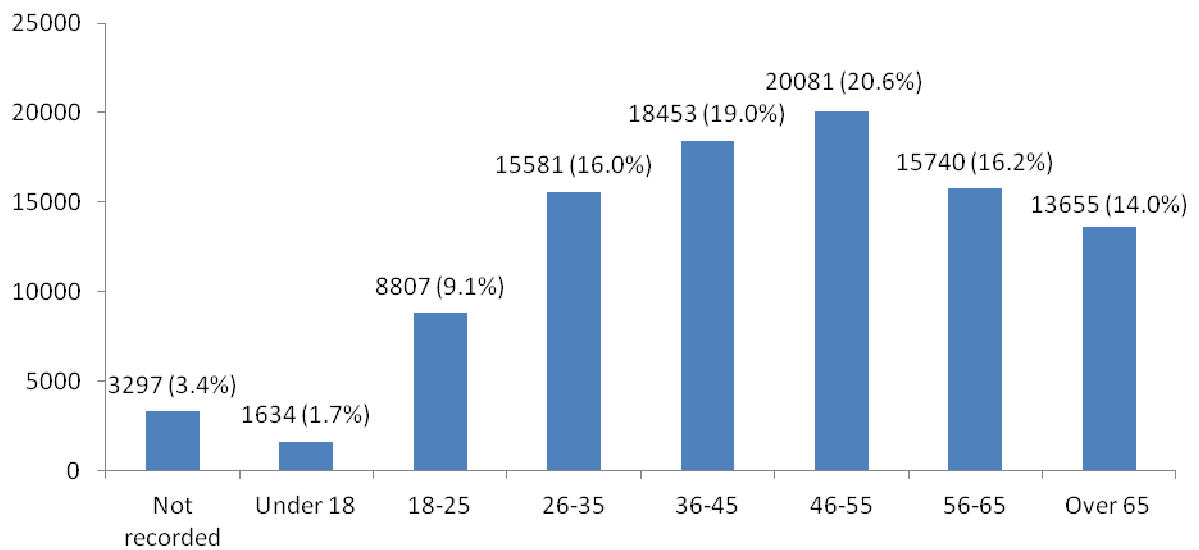


Figure 2: Number of clients by 10 year age band

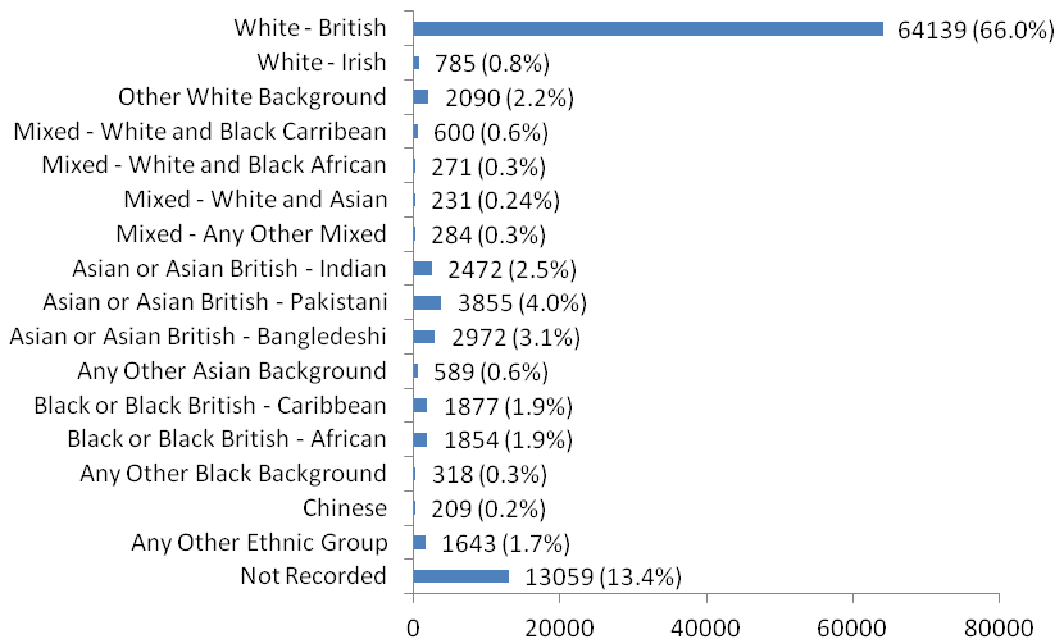


Figure 3: Number of clients by ethnicity

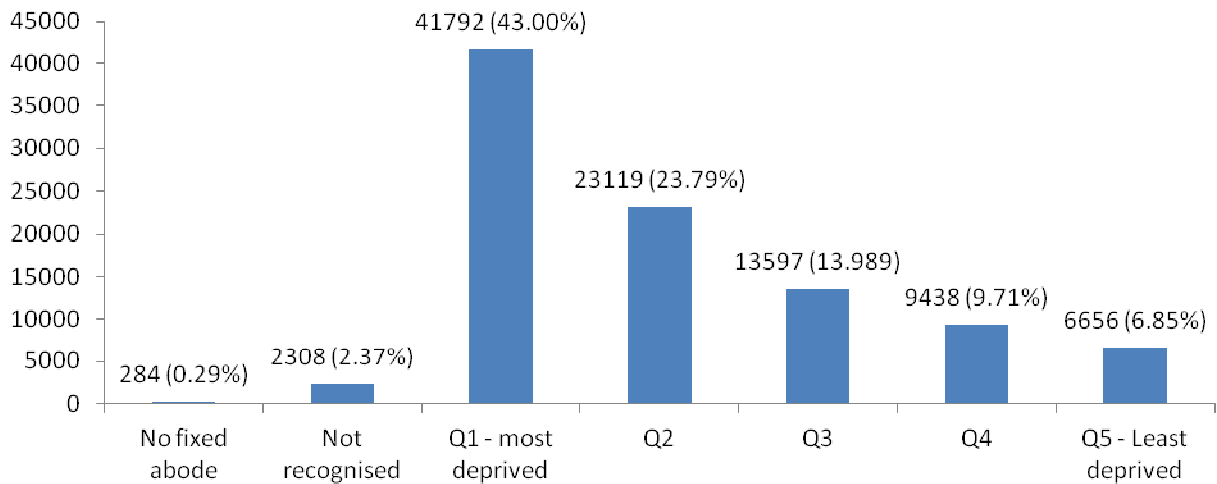


Figure 4: Number of clients by deprivation quintiles

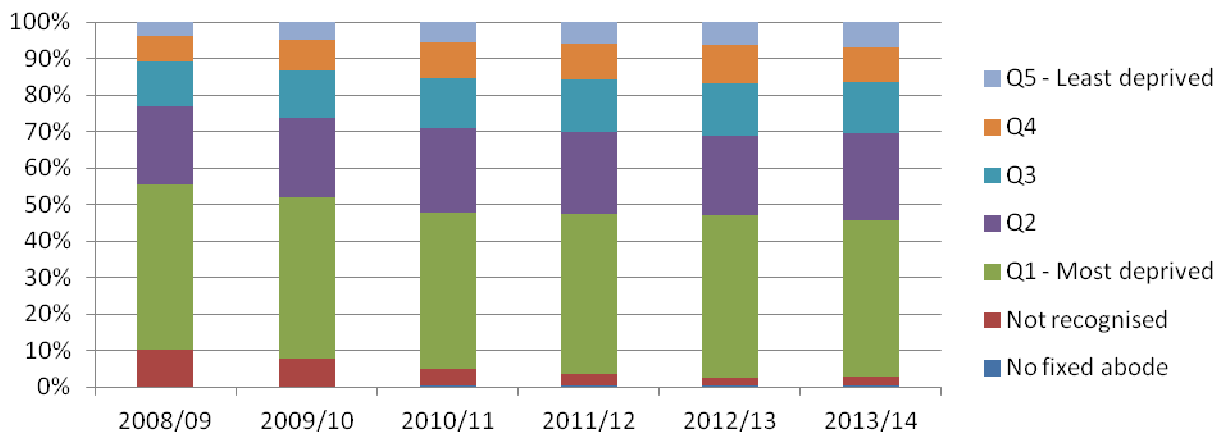


Figure 5: Deprivation quintiles by financial year

Table 1 and 2 describe how clients heard about (Table 1) and were referred into (Table 2) the health trainer service, with almost half (46%) of clients heard about the service from the person who made the referral, with 1 in 5 (21%) hearing of it at a promotional event and 12% by word of mouth. Of those who were referred, more than one third (37.6%, n=36586) were referred by the GP or other primary healthcare provider, 7% (n=6831) by community or voluntary services, and 6.25% (n=6079) by Lifestyle Risk Management Services. In addition, a large number of clients self-referred (37%, n=35972). The proportion of individuals being referred by the GP or other primary health care providers, (37%, n=36586) as well as community and voluntary services (7%, n=10501) are similar to 2011/12 figures for those who completed a PHP, whilst self-referral has decreased from 43% (n=68560) and referrals from the probation service increased from 0.6% (n=960) (DCRS, 2012).

Community engagement is a key health trainer competency – health trainers actively try to engage with the community rather than waiting for people to be referred. These findings show that health trainers continue to actively engage with the community, for example by holding promotional events and that these are an important way in which people find out about health trainers.

How They Heard About the Service (National)	Count	Percent
Not Recorded	375	0.39%
Activity	2931	3.01%
At Work	607	0.62%
By Being Referred	45180	46.46%
Community Services	6672	6.86%
Local Media	367	0.38%
Other	56	0.06%
Other Care Services	5932	6.10%
Poster/Leaflet	3182	3.27%
Promotional Event	20139	20.71%
Website	194	0.20%
Word of Mouth	11613	11.94%
Total	97248	100.00%

Table 1: How clients heard about the health trainer service

Referral Source (National)	Count	Percent
