



Health Trainers in Cheshire and Merseyside

*Commissioned by HM Partnerships on behalf of the
Cheshire & Merseyside Health Trainer Hub*

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1. Introduction

This report aims to describe and analyse how Health Trainer services are delivered across Cheshire and Merseyside. This is a very diverse area with a population of 2.4 million people served by eight Primary Care Trusts with individual populations ranging from 150,000 to more than 450,000.

The idea for the research was developed by the Cheshire & Merseyside Health Trainer Hub and follows on from evaluation work carried out by the author in Knowsley and Liverpool. The research was commissioned following a successful funding bid to the Department of Health by HM Partnerships, which coordinates Health Trainer delivery across the Hub.

By looking at how Health Trainer services are being delivered, the research aims to better understand how they are tackling the underlying causes of ill health and contributing towards the reduction of health inequalities across the sub-region. The report will be a vehicle for sharing knowledge of Health Trainer schemes across the sub-region.

2. Background

2.1 Introduction

In common with many other Western nations, Britain faces threats to public health as a result of modern lifestyles. Modern lifestyles tend to be sedentary, calories tend to be cheap, and large numbers of people are not physically active enough to benefit their health. As a result of consuming too much energy and expending too little, it is estimated that 60% of men and 70% of women are overweight or obese.¹ Other factors exert a powerful negative influence on health. Though banned in the workplace, smoking is still widespread and is known to cause disease and early death. Alcohol is readily available and plays a key role in socialising in relation to both work and leisure. These threats to health affect everybody, from the inhabitants of the Houses of Parliament to the poorest housing estate.

The NHS has accepted that, as well as treating illness and disease as they occur, efforts should also continue to be made to address prevention. Whilst acknowledging the “lack of conclusive evidence for action” in relation to public health interventions, Wanless made a powerful argument for the need to “invest in reducing demand by enhancing the promotion of good health and disease prevention”.²

It is recognised that there are disparities in the experience of health in different parts of the country. For example, the death rate in one Merseyside borough as a result of smoking is the worst in England.³ It is known that health and life expectancy tend to be worse amongst those with lowest incomes. The Black

1 Department of Health, “Choosing Health: Making Healthy Choices Easier”, Department of Health (2004), p.138.

2 Derek Wanless, “Securing Good Health for the Whole Population”, HMSO (2004), p.3, p.5.

3 Department of Health, “Knowsley Health Profile” (2008), p.1.

Report of 1980 established that there were big differences in mortality experienced by different social classes, with those in the lowest social class having much higher mortality risk. Such recognition was shocking given that the population had been in receipt of free healthcare for many decades. One recent Secretary of State for Health has commented, “The fact that poorer people have the worse health remains an indictment on our society.”⁴

Several explanations have been advanced to account for the impact of social inequality on health, without any one gaining conclusive acceptance.⁵ It has been plausibly suggested there are several “layers of influence” affecting the health profile of individuals, such as background economic circumstances, living and working conditions, social and community influences, age, gender and genetics, as well as individual lifestyle.⁶ Perhaps reflecting this uncertainty about “aetiology” – in other words, the causal basis for such disparities – public health interventions have often struggled to demonstrate their impact on health inequality.^{7,8} It has been argued that public health initiatives can be driven forward by policy decisions that proceed in parallel with – and sometimes with limited reference to – the evidence base, leading to a situation in which robust evaluation becomes more difficult.⁹

4 Department of Health, “Health Inequalities: Progress and Next Steps”, Department of Health, 2008, p.3.

5 Mel Bartley, “Health Inequality”, Polity Press, 2004, p.16.

6 Whitehead M, “Tackling inequalities: a review of policy initiatives”, in Benzeval M, Judge K, Whitehead M (eds), Tackling Inequalities in Health, King’s Fund (1995).

7 D. Hills, E. Elliot, U. Kowarzik, E. McGregor, P Miller, J. Rugkasa, S. Russell, F Sullivan, E Wilkinson, “The Evaluation of the Big Lottery Fund Healthy Living Centres Programme: Fourth Annual Report of the Bridge Consortium,” The Big Lottery Fund (2005).

8 Health Development Agency, “Lessons from Health Action Zones”, NHS (2004), p.2.

9 S L Sowden, R Raine, “Running along parallel lines: how political reality impedes the evaluation of public health interventions. A case study of exercise referral schemes in England”, Journal of Epidemiology and Community Health, 2008

2.2 Health Trainers

Health Trainers are part of a national health promotion initiative, outlined in the White Paper, *Choosing Health*, aiming to offer personalised support to help people make healthier choices.¹⁰

Table 1: Health Trainers

- Come from local communities, providing local jobs for local people
- Familiar with local sources of advice and support
- Skilled in supporting individual behaviour change
- Offer personalised advice and practical support to ‘help out’ on health choices
- Friendly, approachable, understanding and supportive
- Guides not instructors
- Accredited by the NHS but not medical professionals
- Work on personal (individual) health guides or plans with the client setting out ‘ambitions’ for health
- Health Trainers are the ‘fundamental building blocks’ for health improvement in the NHS

Choosing Health argued that much illness and disease can be prevented if people make appropriate changes to their lifestyles to reduce risks to their health – for example, stopping smoking, taking more exercise, losing weight where necessary or eating more healthily. The key principle underpinning *Choosing Health* is that of informed choice. Statutory agencies should not tell people what they ought to do but to ensure they have sufficient information and support to take positive steps to improve their own lifestyles.

For this reason, Health Trainers are guides, not instructors, able to support people to set and achieve health goals in a practical, common-sense way.

¹⁰ Department of Health, “Choosing Health: Making Healthy Choices Easier”, Department of Health (2004), Chapter 5.

They provide “support from next door” rather than “advice from on high”. They are intended to be local people, recruited from the local community, who can work one-to-one with other local people to develop personal health plans to improve their health behaviour. The training of Health Trainers is based upon a small number of key “competencies”. At the heart of the Health Trainer role is the aspiration to “enable individuals to change their behaviour to improve their health and wellbeing”.¹¹

The White Paper indicated that Health Trainers would be “starting” in the most deprived communities. In view of the fact that some areas demonstrate wider disparities in health, the Department of Health identified a Spearhead Group containing the fifth of PCTs with the worst health and deprivation indicators. These areas were allocated extra funding to support the early development of Health Trainer services (though not all Spearhead areas in Cheshire and Merseyside were able to accomplish this). At the same time the White Paper also clearly stated that, in due course, “Everyone will have access to an NHS-accredited Health Trainer”.¹²

It is important to be aware that in some respects the Health Trainer model represents a new approach to tackling health inequalities. A thorough review of evidence in relation to Health Trainers, undertaken shortly after the White Paper was published, identified only one similar project (Camden Public Health Assistants) where promoting healthy lifestyles with individuals was being used as a method of improving the health of the local population.¹³ No systematic evaluation of the Health Trainer programmes in “spearhead” areas is available at the time of writing. Local research reviews have been carried out of the early

11 City & Guilds, “Level 3 Certificate for Health Trainers (3075): Centre resource pack”, City & Guilds (2007), p.7.

12 “Choosing Health: Making Healthy Choices Easier”, p.116.

13 Visram and Drinkwater, “Health Trainers: a review of the evidence”, Northumbria University (2005).

adopter phase in the North East¹⁴ and in Bradford¹⁵ and appeared promising though not conclusive.

The Health Trainer programme has faced some criticism on the grounds that the determinants of ill health are much wider than individual lifestyle behaviour and therefore Health Trainers cannot tackle broader health inequalities.^{16,17} It has been argued that Health Trainers will not be able to have an important impact if the client's environment continues to present barriers to behaviour change.¹⁸

A separate issue is whether behaviour changes will be sustained over time. Exercise referral schemes offering short-term benefits may not be effective in increasing physical activity levels in the longer term.^{19,20} A randomised control trial of methods to promote physical activity in a deprived urban area, using individual motivational interviewing based on the stages of change model, found that short-term increases in physical activity were not maintained.²¹ However it is reported that, in one sample, nearly one quarter of clients achieved their health goals as a result of working with the Health Trainer, with nearly one third

14 Visram, Geddes, Carr and Drinkwater, "An Evaluation of the Early Adopter Phase of the Health Trainers Project in the North East", Northumbria University (2006).

15 Jane South, Jenny Woodward and Diane Lowcock, "New beginnings: stakeholder perspectives on the role of health trainers", *The Journal of the Royal Society for the Promotion of Health*, (2007)

16 Maggie Netherwood, "Will health trainers reduce inequalities in health?" *British Journal of Community Nursing* (2007).

17 UK Public Health Association, "Choosing Health or Losing Health? A response from the UK Public Health Association to the White Paper 'Choosing Health – making healthy choices easier'", UK Public Health Association (2004).

18 Tanya Trayers, Debbie A. Lawlor, "Bridging the gap in health inequalities with the help of health trainers: a realistic task in hostile environments? A short report for debate", *Journal of Public Health* (2007).

19 NICE, "A rapid review of the effectiveness of exercise referral schemes to promote physical activity in adults" (2006), p.4.

20 Foster C, Hillsdon M, Thorogood M., "Interventions for promoting physical activity", *Cochrane Database of Systematic Reviews* (2005), p.30.

21 Jane Harland, Martin White, Chris Drinkwater, David Chinn, Lorna Farr, Denise Howel, "The Newcastle exercise project: a randomised controlled trial of methods to promote physical activity in primary care", *British Medical Journal* (1999).

achieving their health goals in whole or in part (presumably during the period of their engagement with a Health Trainer).²²

2.3 Cheshire and Merseyside Context

In Section 4 below we will summarise health improvement issues for each area of Cheshire and Merseyside. Here we will give instead a short summary of some key issues in relation to the area as a whole.

| | <i>thousands</i> |
|------------------------------|------------------|
| Central and Eastern Cheshire | 453.3 |
| Halton and St Helens | 297.0 |
| Knowsley | 150.9 |
| Liverpool | 435.5 |
| Sefton | 276.2 |
| Warrington | 195.2 |
| Western Cheshire | 235.5 |
| Wirral | 310.2 |

Table 2 gives recent population estimates for the eight Primary Care Trusts of Cheshire and Merseyside. It can be seen that the largest PCT, that for Central and Eastern Cheshire, covers three times the population of the smallest PCT, that for Knowsley.

We have mentioned above that differences in health and life expectancy are experienced in different areas. We can illustrate this by reference to the

²² David Hopkinson & Ertan Fidan, "National Health Trainer Data Collection & Reporting System : Updated National Report", BPCSS (2008), p.14.

²³ National Statistics Online, "Final Mid-2007 Population Estimates: Selected age groups for Primary Care Organisations in England; estimated resident population (experimental)," (2009). Crown Copyright 2009. Data reproduced with the permission of the Controller of HMSO.

proportion of people in each of the PCT areas in Cheshire and Merseyside who indicate that their health is not good. Table 3 shows that people describing their health as 'not good' varies from nearly 14% in Liverpool to under 9% in Central & Eastern Cheshire and Western Cheshire.

| | % |
|------------------------------|------|
| Central and Eastern Cheshire | 8.4 |
| Halton and St Helens | 12.3 |
| Knowsley | 13.6 |
| Liverpool | 13.8 |
| Sefton | 11.2 |
| Warrington | 9.1 |
| Western Cheshire | 8.7 |
| Wirral | 11.4 |

This result is particularly striking in that Liverpool has the lowest proportion of older people in its population of any of these areas, at just over 17%, with Central & Eastern Cheshire just under and Western Cheshire just over 21%.²⁵

Within Cheshire and Merseyside there are five Spearhead PCTs – Halton and St Helens, Knowsley, Liverpool, Warrington and Wirral. It can be seen that Spearhead status is not simply based on the proportion of people in each area whose health is not good. Those areas with higher perceived levels of deprivation and poor health receive higher levels of revenue funding. For example, in 2009/10, NHS funding for Liverpool was more than £900m

²⁴ National Statistics Online, "Health and Provision of Unpaid Care (KS08)", Census 2001 (downloaded 2009). Crown Copyright 2009. Census 2001 data reproduced with the permission of the Controller of HMSO.

²⁵ "Final Mid-2007 Population Estimates." The percentages refers to older people aged 65+ (men) and 60+ (women).

compared to £645m for Central and Eastern Cheshire which has a larger population.²⁶

Though Cheshire and Merseyside may appear to be two distinct areas, one with a reputation for leafy affluence and the other as a largely urban area with associated problems, in reality things are far from clear cut. The county town of Cheshire, Chester, is a similar distance from Liverpool as the northernmost outskirts of the Merseyside borough of Sefton. Some towns with postal addresses in Cheshire, such as Ellesmere Port, Runcorn and Widnes, are closely linked to Liverpool and exhibit many similar characteristics linked to the relative decline of traditional industries. Merseyside boasts attractive coastal scenery on the Wirral and Sefton and its own affluent suburbs such as Formby. Nonetheless there is also some truth to the view that Merseyside has particularly intense problems of poverty and deprivation. In one report, produced by the now defunct Office of the Deputy Prime Minister, it was shown that 41 out of 100 of the most deprived Super Output Areas in England fell within the Merseytravel area.²⁷

In Section 4 we will look in more detail at the characteristics of different areas to better understand the role of health improvement and specifically the role of Health Trainers.

2.4 Conclusion

In this section we have situated the work of Health Trainers in the context of health inequalities, described the role of Health Trainers, summarised relevant background literature, and sketched in some relevant background information for the Cheshire and Merseyside area.

²⁶ Department of Health, "2009-10 and 2010-11 PCT Revenue Allocations," Department of Health (2008).

²⁷ ODPM, "Index of Multiple Deprivation 2004 Snapshot", ODPM (2004), p.2.

3. Methodology

The purpose of the research was to look at how Health Trainer services were being delivered in the Cheshire and Merseyside area. It was felt that these areas were geographically and demographically diverse and so delivery methods were likely to vary, with Health Trainer services at different stages of development. It was also felt to be important to include in the research those areas where Health Trainer services were not yet operating. These findings would then be shared across each the Hub to deepen understanding of how each area has interpreted the blueprint for Health Trainers prescribed in the White Paper.

It was anticipated that the research would be carried out in close collaboration with sub-regional partners. Accordingly a short research brief was presented at a meeting of Cheshire and Merseyside Health Trainer Hub on 31st March 2009. The intention was to produce a more detailed specification following the meeting which would meet the needs of partners as closely as possible. In practice few further comments were received on the original brief so this was taken forward largely unchanged.

In addition to the review of background literature carried out in the previous section, the research aimed to describe characteristics of each area and to carry out fieldwork exploring delivery issues. The main element of fieldwork in the research consisted of semi-structured interviews with key personnel in each of the eight areas – specifically, provider agencies, service commissioners and directors of public health. Where possible, personnel occupying all three roles were interviewed, though this was not always possible due to the timescale or for some other reason (e.g. there was no provider in place).