Not Recorded	25	0.03%
Advice and Guidance	2263	2.33%
Community/Voluntary Services	6831	7.02%
Disability Services	116	0.12%
Emotional Wellbeing Services	794	0.82%
GP or Other Primary Care Services	36586	37.62%
Health Trainer Services	3375	3.47%
Hospital Services	2230	2.29%
Lifestyle Risk Management Services	6079	6.25%
Other Local Authority Services	1751	1.80%
Prison	297	0.31%
Probation	929	0.96%
Self	35972	36.99%
Total	97248	100.00%

Table 2: How clients were referred to the health trainer service

4.1 CLIENT PROFILES

Health trainer clients represent a wide range of age groups, ethnicities and areas. However, the single most common characteristics set of health trainer clients, as recorded on the DCRS and detailed in Figure 6, were: age 46-55 years, White British female, Quintile 1 (most deprived), and heard about the health trainer service from the professional who referred them.

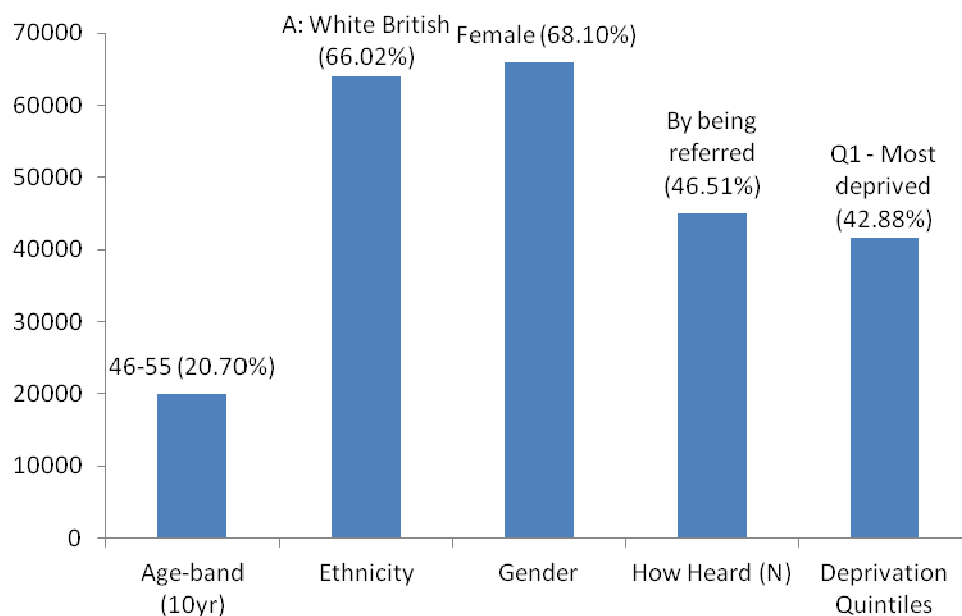


Figure 6: Most common client profile

Most Common Client Groups	Count	Percent
46-55	20059	20.70%
A: White – British	63973	66.02%
Female	65987	68.10%
By Being Referred	45074	46.51%
Q1 – Most Deprived	41549	42.86%
Sample Size	96904	100.00%

This section describes the characteristics of health trainers working in the financial year 2013-14 whose details were recorded on the DCRS.

1. There were 1377 (full time equivalent = 919) health trainers working in England, with 41% based in the North West or the West Midlands (Figure 7).
2. The age distribution of health trainers was slightly younger than that of clients, with age ranges 26-35 years and 36-45 years having the most health trainers.
3. As with clients, more than two thirds (69%) of health trainers were female.
4. And almost two thirds (63%) were white, with almost 10% of South Asian ethnicity and 6% of Black African or Black Caribbean ethnicity.
5. 30% of health trainers were educated to A-level and a further 30% to University level (Figure 8).
6. At the time of employment, 32% of health trainers were from the most deprived areas (Quintile 1) with a further 20% from Quintile 2.
7. Upon employment, 40% of health trainers lived in the same areas as their clients (Figure 9).