Semi-structured one-to-one interviews, using a mixture of open and closed questions, allow for the collection of core information and support a responsive interview process. This approach allows a great deal of flexibility in exploring subject areas and helps to give partners an opportunity to explain their perspective in their own words. Written notes of each interview were typed and forwarded to each interviewee to check accuracy. Fieldwork visits to each area were carried out together with supplementary telephone interviews where this was most convenient for the respondent.

| Table 4: Interviewees for Health Trainer research | |
|--|--|
| Central and Eastern Cheshire | <ul style="list-style-type: none"> • Public Health Improvement Manager • Director of Public Health |
| Halton and St Helens | <ul style="list-style-type: none"> • Health Improvement Manager • Healthy Lifestyles Manager for Halton • Healthy Lifestyles Manager for St Helens |
| Knowsley | <ul style="list-style-type: none"> • Service Manager Promoting Health & Wellbeing Services • Director of Public Health • Head of Health Promotion |
| Liverpool | <ul style="list-style-type: none"> • Service Commissioner • Lead Contractor • Health Trainer Service Manager |
| Sefton | <ul style="list-style-type: none"> • Public Health Workforce Development Manager |
| Warrington | <ul style="list-style-type: none"> • Health Improvement Specialist • Health Improvement Project Coordinator |
| Western Cheshire | <ul style="list-style-type: none"> • Head of Specialist Health Promotion • Associate Director of Public Health |
| Wirral | <ul style="list-style-type: none"> • Health Promotion Strategy Manager • Joint Director of Public Health |

Table 4 lists interviewees from each area according to their role description. The research brief was primarily aimed at gathering information from commissioners and service management rather than from Health Trainers themselves. However, in Halton, St Helens and Wirral supplementary interviews took place with Health Trainers in situ so that a deeper understanding could be gained of how the services operated in these areas. The researcher had previously carried out evaluations with Health Trainers in Liverpool and Knowsley and was able to draw upon this material also.

The research used the findings from fieldwork together with other documents to gain an understanding of health promotion issues facing each area and where Health Trainer fitted into the overall work of health improvement. The qualitative research techniques used in the fieldwork were supplemented with quantitative material from the Regional Hub Activity Report for 2008/9 which became available in the course of the research.

The research report was completed in draft form at the beginning of September 2009 in order to present the findings to a meeting of the Cheshire and Merseyside Health Trainer Hub taking place in that month.

4. Area Profiles

4.1 Introduction

In Section 2 above we gave an overview of some salient characteristics of Cheshire and Merseyside as a whole. In this section we will present as brief a picture as possible of health challenges in each area together with a description of Health Trainer activity. It needs to be borne in mind that the overall picture of health in each area appears to be generally improving. Average life expectancy increased dramatically over the course of the last century, so that someone born in 2004 can now expect to live on average 30 years longer than someone born in 1900.²⁸ Nevertheless there are challenges to public health which have the potential to undermine this progress if not tackled.

4.2 Central & Eastern Cheshire

In April 2008 Cheshire County Council and six District Councils were replaced by two new unitary authorities, Cheshire East and Cheshire West and Chester. The area also has two PCTs, Western Cheshire and Central & Eastern Cheshire. Unfortunately the two local authorities and health trusts are not coterminous, with parts of Cheshire East Council lying outside Central & Eastern Cheshire PCT, and parts of Cheshire West and Chester Council lying within it. For our purposes we will be concentrating on PCT boundaries.

Central & Eastern Cheshire PCT covers the largest population of any of the areas in this study. It encompasses a vast geographical area with many attractive small towns surrounded by rural land. Life expectancy for this area

²⁸ "Choosing Health", page 9.

compares favourably with that for the North West as a whole and is identical to the average for England at 81.8 years for women and slightly higher for men (78.1 years compared to the average of 77.7 years).²⁹ Approximately one fifth of the adult population are smokers (just below the national average), with a similar proportion continuing to smoke during pregnancy.³⁰ One in twenty of the population are estimated to be drinking above safe limits. Just under one quarter of the adult population are thought to be obese. Central & Eastern Cheshire has a higher proportion of older people in the population than the national average. In common with much of Britain, Cheshire & Eastern Cheshire faces a rapidly ageing population, though this is occurring faster in this area than anywhere else in the North West.³¹ This has clear implications for future health care provision.

Though the general picture of health appears close to the average, it is also clear that Central & Eastern Cheshire faces many similar issues to all other areas in this study in terms of unnecessary suffering and early death linked to lifestyle. More than a third of deaths in the area are linked to cardio vascular disease (CVD) and of these more than one quarter could be prevented through lifestyle modification.³² There are striking differences in average life expectancy across Central & Eastern Cheshire and sometimes within individual towns. For example, average life expectancy for women in Macclesfield can vary by as much as 14 years.³³ To address these inequalities Central & Eastern Cheshire PCT has identified eighteen 'middle super output areas' (areas of population size smaller than ward level), mainly in Crewe and Winsford but also Macclesfield, for further action to tackle lower than average life expectancy.

29 Central and Eastern Cheshire PCT, "Annual Public Health Report", 2009, p.13.

30 "Annual Public Health Report", p.11.

31 "Annual Public Health Report", p.9.

32 "Annual Public Health Report", p.12.

33 "Annual Public Health Report", p.13.

In 2008 Central & Eastern Cheshire PCT issued a call for expressions of interest to provide a Health Trainer service for its population. Two external organisations were shortlisted for this contract early in 2009. However the decision was taken not to proceed with the service.

Though the White Paper does clearly state that Health Trainers will be available to “everyone”, it is important to appreciate that such services are not mandatory. Central & Eastern Cheshire PCT faced a significant financial deficit and needed to make tough decisions about where best to invest available monies. Such investment needed to be geared to demonstrating overall cost savings through health initiatives delivering proven health improvements. It was felt that conclusive evidence in relation to Health Trainers was not yet available and that money invested elsewhere could provide a better return on the investment. A further element in the decision not to proceed with a Health Trainer service was that, for a small number of such personnel to be effective, other services needed to exist for Health Trainer to liaise and to work with, which had not yet been fully developed in the area.

4.3 Halton & St Helens

Halton and St Helens PCT covers two distinct local authorities, St Helens Council and Halton Borough Council, both of which are Spearhead areas. Approximately 60% of the total PCT population lives in St Helens whilst 40% lives in Halton.

St Helens is a sizeable town with generally worse health than the average for England. Average life expectancy is also somewhat below the national average, by more than 2 years for men and nearly 2 years for women.³⁴ In deprived areas life expectancy can be over 9 years less for men and nearly 6

³⁴ Department of Health, “St Helens Health Profile” (2009), p.4.

years less for women than in other parts of the borough.³⁵ Early death rates from CVD and cancer are both higher than average.³⁶ Obesity rates in children starting school in St Helens are the second highest in the county (though puzzlingly more children are physically active in the borough than the national average).³⁷ Halton has an early death rate from cancer which is the worst in England. Average life expectancy for both men and women is 3 years below the national average, which is the third worst for women in England as a whole. Gaps in life expectancy in Halton between the most deprived and least deprived areas are more than 7 years for men and nearly 6 years for women.³⁸ Just over one third of St Helens' population and nearly half of Halton's population live in areas which are amongst the fifth most deprived in the country.³⁹

Both Halton and St Helens have Health Trainer services which have developed slightly differently in each area but are now becoming more closely aligned. In St Helens the Health Trainer service is delivered as part of a combined PCT and council team whereas in Halton the service is provided by the PCT. St Helens has the equivalent of 6 Health Trainer posts whilst Halton has 5. The overall strategic management for the service lies with Halton and St Helens PCT's health improvement manager, with an operational manager based with Health Trainers in each of the two areas.

Health Trainers in Halton and St Helens operate in a slightly different way to those of other areas in this study in that they operate from a central location rather than being physically based in the target areas.

35 "St Helens Health Profile," p.1.

36 "St Helens Health Profile," p.3.

37 "St Helens Health Profile," p.1.

38 "St Helens Health Profile," p.1, p.4.