In Figure 8 below the educational level of health trainers is described and 13% are recorded as 'N/A' which indicates that they had no formal educational qualifications on appointment. This compares with 22.5% of people nationally who have no qualifications³.

A core aim of the health trainer programme is that health trainers come from the same geographic areas and deprivation quintiles as their clients, so we can see from Figure 9 that to an extent this continued to be the case in 2013-14. Employing people from areas of deprivation serves a dual purpose: to improve access for clients from those areas and to help people into work and jobs, both of which were original aims of establishing a health trainer workforce.

³ <http://www.nomisweb.co.uk/census/2011/QS501EW/>

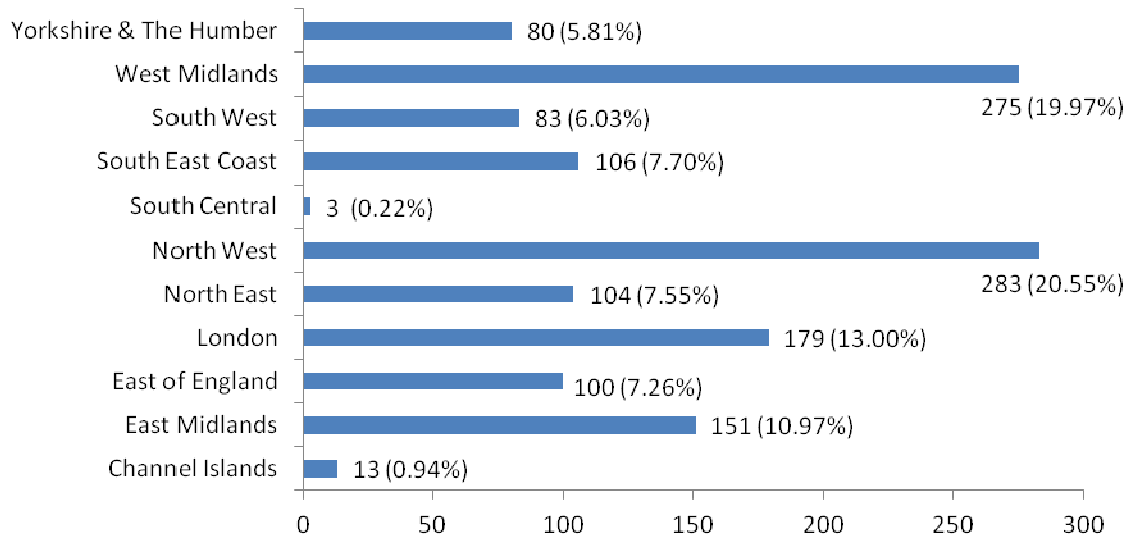


Figure 7: Number of health trainers by region

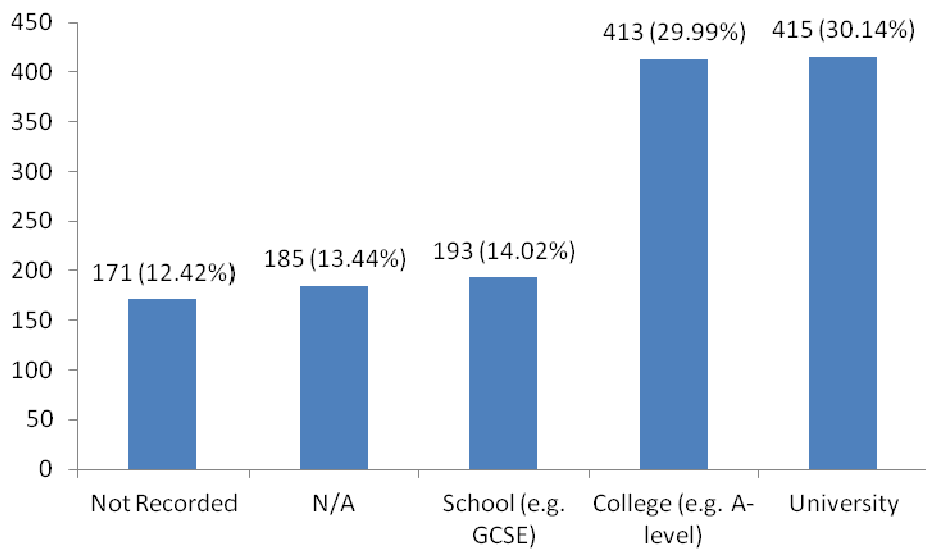


Figure 8: Number of health trainers by educational level

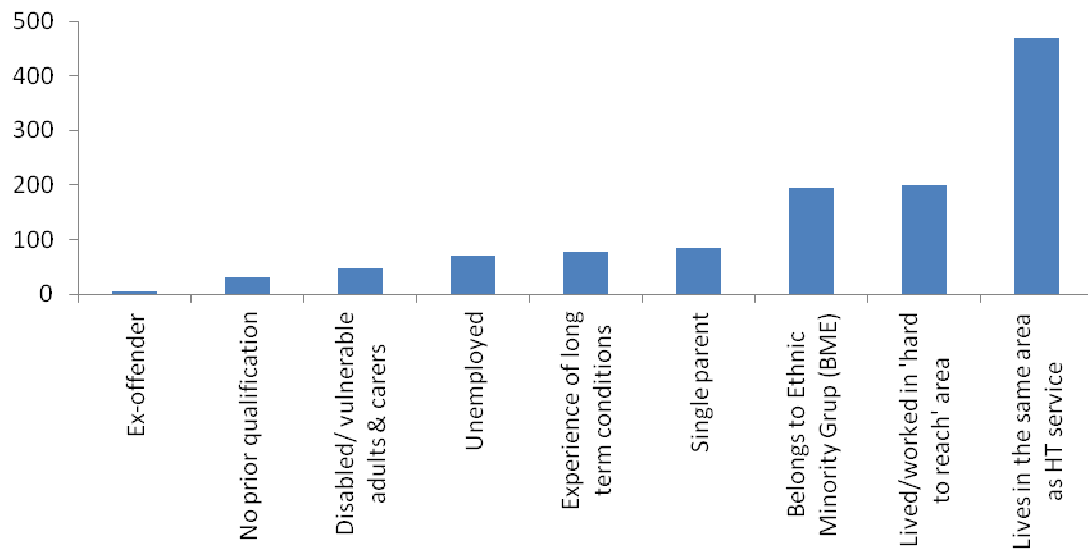


Figure 9: Additional personal information on health trainers

Additional Personal Information	Count	Percent
Ex-Offender	5	0.42%
No Prior Qualification	30	2.54%
Disabled/Vulnerable Adults & Carers	48	4.06%
Unemployed	71	6.01%
Experience of Long Term Conditions	77	6.52%
Single Parent	86	7.28%
Belongs to Ethnic Minority Group (BME)	195	16.51%
Lived/Worked in 'Hard to Reach Area'	200	16.93%
Lives in Same Area as HT Service	469	39.71%

Of those 96,080 clients recorded as having an initial assessment with a health trainer, 59% (56893) went on to develop a full PHP (Table 3), while 8% were given information and 13% were signposted to other services: the majority (42%) to lifestyle risk management services (such as smoking cessation or weight management), others to GP, advice or guidance, or community or voluntary services. Most clients with PHPs were working on diet as their primary issue (Figure 10).

PHP Stage Status	Count	Percent
PHP Not Set	39187	40.79%
PHP Set	56893	59.21%
	96080	100.00%

Table 3: Number of clients who had a PHP set

Most health trainer services retain the original PHP options (Diet, exercise, alcohol and smoking) but, commissioning models have diversified, perhaps encouraged by the movement of commissioning into local authorities and by government localisation policy⁴. Some services now offer a wider range of additional potential goals as recorded in DCRS, such as mental health, weight management, financial support, general health and dental health. With the exception of weight management, these are reflected in Figure 10 via the “other” category due to their low level usage

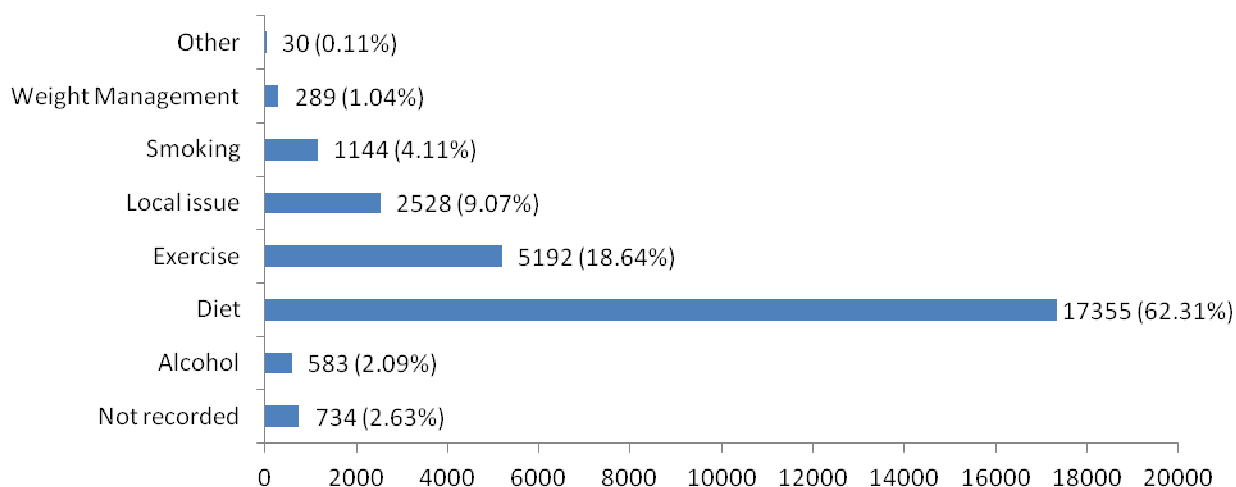


Figure 10: Primary issue chosen by clients with personal health plans

One of the key roles of health trainers is to enable clients to access other services and 13% of people who initially saw a health trainer were signposted to another service rather than developing a PHP with the health trainer. The range of services they were signposted to are described in Figure 11.

⁴ <https://www.gov.uk/government/policies/giving-local-authorities-more-control-over-how-they-spend-public-money-in-their-area--2>

For those clients who did develop a PHP, a referral to another service may be used to support the intervention and health trainers can accompany people to their first visit to the service or activity the client has been referred to if they lack the confidence to go alone (Figure 12).

Thus health trainers are performing an important role as a 'bridge' between clients who mainly come from areas of deprivation and services which they have not accessed previously.