39 Halton and St Helens PCT, "The Annual Report of the Director of Public Health" (2007), p. 8.

St Helens Health Trainers operate as a team from the Bold Miners Centre in Parr just over two miles east of the town centre. Being in this location allows them to work in close proximity to colleagues within a wider Health Improvement Team, which includes services such as exercise referral, weight management and smoking cessation. Each St Helens Health Trainer covers an area of the town from their base and organises appointments locally in four or five venues in the community, such as libraries or community centres, with particular emphasis on more deprived areas of the borough. St Helens Health Trainers work with clients aged over 16. Clients can be seen over a 12-month period, with up to five follow-up appointments after an initial visit.

Within the Health Improvement Team are a number of Lifestyle Advisors within a Lifestyle Referral Programme who also, it seems, work with individual clients on personal health plans.⁴⁰ Lifestyle Advisors see clients referred through GP surgeries and work with people who may be at high to medium risk of CVD or have long-term conditions where more expertise is required. In practice the two roles of Health Trainer and Lifestyle Advisor appear to dovetail.

Halton has two main towns, Widnes and Runcorn, located to the north and south of the River Mersey. The towns are linked by the very busy Silver Jubilee Bridge. Halton Health Trainers operate from Midwood House in Widnes and, like St Helens, seek to target activities and “clinics” in deprived communities from their central base. Interestingly, the service was initially targeted at those aged over 50 and continues to work with this age group through volunteer peer mentors whose role is to tackle social isolation. The main Health Trainer service now works with those aged 18 or over. Historically, the service has operated primarily through home visits to clients, though this appeared to be changing now that the two teams for Halton and St Helens are working more

⁴⁰ Halton and St Helens PCT, “Choices Lifestyle Advisor”, Leaflet (undated).

closely together. The service does still appear to offer a significant proportion of home visits (estimated at one meeting as accounting for one third of activity). The reasons for the early focus on older people and home visits were not clear. Again, Halton also has Lifestyle Advisors to whom Health Trainers can refer if required, though it appeared from discussions that the role focused more specifically on weight management than colleagues with the same title in St Helens.

All Health Trainers carry out some form of Health Check with clients, reviewing aspects of the lifestyle which may affect health, such as eating patterns and exercise levels. One key difference between Health Trainers in Halton and St Helens and in areas such as Knowsley and Liverpool is that they are able to carry out measurements as part of the Health Check, such as blood pressure and Body Mass Index (based on the ratio of height and weight). This may be helpful in ensuring that behaviour change goals are SMART – specific, measurable, achievable, relevant and timely – in line with Health Trainer guidance.⁴¹ However it does mean that Health Trainers will need to be able to transport pieces of equipment with them (such as scales, measurement charts and blood pressure monitors) which may be difficult for those without motor transport.

4.4 Knowsley

Knowsley is a metropolitan borough of Merseyside located to the east of Liverpool. In many respects Knowsley represents an ‘overspill’ area of Liverpool, with large housing estates built in the post-war years to accommodate housing shortages in the city itself.⁴² Almost 30% of the

41 Susan Michie, Nichola Rumsey, Anna Fussell, Wendy Hardeman, Marie Johnston, Stanton Newman, Lucy Yardley, *Improving Health: Changing Behaviour, NHS Health Trainer Handbook*, British Psychological Society and the Department of Health (2008), p.31.

42 Knowsley Council and Knowsley Primary Care Trust, “Healthier Together,” (2007).

population lives in social housing compared to just over 20% in the North West as a whole.

Knowsley is the eighth most deprived local authority in England according to the main overall index of multiple deprivation measures, with just over 46% of the population living in areas that are within the 10% most deprived in the country.⁴³ Life expectancy across the borough is nearly 3 years lower than the average for England.⁴⁴ Almost a third of people are current smokers compared to just over a quarter in England as a whole. In one area, Page Moss in North Huyton, smoking prevalence is 46.5%.⁴⁵ Overall the death rate in the borough as a result of smoking is the worst in England.⁴⁶ As well as reduced life expectancy, there are higher than average levels of chronic ill-health that reduce quality of life – in particular heart disease, respiratory disease and cancer (especially lung cancer).⁴⁷ 13.6% of the working age population of Knowsley claim Incapacity Benefit & Severe Disablement Allowance, the highest claimant rate of all local authorities in the North West.⁴⁸

The Health Trainer Service was commissioned by Knowsley Primary Care Trust (PCT) at the end of 2006 and became fully operational in summer 2007. It aims to offer a service to all those people aged over 19 years who are resident in Knowsley or registered with a Knowsley GP. This gives an overall target population for the Health Trainer service of approximately 110,000⁴⁹ people, more than 70% of the entire population of the borough, though there is also an expectation that Health Trainers will focus particular attention on areas of

43 Knowsley Council and Knowsley Primary Care Trust, "Knowsley Profile," (2008), p.4.

44 Knowsley Council and Knowsley Primary Care Trust, "Knowsley Health Statistics" (2007), p.13.

45 "Knowsley Health Statistics", p33, p.62.

46 Department of Health, "Knowsley Health Profile" (2008), p.1.

47 "Knowsley Health Statistics", p.12.

48 "Knowsley Profile," p.4.

49 "Knowsley Health Statistics", p5.

deprivation. Knowsley Health Trainers see clients for up to 6 one-hour visits, though in a small number of cases this may be exceeded.

Knowsley Health Trainers are based within Health Visitor Teams in six primary care settings based upon three localities of the borough: St Chads Clinic and Towerhill Primary Care Resource Centre in Kirkby (north); Manor Farm Primary Care Resource Centre and North Huyton Primary Care Resource Centre in Huyton (central); and Halewood Health Centre and Whiston Primary Care Resource Centre (south). Many of these premises are large-scale, brand-new buildings with a wide range of services available, including GP surgeries and a variety of clinics as well as Health Visitors. Numbers of Health Trainers vary somewhat as some members of staff are part time, but they are equivalent to 6.6 full-time posts.

In some respects these settings would appear to be ideal for the work of Health Trainers to flourish. In practice the service encountered some difficulties in meeting suitable levels of referrals and personal health plans. One key problem was the location in Health Visitor teams, since these staff primarily work with children rather than adults and hence were not in a position to make referrals to Health Trainers. During the first year of full operation the service was not able to achieve its ambitious target of 1000 referrals and 450 personal health plans per year, though in other areas, such as numbers of promotional events and talks carried out, the programme exceeded expectations. Health Trainers also found there were not always suitable services available to refer clients on to.

Several recent changes to the service have made a positive difference to the work of Health Trainers in Knowsley and the future looks more optimistic. In the second half of 2008 a programme of CVD checks was commissioned by the PCT from an external provider, Optimal, with Health Trainers linked in closely. This has resulted in “dramatically” increased levels of referrals, to the extent

that the service has employed three assistants in addition to the existing staff team. The service has noted that many people appeared to find the title 'Health Trainer' confusing and has rebranded the posts as 'Lifestyle Advisors', which appeared to be better understood. The overall management of the service has changed and the intention is to merge the Lifestyle Advisors with the Community Health Development Team. Both teams fall within Health and Wellbeing Services, bringing together a wide range of health promotion activities across Knowsley.

4.5 Liverpool

Liverpool is the most deprived local authority in England according to the main overall index of multiple deprivation measures. More than half the population live in areas that are amongst the most deprived 10% in the country.⁵⁰ Both male and female life expectancy are lower than average, with male life expectancy (73.4 years) the third lowest and female life expectancy (78.1 years) the lowest in England. Smoking is a significant factor in reduced life expectancy, with the death rate from smoking the second highest in England. Liverpool has the highest rate of hospital admission for alcohol-related conditions in England.⁵¹ The proportion of Incapacity Benefit claimants in the population (13.1%) is nearly double the average for Great Britain (7.1%). Just under two thirds of people (64.2%) of working age are in employment in Liverpool compared to nearly three quarters (74.4%) for Great Britain as a whole.⁵²

Whilst Liverpool clearly has some serious public health concerns, the overall picture is not entirely negative. For example, the percentage of adults who are

50 City of Liverpool, "The Indices of Deprivation 2007" (May 2008), p2-3.

51 Department of Health, "Liverpool Health Profile" (2007), p.1.

52 City of Liverpool, "Key Statistics Bulletin Issue 5" (November 2008), p.2.

obese is thought to be below the national average.⁵³ Though the public health statistics do paint a rather bleak picture, Liverpool remains a thriving metropolis with new retail developments in the city centre reinforcing its reputation as one of the North West's principal shopping and cultural areas.