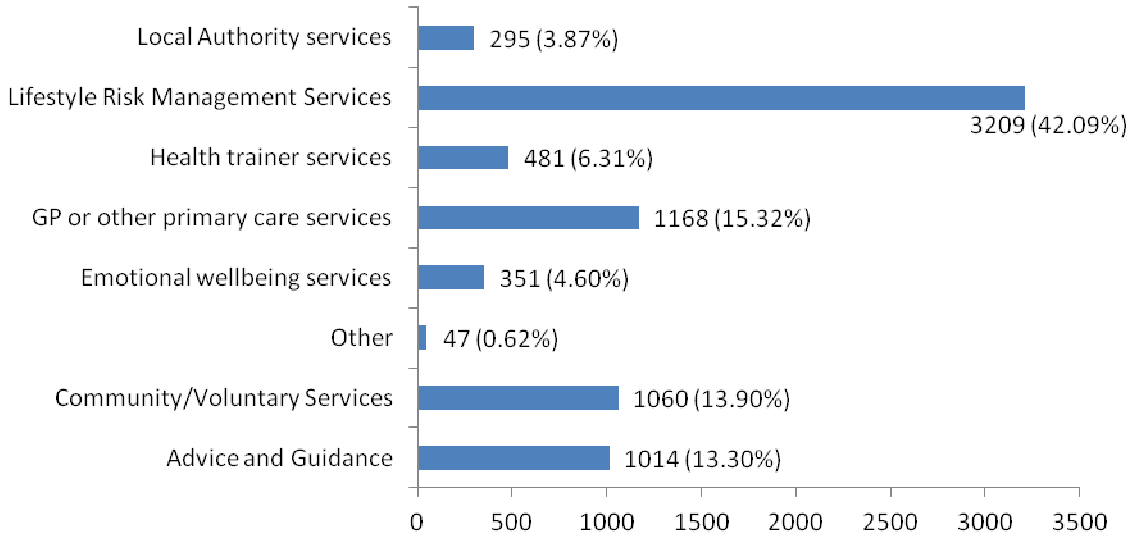


Figure 11: Services clients were signposted to

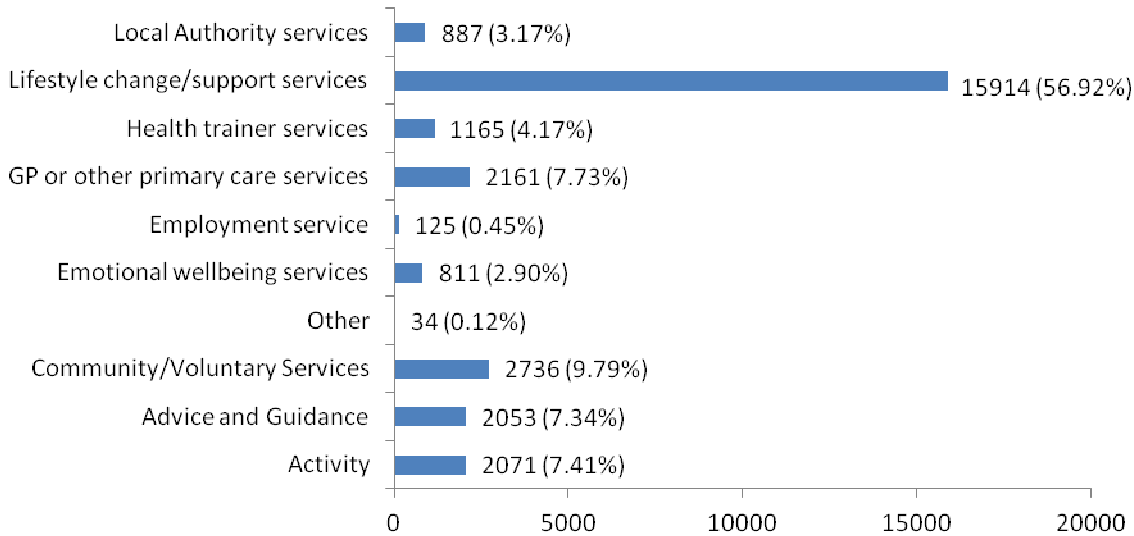


Figure 12: Services clients were referred to⁵

49.46% of those clients who set a PHP achieved their goals, and a further 23.05% part achieved them (Figure 13). 16.41% of those who set a PHP were lost to follow-up.

⁵ In both Figure 11 and Figure 12 some categories may overlap – for example lifestyle and emotional wellbeing services may be run by voluntary groups or within the local authority.

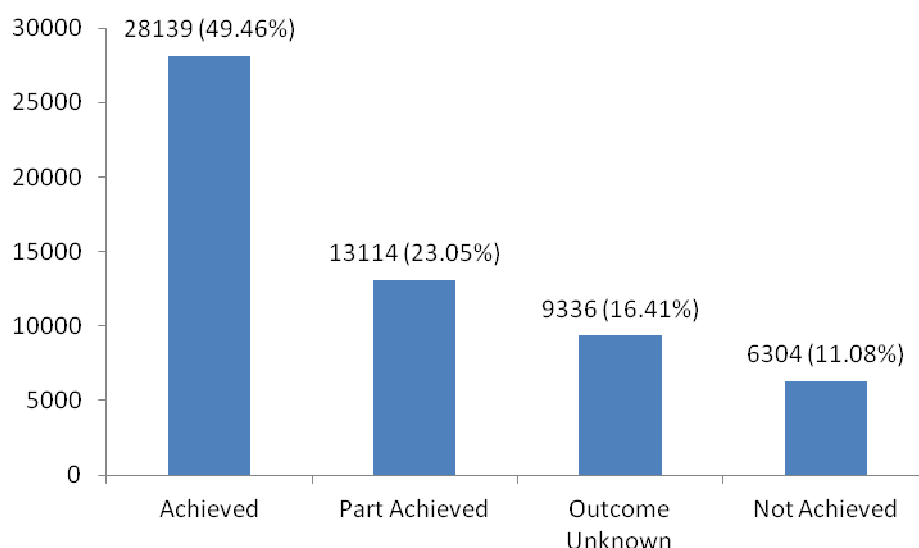


Figure 13: Number of clients who completed a PHP achieving personal health plan goals

An examination of client outcomes in relation to demographic characteristics revealed no notable gender differences in signposting and not many differences across quintiles. Those recorded as being of no fixed abode were much more likely to be referred to local authority (26.8%) or community and voluntary services (36.6%) than the rest of the population (3-4% and 9-14% respectively), and much less likely to be referred to lifestyle risk management services 4.2% versus 41-46%). Those in the probation service or in prison were more likely to be referred to GPs (32-33% versus 15%) and those in the probation service were more likely to be referred to community and voluntary services (36% versus 13%) than the rest of the population. People with long-term conditions, carers and long term unemployed were highly likely to be signposted to lifestyle risk management services (60%, 66% and 53% respectively). People who were disabled or had difficulty accessing services were most likely to be referred to GP or other primary care service.

This shows that the most deprived groups benefit the most from signposting and referral, which again highlights the important bridging role health trainers have in helping people to access services.

In terms of achievement of PHP goals, similar proportions of men and women achieved their goals, and there was no noticeable difference across age bands, deprivation quintiles, or ethnic groups, except that mixed (white and Asian or white and black African) were more likely to fully achieve but less likely to partly achieve their goals, these groups plus mixed (white and black Caribbean) were less likely to not achieve their goals, and mixed (other) were more likely to not achieve their goals. People who described themselves as disabled were about 5% less likely to fully achieve their goals but 5% more likely to partly achieve them, compared to non-disabled people. People in the prison or probation services were around 10% more likely to fully achieve their goals and 10% less likely to partly achieve their goals than the non-offending population.

The World Health Organisation defines mental health as a state of wellbeing in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community⁶. UK Figures show that one in four individuals will experience a mental health problem in the course of a year, with one in six experiencing a mental health issue at any given time⁷. Good mental health and wellbeing are associated with improved physical health (Department of Health, 2011), so, both in its own right and because of this link to physical health, improved mental health is an important outcome for health trainer services.

Overall, improvements in self-efficacy, general health and wellbeing following a health trainer intervention, were observed (Table 4, Figure 14). Self-efficacy scores improved by 10.8% on average, general health 25.9% and WHO-5 wellbeing 30.9%. Measures to assess mental wellbeing, including WEMWBS and SWEMWBS, were optionally introduced by DCRS in 2012, along with other measures for anxiety, depression and self-esteem, but all are less used than the self-efficacy, general health and WHO-5 ratings. Where the new scores were used, improvements in mental wellbeing were apparent, WEMWBS showed a 13.0% improvement in mental wellbeing scores, and SWEMWBS 27.2%.

Wellbeing Measure	Count	Before	After	Change
Self-efficacy	8720	67.55%	74.86%	+ 10.82%
General Health	16653	54.25%	68.29%	+ 25.88%
WHO-5	13483	45.76%	59.89%	+30.88%
WEMWBS	225	57.83%	65.43%	+13.14%
SWEMWBS	141	55.14%	70.16%	+27.24%

Table 4: Changes in wellbeing scores before and after health trainer intervention

⁶ http://www.who.int/features/factfiles/mental_health/en/

⁷ <http://www.mentalhealth.org.uk/help-information/mental-health-statistics/>

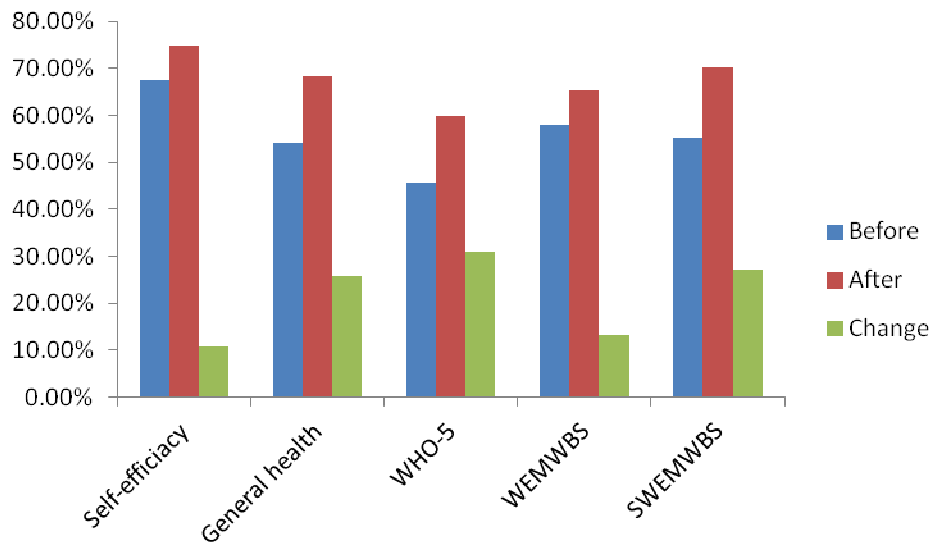


Figure 14: Changes in wellbeing scores before and after health trainer intervention

7.1 WELLBEING BY CLIENT DEMOGRAPHICS

7.1.1 Self-efficacy Scores

Self-efficacy scores improved across all deprivation quintiles. Men’s scores improved more than women’s (12.8% and 10.0% increase respectively). Improvements were seen across all age groups with the greatest improvement in the 18-25 year group.

Improvement was seen across all ethnic groups except Black Caribbean, which showed a 1.8% decrease, but this is probably an anomaly due to a small sample size. The greatest improvements were seen in the Mixed – White and Black African Group (14.4%) and “Any Other Ethnic Group” (39.0%).

There was a little difference in improvement between disabled and non-disabled clients of 13.4% and 10.8% respectively.

Table 5 shows larger improvements in self-efficacy scores were reported for people in prison or on probation (36.9%), and also for people with long term conditions (17.5%) and carers (17.2%).

Additional Personal Info	Count	Before	After	Change
Carer	84	60.44	70.82	▲ 17.17%
Difficulty Accessing Services (e.g. NHS)	107	64.67	72.21	▲ 11.66%
Disability/Vulnerable Group	611	65.29	72.78	▲ 11.47%
Long Term Condition	794	60.47	71.03	▲ 17.46%
Long-term Unemployed (1yr+)	164	61.29	70.07	▲ 14.33%
Offender	135	57.18	78.25	▲ 36.85%

Table 5: Change in self-efficacy scores (after health trainer intervention) for different groups of clients

7.1.2 General Health Scores

General Health scores also improved across all deprivation quintiles. Data for quintile 5, the least deprived, showed the smallest change across all quintiles. The greatest improvements (49%) was seen in those recorded as having “no fixed abode”, however this could be an anomaly related to the small sample size. Overall, general health scores for males and females improved. For males, a 27.3% increase in scores was observed, in comparison to a 25.3% increase for females. Improvements in general health scores were observed for all age categories. Changes in scores were greatest among those under 25 years. Overall, improvements in general health scores were observed across all ethnic groups. Improvements were also observed across disabled (34.2%) and non-disabled (24.5%) groups.

Baseline general health scores were lowest for those in long term unemployment. Largest improvements in scores were observed for long term unemployed, people with long term conditions and clients in prison/ probation service (Table 6).

Additional Personal Info	Count	Before	After	Change
Carer	160	52.25	68.81	▲ 31.69%
Difficulty Accessing Services (e.g. NHS)	205	48.34	66.78	▲ 38.15%
Disability/Vulnerable Group	1265	52.01	66.9	▲ 28.63%
Long Term Condition	1431	46.32	64.63	▲ 39.53%
Long-term Unemployed (1yr+)	324	44.72	62.41	▲ 39.56%
Offender	172	50.23	71.34	▲ 42.03%

Table 6: Change in General Health scores (after health trainer intervention) for different groups of clients

7.1.3 WHO-5 wellbeing Scores

WHO-5 wellbeing scores⁸ improved across all deprivation quintiles. Data for quintile 5, the least deprived, showed the smallest change across all quintiles. ‘No fixed abode’ showed the greatest change. Baseline and completion scores were highest among quintile 4 and 5 (the least deprived). Overall, WHO-5 wellbeing scores for males and females improved. Notably, males had lower average baseline scores, however, greater change was observed, in comparison to females (31.1% versus 30.4%). Improvements in WHO-5 scores were observed across all age groups. The greatest improvement in scores was among clients aged 18-25 years. Positive changes in WHO-5 wellbeing scores were observed across all ethnic groups. Overall, clients self-identified as ‘any other ethnic group’ had the lowest baseline WHO-5 wellbeing score, but reported the largest change. Data showed improvements in WHO-5 scores for those with (36.7%) and without (30.1%) a disability.

Table 7 shows that baseline scores were lowest for the long-term unemployed and those with long term conditions, and the largest improvements were seen in these two groups.

Additional Personal Info	Count	Before	After	Change
Carer	114	39.68	55.58	▲ 40.07%
Difficulty Accessing Services (e.g. NHS)	140	39.26	56.26	▲ 43.30%
Disability/Vulnerable Group	1062	41.21	55.63	▲ 34.99%
Long Term Condition	1325	35.45	53.53	▲ 51.00%
Long-term Unemployed (1yr+)	323	33.31	53.24	▲ 59.83%
Offender	192	43.67	63.6	▲ 45.64%

Table 7: Change in WHO-5 wellbeing scores (after health trainer intervention) for different groups of clients

The picture emerging across all the data for self-efficacy, general wellbeing and mental health as measured by WHO-5, is that health trainer interventions are making a real difference to the mental health and wellbeing of many clients over a relatively short period. Of particular note are the benefits to men who are often perceived as reluctant to engage with programmes to benefit their health, a finding supported by an evaluation of the Premier Health programme which achieved very positive results working exclusively with men⁹. Young people, again a group which has been perceived as ‘hard to engage’, also had significantly improved self-efficacy and wellbeing. And health trainers are making a particular difference to groups of people who start out with the lowest scores for general health and wellbeing – people living in the most deprived neighbourhoods or with no fixed abode, offenders, the long term unemployed and people living with long term conditions. Again these findings are reflected in local evaluations where clients from these groups consistently talk about the huge difference health trainer interventions have made to their lives¹⁰.