In Liverpool the Health Trainer programme commenced in 2006. It is the only Health Trainer programme within Cheshire & Merseyside to be delivered by the voluntary sector, through a partnership of PSS and Age Concern Liverpool. Liverpool has 14 full-time Health Trainers arranged in pairs across seven Neighbourhood Areas covering the whole of the City. The Health Trainer service is available to anyone aged 16 or over – 80% of the population – giving a potential target population for Health Trainers of approximately 360,000 people.⁵⁴

Liverpool's Health Trainer programme is delivered not just by the voluntary sector but in partnership with locally-based organisations, mostly themselves registered charities, and Health Trainers are physically based in local locations. For example, in the Eastern Link area the Health Trainers operate from a substantial community centre in Dovecot, and in North Liverpool from Vauxhall Neighbourhood Council. In some cases Health Trainers are actually employed by "anchor organisations" such as the Communiversity in Croxteth, though most are employed by PSS itself. The service has a very good reputation with local PCT commissioners, partly through its ability to understand local communities and provide support in a way that is accessible to local people.

Much of the work of Health Trainers in Liverpool has focused around community venues, but the service has also sought to make inroads into GP surgeries. One Health Trainer is now based in Brownlow Group Practice close to the

⁵³ Department of Health, "Liverpool Health Profile" (2007), p.1.

⁵⁴ National Statistics Online, "Final Mid-2007 Population Estimates".

campus of Liverpool University. Other Health Trainers hold regular sessions in surgeries. The Health Trainer service has also worked closely with local initiatives such as the Healthy Communities Cancer Collaborative and played a key part in campaigns such as 'Lose a Million'. Nonetheless there is further work to do to promote the Health Trainers to GP practices and obtain more referrals from GPs. Many referrals are self-referrals obtained as a result of the publicity efforts of Health Trainers, who report very large number of annual contacts with individuals (more than 20,000 in 2008/9) through their local activities, though fewer go on to complete Personal Health Plans.

The service appears to have benefitted through operating via a third sector organisation which has helped to generate creative approaches to delivery. PSS and Age Concern have worked closely with Merseyside Fire and Rescue Service, based on a shared perception that behaviours such as smoking or excessive alcohol consumption are often a contributory factor in starting fires. PSS now provides its own training to Health Trainer and other bodies and has been responsible for training fire advocates both to Level 2 (Health Champions) and Level 3 (qualified Health Trainers). Two Health Trainers in South Liverpool are now physically based at the Community Fire Station for Speke/Garston. A further project working with prisoners in HMP Liverpool was successful in training prisoners both to Level 2 and Level 3 (which is thought not to have happened elsewhere).

Liverpool PCT has hugely ambitious plans for health improvement in the city. It plans to invest £100m in new and refurbished buildings and to recruit hundreds more staff. One key aim is to ensure that every patient in Liverpool will be able to see a GP within a maximum 15 minute walk, with a greater range of services

available as well as improved accessibility.⁵⁵ During 2009 the Health Trainer service was retendered by Liverpool PCT as a result of proposed increased investment in the service, with PSS and Age Concern being successful in their bid, which should see the expansion of Health Trainer numbers to nearly 40 within 3 years.

4.6 Sefton

Sefton is a local authority to the north of Liverpool bordered by Lancashire to the east. The borough shows considerable diversity, with concentrated areas of deprivation in half a dozen wards just outside the City centre in and around Bootle, which is an integral part of the City's conurbation and appears to experience similar health problems. By contrast North Sefton is perceived as relatively affluent, though smaller pockets of deprivation are to be found near the town centre of Southport in the far north.

Life expectancy in the borough as a whole is slightly lower than the England average though slightly higher than that for the North West as a whole. These averages can be misleading because of wide disparities experienced in this area. In Linacre ward in Bootle the proportion of people with limiting long-term illness is 27% compared to 22% in Sefton as a whole and just 18% across England.⁵⁶ Life expectancy for males in this ward is 11 years below that of nearby Maghull. For women life expectancy varies by as much as 8 years across the borough.⁵⁷ Though smoking rates appear to be somewhat lower than the England average, smoking is thought to account for half the gap in life expectancy in the borough,⁵⁸ killing 600 people per year.⁵⁹

55 Liverpool PCT, "A New Health Service: Better health, better care and better services for the people of Liverpool," Liverpool PCT (2008).

56 National Statistics Online, "Health and Provision of Unpaid Care (KS08)", Census 2001 (downloaded 2009).

57 Sefton PCT, "Sefton's Health: Annual Report of the Director of Public Health" (2008), p.6.

58 "Sefton's Health," p.14-15.

CVD causes a third of all deaths in Sefton, most of which are believed to be preventable with lifestyle changes such as stopping smoking and taking more exercise. CVD rates are more than 50% higher in deprived areas.⁶⁰ Death rates from cancer are 30% higher in the poorest areas⁶¹ and respiratory diseases are twice as common in such areas.⁶² There appears to be relatively little difference between areas of Sefton in terms of physical activity.⁶³ Levels of obesity in adults are similar to the average for England.⁶⁴

Sefton does not currently have dedicated Health Trainers though it is planning to do so. However Sefton did mount a training course from October 2007 to January 2008 with 15 students passing an assessment to become accredited Level 3 Health Trainers. The intention was that students, who came from the voluntary sector, local council and PCT, would implement the knowledge gained on the course in their own areas of work. The model here is one in which the Health Trainer qualification does not lead to the recipient practising in the role but instead having their work informed by the competencies.

Sefton PCT board has now allocated funding to pilot a paid Health Trainer service to be up and running towards the end of 2009. This will employ a small number of Health Trainer staff working closely with CVD checks which have been commenced in pharmacies in Neighbourhood Renewal Areas. It is intended the Health Trainer service will work one-to-one with individuals to support goals such as weight loss and particularly smoking cessation. Sefton PCT plans to have a single telephone number for access to Lifestyle Services, with which the Health Trainers will be integrated. Sefton PCT also plans to train

59 Department of Health, "Sefton Health Profile" (2008), p.1.

60 "Sefton's Health," p.18.

61 "Sefton's Health," p.24.

62 "Sefton's Health," p.30.

63 "Sefton's Health," p.18.

64 "Sefton Health Profile", p.1.

a hundred people from various organisations across Merseyside to the lower Level 2 qualification to help them understand health improvement issues in their own workplace.

4.7 Warrington

Warrington is a sizeable town on the River Mersey midway between Merseyside itself and the Greater Manchester conurbation to the east. Warrington has similar health to the average for England as a whole⁶⁵ and is described on the PCT's website as one of the most "prosperous districts in the country".⁶⁶ Though Warrington was designated a Spearhead area in 2004, the town no longer falls within the bottom fifth nationally for the relevant indicators.⁶⁷

Warrington in some respects appears to be typical of England as a whole with areas of poverty and affluence living side by side. In Warrington male life expectancy is one year below the average and female life expectancy just over half a year below.⁶⁸ As with so many areas in this study, the average figures masks considerable variations, such that in the most deprived area men live more than six years less and women more than four years less than in more affluent parts of the town.⁶⁹ Warrington is divided into 125 Super Output Areas, with 15 falling into the most deprived fifth of areas in England. These areas, containing 12% of the population, are mostly concentrated in inner Warrington. At the same time there are 45 areas which lie in the most affluent fifth of areas nationally, a rise from 37 in 2004.⁷⁰

65 Department of Health, "Warrington Health Profile" (2008), p.1.

66 Warrington PCT, "Profile of Warrington", downloaded from the website (2009).

67 Warrington Partnership, "Healthier Together" (2008), p.8-9.

68 "Warrington Health Profile", p.4.