⁸ A measure of current mental well-being

⁹ <http://healthtrainersengland.com/evidence/evaluation/national-evaluation/>

¹⁰ <http://healthtrainersengland.com/evidence/evaluation/local-evaluation/>

7.2 WELLBEING AND ACHIEVEMENT OF HEALTH GOALS

Table 8 and Figure 15 show an association between self-efficacy, general health, WEMWBS and SWEMWBS and WHO-5 scores, and achievement of PHP goals. The greatest improvements in self-efficacy and WHO-5 scores were seen in those who wholly or partly achieved their PHP goals, whereas smaller increases or even decreases in scores were seen in those who did not achieve their PHP goals or whose outcome was unknown. In particular, a 6% decrease in self-efficacy scores and a 19.7% decrease¹¹ in WEMWBS scores was seen in those clients who did not achieve their PHP goals. This could reflect an increasing awareness in the client, after having tried to change, of how difficult behaviour change can be, and therefore a decrease in their level of belief that they can make changes to their lifestyle. It is important for health trainers to be aware of this and perhaps to offer further sessions to try to support clients to remain positive. Behaviour change is a complex process, as discussed in the section entitled 'Focus on Mental Health' (page 5), which is illustrated by the number of theories that have been developed to explain it. For example, the Stages of Change Model (Prochaska and DiClemente, 1984) suggests individuals go through a number of stages before adopting a particular behaviour change. So it is important to recognise the effort that clients have to make and that if they have not achieved change they may need additional support to 'have another go'.

Wellbeing Measures	Count	Achieved	Part Achieved	Not Achieved
Self-efficacy	8297	+ 12.38%	+4.26%	-6.01%
General Health	16737	+28.05%	+19.73%	+6.71%
WHO-5	13542	+33.86%	+21.38%	+4.11%
WEMWBS	228	+17.28%	+21.06%	-19.66%
SWEMWBS	142	+26.94%	+9.91%	N/A (N=0)

Table 8: Association of wellbeing measures with achievement of PHP goals.

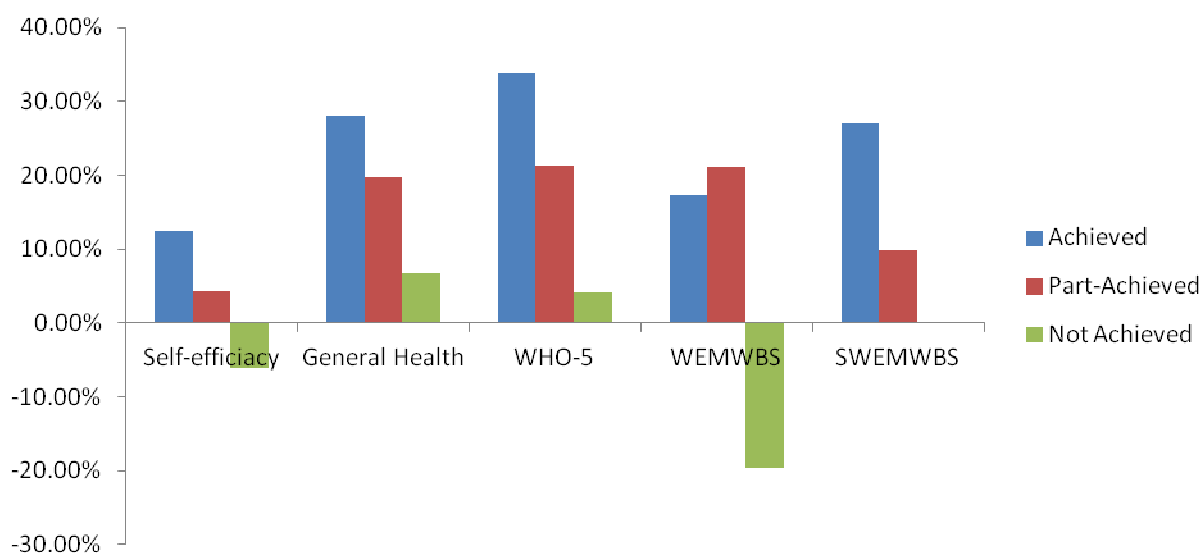


Figure 15: Association of wellbeing measures with achievement of PHP goals

¹¹ Only a small 6 services currently utilise WEMWBS, which unfortunately has led to inconsistent result linearity, with the 'Not achieved' results being represented by one organisation contributing over 90% of the sample.

One of the four health trainer competencies¹² is to ‘engage with communities’ and activities with communities can be recorded in the DCRS, although only a minority of health trainer services use these fields. The number of community activities delivered, as a proportion of those recorded on the DCRS, varied considerably across regions. The largest proportion of activities (n=3074, 31.40%) were delivered in the North West, with a further 16.19% (n=1585) delivered in the West Midlands.

Engaging the community through community group activities was the most common activity type undertaken (n=5357, 54.72%), with a further 19.86% (n=1944) carrying out community engagement activities through informal meetings and discussions. See Figure 16 for a full breakdown of activity type.

Of the 17,561 clients who heard about the health trainer service through a promotional event, 37% (n=6492) were from the most deprived quintile, compared to 9.9% (n=1730) from the least deprived quintile. This shows that undertaking activities which reach people living in deprived areas is particularly important to access people who might not normally use preventative health services.

See Figure 17 for a breakdown for place of activity. Whilst the majority of activities were delivered in the community (n=7427, 75.87%), a further 8.78% (n=859) took place on a NHS site and 8.56% (n=839) in work places.

A range of topics were covered during activities (see Figure 18). Topics most frequently covered in activities were exercise (n=2579, 26.25%), diet (n=1800, 18.32%) and local issues (usually mental health) (n=989, 10.07%).

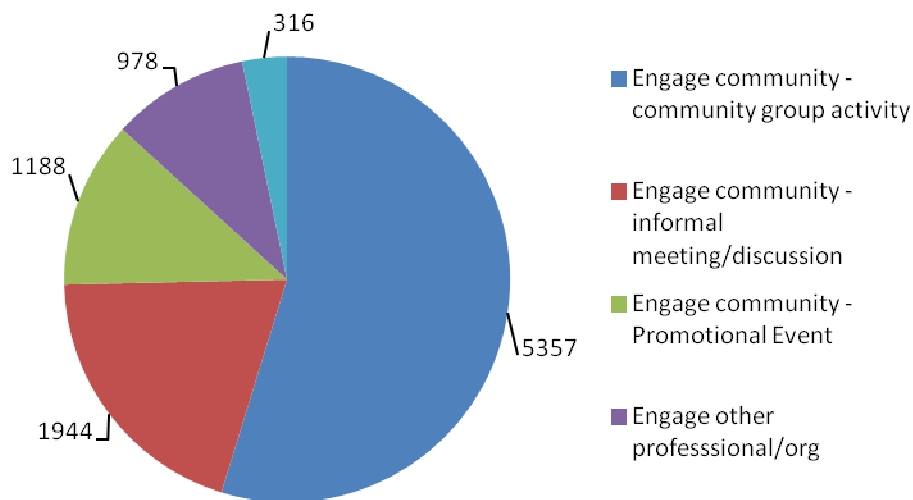


Figure 16: Breakdown by activity type

¹² <http://healthtrainersengland.com/careers/competencies/>

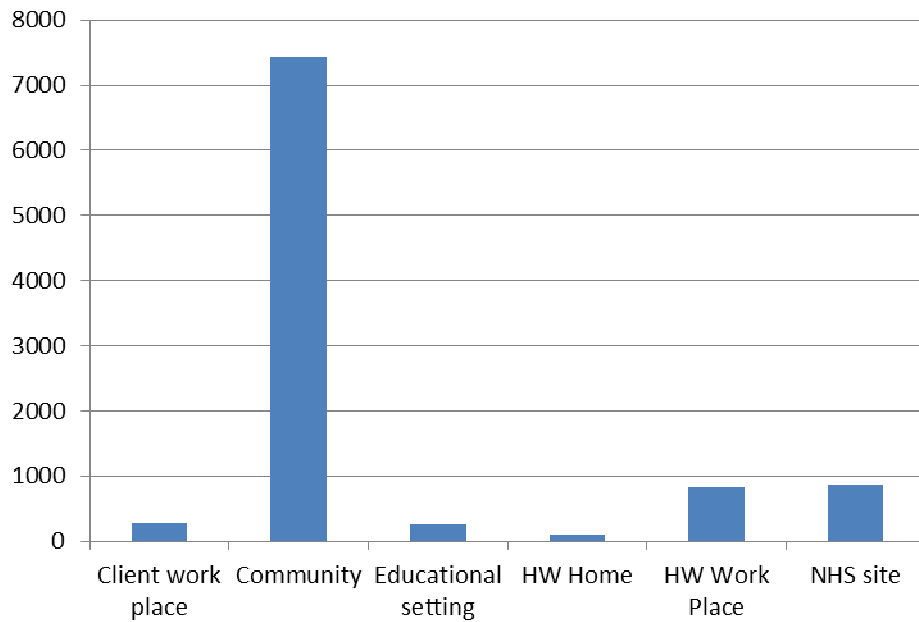


Figure 17: Breakdown for place of activity

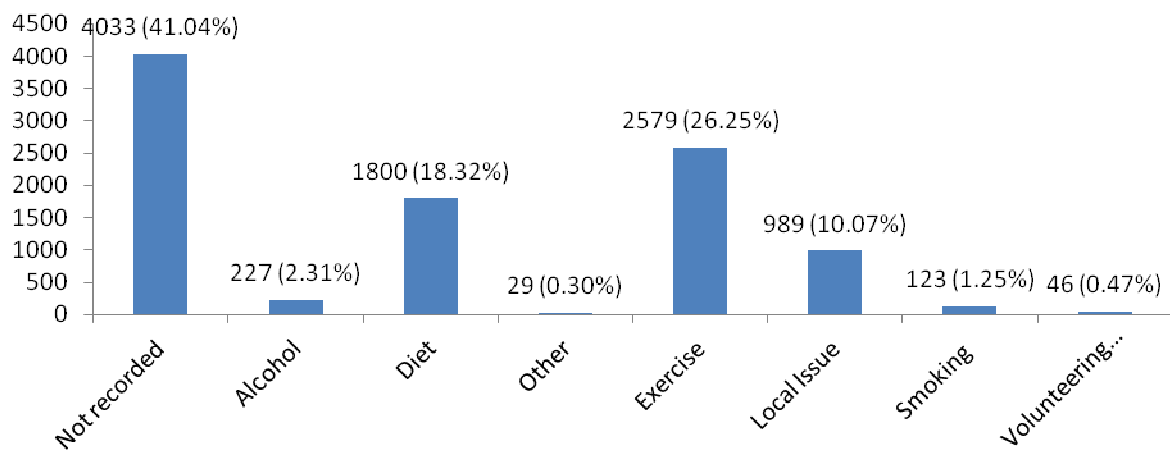


Figure 18: Breakdown of activity topics (April 1st 2013 – March 31st 2014)

This report summarises health trainer activity in the financial year 2013-2014, using data recorded from the DCRS, with a particular focus on mental health and wellbeing.

Supporting clients to adopt behaviours that promote health and wellbeing is a core aim of health trainer services (Department of Health, 2008). That 49% of clients who completed a PHP achieved the goals set, and a further 23% achieved their goals in part, is an impressive result and demonstrates that health trainers are helping people, many of whom are living with disadvantage, to make real changes in their lifestyles. A recent review of evidence covering 26 studies on health-related advisor roles concluded that such interventions are effective in improving health and wellbeing (Carr et al., 2011) – adding weight to the findings summarised in this report.

As discussed in the body of this report, the mental health data 2013-2014 collated by the DCRS, self-efficacy scores, WHO-5 wellbeing and General Health scores all showed considerable improvements in client scores following the health trainer interventions. However whilst improvements in self-efficacy scores have been observed since the 2011-2012 review (2011-2012, 8.45%; 2012-2013, 9.14%; 2013-2014, 10.82%), the proportion of clients improving their WHO-5 wellbeing and General Health scores has decreased by over this time period by 6.46% for WHO-5 wellbeing and 8.06% for general health. Reasons for this decline cannot be confidently inferred from the data available but could be attributable to a number of factors, for example a worsening of people's living conditions.

The DCRS is useful in providing an overview of health trainer services. However, the limitations of this dataset must also be understood. Firstly, whilst approximately 60% of health trainer services use the DCRS service, data is not available for all health trainer settings. Secondly, not all health trainer settings choose to use the same data fields, leading to differences in response rates/ sample sizes, particularly for newer data fields/ measures. Finally, as with any large dataset, there is a possibility of data being wrongly recorded/ use of incorrect fields, particularly in the case of categories with a large number of fields.

Despite the above limitations, most of which are common to all large datasets, the DCRS remains a highly valuable tool for practitioners, researchers, commissioners and policy makers who need to make sense of how health trainers are working in England. The reporting system provided by DCRS makes greatly detailed and flexible data analysis possible even for non-technical users. The detailed level of quantified before- and after- data, and the ability to cross-compare data against any demographic indicator provides a level of strategic analysis that is not readily available at a national level elsewhere. It allows triangulation of data from many angles which, to date, all appear to validate the success of the health trainer approach.

In conclusion, the data reviewed demonstrates that health trainer services are successful in reaching many communities and groups that are sometimes deemed 'hard to reach' and offering clients support to change behaviour. Moreover, the vast majority of clients who see a health trainer are making behaviour changes in order to benefit their health. Importantly with the support of health trainers, people are not only improving their physical health but reporting improvements in their mental health and wellbeing.

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¹³ Available from:

<http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Healthcare/Mentalhealth/Publicmentalhealthandwellbeing/index.htm>

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Copies are freely available via Leeds Metropolitan University press releases www.leedsmet.ac.uk/healthtogether/ or via request to the DCRS Support Team (dcrs.support@nhs.net / 0845 548 3277).