69 "Warrington Health Profile", p.1.

70 Warrington PCT and Warrington Borough Council, "Warrington Joint Strategic Needs Assessment 2009: Supplement 1 Income Deprivation and Health Inequalities" (2009), p.5-6.

Smoking prevalence in Warrington shows great variability. In the most deprived fifth of the population smoking levels appear to be high and rising, moving from 35% in 2001 to 38% in 2006 according to local lifestyle surveys.⁷¹ By contrast smoking levels in the remainder of the population appear to have fallen during the same period, with rates dropping to 11% in the most affluent fifth of the population. Levels of obesity prevalence and unsafe drinking are all highest in the most deprived fifth of the population.⁷² Early death rates from CVD remain higher than the England average⁷³ and represent a key priority for the PCT.

Warrington's Health Trainer service was becoming established as this report was being written. Warrington's Health Trainer service will be known as the Wellbeing Service and its Health Trainers designated as Wellbeing Mentors. Six Wellbeing Mentors have been recruited (5.5 whole time equivalent posts) and are undergoing training to Level 3. Four Wellbeing Volunteers have been recruited and trained to the lower Level 2 standard (designated elsewhere as Health Champions). In addition there will be a further six Health Care Assistants trained to Level 3 who will carry out CVD screening, with the option to refer clients onto a Wellbeing Mentor. Warrington PCT hopes to attain an average of twelve new clients per month for each of its Health Trainers. It is hoped that half of clients will achieve the goals in their "wellbeing plan" within three months of this being agreed and that half of these will maintain the behaviour change after twelve months.

4.8 Western Cheshire

Western Cheshire PCT covers an area of some variety including the city of Chester, the industrial town of Ellesmere Port and a number of smaller market towns and villages. As explained above, local government reorganisation in

71 "Supplement 1", p.10.

72 "Supplement 1", p.9.

73 "Warrington Health Profile", p.3.

Cheshire has created two new unitary authorities which are not coterminous with PCT boundaries. The recent public health report from Western Cheshire PCT refers to the much larger Cheshire West and Chester area rather than to its own boundary, which contains 90,000 fewer people.⁷⁴ It needs to be borne in mind that there may be some statistical overlap in this summary with section 4.2.

Western Cheshire PCT covers an area where health is generally good. Life expectancy in areas such as Chester⁷⁵ and Ellesmere Port and Neston⁷⁶ is similar to the England average for both men and women. Smoking rates vary considerably. It is estimated that in Western Cheshire as a whole the overall rate of smoking is 24.5%, though rather lower in Chester (20%) and slightly higher in Ellesmere Port and Neston (25%).⁷⁷ Estimated rates of obesity for Western Cheshire are similar to the average for England but somewhat higher in areas such as Ellesmere Port and Neston (26%).⁷⁸ Adult participation rates in sport or active recreation appear higher than average.⁷⁹

As with all areas considered in this study, whether rich or poor, the underlying challenge is to address the impact of lifestyle on health. More than a third of deaths in Cheshire West are linked to CVD, more than a quarter are caused by cancer and nearly one in eight by respiratory diseases – many of which could be prevented with changes to lifestyle.⁸⁰ The impact of these factors are disproportionately felt in areas of greatest deprivation. In Chester both men and women have five years shorter life expectancy in the most deprived areas than

74 Western Cheshire PCT, “Western Cheshire Annual Public Health Report” (2008), p.4.

75 Department of Health, “Chester Health Profile” (2008), p.1.

76 Department of Health, “Ellesmere Port and Neston Health Profile” (2008), p.1.

77 “Western Cheshire Annual Public Health Report”, p.11.

78 “Western Cheshire Annual Public Health Report”, p.14.

79 “Western Cheshire Annual Public Health Report”, p.15.

80 “Western Cheshire Annual Public Health Report”, p.6.

the least deprived.⁸¹ In Ellesmere Port and Neston men from the most deprived areas have nearly seven years shorter life expectancy and women nearly eight years.⁸²

Western Cheshire PCT does not currently have a Health Trainer service. It is intending to consider a model for delivery and costing for this, though identifying funding may be an obstacle. Western Cheshire PCT does have initiatives such as weight management and stopping smoking services but has recognised that its expenditure on healthy lifestyles is below the average of comparable PCTs.⁸³ One key commitment is for a large-scale and systematic programme of vascular checks for those aged over 40.⁸⁴ The development of a Health Trainer service could be naturally linked to the CVD checks programme in the way we have seen in Knowsley.

4.9 Wirral

Wirral has generally worse health than the average for England.⁸⁵ It lies within the bottom fifth of local authority areas according to the index of multiple deprivation, with the greatest concentration of deprivation in the east of the borough in the docklands areas adjoining the River Mersey. Some 27 of Wirral's 207 Lower Super Output Areas fall within the most deprived 5% nationally.⁸⁶ It is estimated that 22.8% of the adult population smoke, which is lower than the national average, though rates in the most deprived areas are slightly more than 25% compared to the least deprived areas where smoking rates fall as low as

81 "Chester Health Profile", p.1.

82 "Ellesmere Port and Neston Health Profile", p.1.

83 Western Cheshire PCT, "Transforming Health and Healthcare, Getting it Right: a strategy to improve health and healthcare services for the people of Western Cheshire, 2009/10 – 2013/14" (2008), p.47.

84 "Transforming Health and Healthcare", p.48.

85 Department of Health, "Wirral Health Profile" (2008), p.1.

86 Wirral PCT, "Strategic Plan 2009-13", p.19.

10.1% (men) and 9.4% (women).⁸⁷ There are striking variations in life expectancy in the borough as a whole, from 72.6 years in Tranmere ward to 83.8 years in Royden ward in the west of the peninsula.⁸⁸ The rate of hospital stays related to alcohol is the second worst in the country.⁸⁹ Early death rates from cancer and from CVD are also higher than the England averages.

The main strategic goal of Wirral PCT is to reduce these health inequalities.⁹⁰ Wirral's Health Trainers were established relatively recently, with recruitment taking place in July 2008, and link in closely with the vision of the PCT by being closely targeted on areas of greatest deprivation. Wirral has 12 Health Trainers (equivalent to 11.5 full-time posts) almost all based in four Health Action Area Teams. The purpose of the teams is not to cover the borough as a whole but to focus on the most deprived areas, many of which are linked together geographically. One further Health Action Team, containing one of the Health Trainers, works to tackle health deprivation in those areas that fall outside the four geographically designated Health Action Areas. It can be seen therefore that Wirral's Health Trainers are focusing their efforts on 15% of the population who fall into the most deprived 5% nationally.⁹¹

Health Trainers are physically located in non-NHS premises within the four areas (a school, a YMCA, and two multi-purpose community centres). Each Health Area Action Team contains Health Trainers working closely with a Community Health Advisor, who organises and links in with other health promotion activities in the area, and a Team Leader and administrator. Wirral Health Trainer service does not at present produce its own publicity material such as service leaflets – unlike the other three services discussed in this report

87 "Strategic Plan", p.35.

88 "Strategic Plan", p.25.

89 "Wirral Health Profile", p.1.

90 "Strategic Plan", p.15.

91 Wirral PCT, "Health Action Areas and Community Programme Progress Update" (2008), p.1.

– but is marketed as part of the Health Action Area Team itself. The Health Trainer service is however recruiting a Programme Manager to take a strategic role in developing the service further.

Wirral has set ambitious targets for the production of Personal Health Plans by Health Trainers, aiming for 2000 plans per year. The Health Trainer programme is already linked in closely with a programme of CVD checks being carried out in a similarly targeted way by a private company commissioned by the PCT. Those at high risk of CVD are referred to a Health Trainer, which should help ensure a flow of appropriate referrals to the service. The borough plans to be able to offer CVD checks to everyone at risk across the borough through GP surgeries and aims to recruit a further 26 Health Advocates (otherwise known as Health Trainer Champions – qualified to Level 2, one stage below Health Trainers) to support this.

Health Trainers work with those aged 18+ but are primarily targeting people aged 40 to 74 years within the Health Action Areas. It is evident that this approach leads to a much narrower overall target population than an area such as (for example) Liverpool. It can be estimated that under half of the population of Wirral falls into these age groups.⁹² Bearing in mind that Health Trainers are focused on the Health Action Areas, this suggests that the overall target population for Health Trainers in Wirral is between 20,000-25,000 people.

The service does appear to have an upper limit in place for the number of meetings to be held with the client or the timescale of the intervention, instead basing this on need in each case whilst seeking to ensure that the client does not become dependent on Health Trainer support. Like colleagues in Halton & St Helens – but unlike Knowsley and Liverpool – Health Trainers in Wirral are

⁹² Wirral PCT and Wirral Borough Council, “Wirral Population: JSNA Consultation Document” (2008), p.2.

able to take a range of measurements such as blood pressure, height and weight.

4.10 Conclusion

The area profiles demonstrate that all areas in this report are experiencing population health issues that appear to be closely linked to modern lifestyles. These problems are exacerbated in areas of deprivation, most obviously with noticeably higher levels of smoking in these areas leading to increased rates of a number of ailments such as cancers and CVD and lowered life expectancy. The overall picture of health disparity is complex, and lifestyle is not the only factor involved, but support for lifestyle change appears to be a promising and perhaps inevitable step towards systematic health promotion.

| Area | Health Trainers |
|------------------------------|------------------------|
| Central and Eastern Cheshire | No |
| Halton and St Helens | Yes |
| Knowsley | Yes |
| Liverpool | Yes |
| Sefton | Planned |
| Warrington | In training |
| Western Cheshire | No |
| Wirral | Yes |

As Table 5 shows, Health Trainer services were up and running in four areas (Halton & St Helens, Knowsley, Liverpool and Wirral) and in training in one further area (Warrington). There was one area where services may possibly be developed (Western Cheshire), one area where services had been agreed and were actively under development (Sefton), and one area where such services appear to have been ruled out (Central & Eastern Cheshire).

5. Key Themes

5.1 Introduction

The previous section presented a profile of each of the areas in this study and described the extent of progress in each area in establishing a Health Trainer service. In this section we attempt to draw out some common themes of the research as they emerged from interviews and our analysis of the relevant data. In this section too we will seek to bear in mind the original aims of the Health Trainer initiative as set out in the White Paper and compare these aims with local implementation.

5.2 Strengths of Health Trainer Services

Interviewees were able to identify several key benefits of Health Trainer services (these are summarised in Table 6). Chief amongst these strengths was the ability to work one-to-one with clients and to spend time listening to them and working with them. It was acknowledged that “GPs for instance do not always have enough time” and group work may not always be suitable. Health Trainers were therefore filling a gap in services.

The White Paper has characterised statutory intervention as sometimes appearing like “advice from on high”. By contrast Health Trainers in this study were perceived to be non-judgmental, more like “a friend helping a friend,” which went down well with local people in deprived communities who may “want help, but they don’t like authority”. Health Trainers are able to present themselves as non-clinical and non-medical – as one interviewee put it, they are not a “treatment”. In some cases tunic tops with NHS logos can inadvertently

give the impression that Health Trainers are nurses, and medical vocabulary does still come through (e.g. talk of Health Trainers holding “clinics”).

| Table 6: Strengths of Health Trainer services |
|--|
| <ul style="list-style-type: none">• Work one-to-one• Have time to spend with the client• Non-judgmental• Non-clinical/non-medical• Personalised service• Can accompany people to activities• Practical focus• Understand the challenges faced by local communities• Empower people• Promote health ‘literacy’ and understanding of messages about healthy living• Bridge between communities and PCT |

Health Trainers are able to offer a personalised service, setting appointment times based on convenience for the client and meeting in a suitable location. They are able to accompany clients to activities. Health Trainers have a practical focus on areas such as diet, exercise and weight management. Through working closely with individuals in local communities they appeared to be in a good position to understand the challenges being faced. Their role was partly to empower local people to find their own solutions and take responsibility for their own health. They were also felt to be capable of acting as a bridge between the local PCT and the local community, translating health messages into terms that were more understandable.

5.3 Job Title

All four areas with Health Trainer services reported that clients easily confused their role with that of personal trainers or fitness coaches as a result of the

rather ambiguous job title. This seems understandable since Health Trainers are not, in fact, engaged in training in any commonly understood sense of the word. One area has instead adopted the title “Lifestyle Advisor” and has found this works much better, particularly where Health Trainers work closely with CVD checks where nurses may discuss their client’s lifestyle as containing risk factors.

5.4 Measuring the impact of local Health Trainers

It is evident from the White Paper that the precise manner in which Health Trainers operate in each area must depend to a considerable extent on local priorities and local interpretations. This does mean that it can be difficult to assess Health Trainer performance according to a common framework. As one interviewee commented, “whilst the flexibility is welcome it does make it harder to show any effects of the service”. There exists a national data collection and reporting system (DCRS) for use by Health Trainers but this is not compulsory and not all the areas within this study are utilising it.

Annual data collection reports produced by the North West Hub, based on self-completed Activity Reports from each PCT area, show some variations in key statistics, particularly in the proportion of clients who make Personal Health Plans (PHPs). It is known from discussion with interviewees in this study, and earlier detailed studies carried out by the same author in Knowsley and Liverpool, that not every client who is assessed will either need or want to undertake a Personal Health Plan. As one interviewee put it, “Some people will just want a meeting and some advice”. In some cases clients may simply want further information and signposting, or may feel they are not ready to commit themselves to making a health plan.^{93, 94}

93 Gary Kitchen “Evaluation of the Liverpool NHS Personal Health Trainer Service: Second Evaluation Report” (2009).

However there is wide variation between areas in the North West in the proportion of clients seen who go on to make a plan, ranging from 3% to 100%, with no consistent picture emerging.⁹⁵ It is possible that different interpretations are being made locally of what these categories mean. One interviewee said, “it would be useful if we had some agreed definitions for... measuring our services”. In each of the four areas of Cheshire and Merseyside with a Health Trainer service, there were different paper interpretations of what constituted a Personal Health Plan (PHP).

Though statistics for Cheshire & Merseyside are available from the Hub Annual Summary Report, we have not reproduced them here because of these difficulties of interpretation. As may be expected, the area where clients set fewest PHPs overall is the area where there are fewest Health Trainers (Knowsley) and the area where clients set most PHPs overall is the area with the most Health Trainers (Liverpool). It would be particularly useful in helping PCTs to set targets for the production of PHPs to be able to state average figures that may be achieved for each Health Trainer. This is not easy because the report contains head-count numbers of Health Trainers rather than whole-time equivalent figures. But as a rule of thumb, no area within Cheshire and Merseyside appeared to have exceeded 50 PHPs per Health Trainer per year during 2008/9.

5.5 Health Trainers and CVD Checks

One of Wirral’s main priorities is to work with those at higher risk of CVD, so there is a close link between Health Trainers and a programme of CVD checks with the over-40 age group taking place in areas of deprivation in the borough. In both Sefton and Warrington the intention is that Health Trainers will work

94 Gary Kitchen, “Support From Next Door: An Evaluation of Knowsley Health Trainers” (2009)

95 North West Health Trainer Hub, “North West Final 2008-09 Hub Annual Summary Report” (2009).

closely around CVD checks too. Meanwhile, in Knowsley, Health Trainers are now very closely linked in with the programme of CVD checks also.

In some respects, closer linkage of Health Trainers with CVD checks appears sensible. People who discover they have heightened risk of CVD may be better motivated to change than the general population. The impact of CVD prevention activity should also become apparent in a reasonable timescale, since it might be expected that areas with high levels of early warning checks would begin to show reducing numbers of CVD cases. Linking Health Trainers to CVD checks can help ensure they are working with the right people at the right time to make a practical difference to their health outcomes. In essence, though, this is a form of indirect targeting of Health Trainers by age and in relation to a specific set of diseases, which does not seem to be the intention of the White Paper. Health Trainer may also require further training to deal with the issues raised as a result of the CVD check and risk assessment.

5.6 Health Trainer recruitment

One of the expectations of *Choosing Health* was that Health Trainers would be local people with local knowledge of their own communities. In practice there appear to be some obstacles to achieving this. The key means of recruitment for the NHS appeared to be web-based and local people did not necessarily use this method to find jobs. Though some Health Trainers have been recruited to Band 3 in the NHS Agenda for Change workforce pay scale, it is now more difficult to do so since such staff are required to have the equivalent of NVQ/VRQ Level 3 on application (i.e. not simply at the end of their training period). In some areas, particularly where Health Trainers needed to travel within a wide work area, or needed to transport equipment, it appeared that doing the job without car ownership may have been difficult, which could potentially be an indirect obstacle to people from local communities applying for

posts. Finally, it was felt that the NHS recruitment model could mean that the “selection procedure is daunting”.

In practice, therefore, not all Health Trainer recruits came from local communities and some were over-qualified for the role. It was felt that more professional people were likely to apply for these posts in future as the job market contracted under the impact of recession. However in some areas, particularly Liverpool where staff are employed by the voluntary sector and not subject to PCT pay bandings, it appeared somewhat easier to recruit locally. Staff turnover was mentioned as a factor in some areas, as Health Trainers build on their training and experience to make progress in their career. This did pose a problem as training up new Health Trainers would take a number of months and training for very small numbers of Health Trainers at a time was not practical.

5.7 Working with GPs

Though no figures are available across Cheshire and Merseyside as a whole, Health Trainer services in the study appeared to receive relatively few referrals through GP surgeries. There appeared to be a need to build up links with GP practices and to explain the role of Health Trainers, which was not always clear even to medical professionals. HM Partnerships is currently working on a social marketing campaign across Cheshire and Merseyside to encourage and support GPs to engage with Health Trainer services.

5.8 Listening to Health Trainers

A number of interviewees believed that Health Trainers “have a lot to tell us about what is going on out there”. Health Trainers work closely with the local community and are in a good position to understand the health needs of the

local population: “how can we make use of the intelligence that they receive in terms of priorities for those communities?” Joint initiatives across Cheshire and Merseyside, such as having sub-regional meetings of Health Trainers from time to time to share information, could be beneficial.

5.9 Conclusion

In this section we have drawn out a number of common themes emerging from interviews. Together with the area profiles, this gives us a good understanding of how Health Trainer services are operating, the perceived benefits of the service, and issues which have arisen in the process of implementation and operation.

6. Summary and Conclusion

The sections of this report have served to describe and analyse the delivery of Health Trainer services across Cheshire and Merseyside. Following an introduction in Section 1, we set out in Section 2 the background context for understanding health promotion initiatives and in particular what Health Trainer services are aiming to achieve. In Section 3 we described the methodology of the research, combining a mixture of desk-based research and semi-structured interviews with key personnel in each area. In Section 4 we drew upon both research and interviews in order to provide a portrait of Health Trainer operation in each area. In Section 5 we sketched out some key themes emerging from the interviews. In this final Section, we wanted to take the opportunity to summarise the findings within a wider context.

Though the causes of health disparity are not fully understood, it is clear that how people live their lives has an influence on their life expectancy, and that pressures towards less healthy behaviours seem to be exacerbated in areas of highest deprivation. We do not know entirely why this is the case. It is possible that smoking, for example, serves as a form of consolation for those living on low income or coping with the pressures of unemployment – one with dire consequences for long term health.

In some respects the language of deprivation is not really suitable for capturing these experiences, which seem to relate to disparities in consumption (of calories, or cigarettes, or alcohol) rather than to the scarcity we associate with poverty. We must not forget that, behind the statistical number-crunching, for many people in poor neighbourhoods life is too often an unpleasant struggle for survival in which looking after one's own health may have a very low priority.

Many PCTs state that their chief goal is to tackle health inequality. But we also need to recognise that what is happening in the most deprived communities simply reflects what is happening in society at large. Too many people engage in harmful behaviours, such as smoking or excessive drinking. Too many people eat too much and exercise too little. These problems do not just affect deprived communities (though they are sometimes more starkly obvious there) but are apparent in the population as a whole. There are huge pressures towards a sedentary lifestyle for both adults and children, such as the doubling of car usage in a generation, the rise of an office-based service economy and the huge increase in the consumption of screen-based media. What needs to be avoided is the sense that sometimes deprived communities may feel as if they are being lectured by the rest of society, which is after all far from perfect.

The thinking behind the Health Trainer concept is straightforward. If people can be encouraged to stop smoking, take more exercise, eat a healthier diet, and drink at safer levels, this will benefit their health and have a positive impact on both their quality of life and its quantity (i.e. how long they live). Health Trainers add to existing initiatives by focusing on work with the individual (rather than groups) but in a generic way (dealing with a range of issues). In this report we have described how Health Trainer services have developed (or are being developed) across Cheshire and Merseyside and how they are being utilised to promote the health of local populations.

Health Trainers need to be deployed to have the maximum impact on health promotion and the reduction of health inequalities. There is some ambiguity in the White Paper as to whether Health Trainers are intended to be a geographically universal service or instead one which is meant to be focused on deprived communities with higher than average levels of lifestyle-related health issues and reduced life expectancy. Nor does it offer guidance on whether

Health Trainers should seek to focus on particular age groups, where they can arguably achieve most impact.

The situation is even more complex than it appears at first sight, since not everyone living in a deprived area will necessarily be suffering from deprivation themselves; meanwhile very many people with low incomes will be dispersed into more affluent wards and their needs masked by averaging. It is evident that a service cannot both be equally available to everyone within a Primary Care Trust and at the same time targeted on specific geographical population areas, specific population groups (e.g. people in the most deprived circumstances) or specific age groups.

Each area in this study has found its own way of dealing with this logical conundrum. None of the existing Health Trainer services in Cheshire and Merseyside excludes anyone from using the service (apart from those below the age threshold). In three of the areas – Halton & St Helens, Knowsley and Liverpool – the approach appeared to be to publicise the service as widely as possible throughout the PCT area and then to try to ensure a higher proportion of individuals from deprived communities through more intense targeted work. Wirral appeared to have adopted a more closely focused approach by linking Health Trainers to discrete Health Action Areas covering 15% of the overall population.

Several interviewees emphasised that some PCTs are experiencing deficits which was affecting both existing and planned services. It is clear that, at national level, expenditure is outstripping income and leading to a huge hole in the public finances. In our view this must inevitably lead to cuts in expenditure, which may happen sooner or later, but are likely to affect all statutory agencies to some extent. The question of targeting resources, and perhaps how Health

Trainers are deployed to achieve the maximum impact, may need to be considered urgently in the near future.

Health promotion services operate with an understanding that health and life expectancy are closely linked to income. It follows, I think, that during recession, where people's living standards as a whole will inevitably fall and worklessness will rise, economic changes may have a negative impact on public health. It is likely that, during such times, Health Trainers will be needed more than ever.