PROPOSAL TO CEASE OXFORDSHIRE'S HEALTH TRAINER INITIATIVE: CONSULTATION PAPER FOR OXFORDSHIRE'S JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

THURSDAY 10 MARCH 2011

1. Summary

One of the major roles of the Director of Public Health is to provide the people of Oxfordshire with a range of services that will improve health and give excellent value for every penny of taxpayers' money. This includes setting up new services, reviewing existing services and ceasing services that do not give good value for money. As a custodian of the public purse the Director of Public Heath has to ensure that each penny spent gives the best return in terms of health outcomes. This means that, as for other public bodies, difficult decisions have to be made: when value for money is poor and improvements cannot realistically be made, some programmes must inevitably cease.

As part of a much wider review, the Health Trainer Initiative (which was set up by the Public Health team in 2006) has been shown to give a poor return on investment. The initiative does not reach sufficient numbers of people, is extremely expensive and the service model cannot realistically be improved. In the meantime, more promising alternatives have come forward. It is therefore proposed to cease this initiative as soon as possible. The Health Overview and Scrutiny Committee are asked to scrutinise this proposal. This is particularly important because the service was originally set up to reduce health inequalities.

It is emphasised at the outset that the motivation for ceasing this service is its lack of effectiveness and poor value for money demonstrated as part of a review begun in 2009. The motivation is not cost reduction.

2. Context within which these changes are proposed

Along with all public sector bodies, the Public Health function is going through a period of unprecedented change. This section outlines the reasons for change relevant to this service. Throughout this period, we are committed to keeping a strong public health function in Oxfordshire and to transfer it successfully to Local Authorities in 2013.
To prepare for this, since November 2009, the public health team have been reviewing all work programmes in detail to ensure that they meet the needs of the future. A number of these changes are directly relevant to the proposals for the Health trainer initiative. These are:

- Transferring services currently provided in-house by the public health team into NHS provider Trusts. The smoking cessation advice service and TB community nurse service are examples. They are planned to transfer to the Mental Health Trust shortly, along with other Community Health Oxfordshire services. This is not a straightforward process. NHS provider trusts go through a process of *due diligence* to ensure that the services they accept are financially viable; that they can deliver the outcomes required; and that

they are guaranteed to have the support of commissioners for the medium term.

- Preparing to transit the Public Health function to Local Authorities under a nationally set capitation budget. Benchmarking shows that the Oxfordshire public health team is considerably larger than teams in neighbouring counties (up to four times bigger) and any national budget is highly unlikely to cover current costs - this would put local Authorities in the invidious position of inheriting a service that could not be afforded. National 'shadow' budgets for public health will be produced from April 2012. It is important therefore that all services are reviewed and that we can justify every penny spent.

The public health team are also required to accommodate other changes which include:

- The need to divide all services currently managed within the directorate into those destined for transit to local authorities in 2013 and those destined to remain in the NHS. (Examples are managing prescribing in the county and priority setting for expensive cancer drugs).

- Preparing to provide improved support to GP commissioning consortium and NHS 'Clusters' as they form.

- Dividing services carefully into those which will remain local (including health improvement and fighting health inequalities) and those which will move to regional or national levels in due course (including some screening and immunization services)

To help make decisions about these changes it was necessary to undertake an extremely thorough evidence-based, value for money review of all public health services. Over one hundred services and initiatives have been considered in detail and we now have a very good understanding of what 'works' and what does not for each of these services, and we also know which services give a good return on public money.

To support the public health team in this work and ensure good governance, a Public Health Transition Group was set up which includes the Chair of Oxfordshire's Joint Health Overview and Scrutiny Committee and a PCT non-executive director. This was reported at the last Health Overview and Scrutiny Committee meeting.

The Health Trainer Initiative is therefore just one of many services that have been reviewed. It is proposed to cease the service because, unfortunately, it shows particularly poor performance and poor value for money which cannot be practically ameliorated. The main 'driver' for this proposal is the drive to give good value for money. This proposal is not motivated by the need to make 'cuts' to budgets.

3. What is the Health Trainer Initiative?

3.1 Description and History of the Health Trainer Initiative

The purpose of the service is to **prevent premature death in adults** in areas where there is a **wide gap between death rates** between the best off and the worst off, by **working with individuals** to set health goals and to meet those goals.

The concept behind health trainer initiative was first described in the Choosing Health White Paper in 2004. In Oxfordshire, a pilot Health Trainer initiative was set up in July 2006 as an experimental approach to try to improve the health of hard-to-reach individuals in deprived parts of Oxford City and Banbury. The public health team supported this initiative because we believed it might prove to be the key to reaching out to 'hard to reach' communities. As a team it is our intention to seek out the best ways of reducing inequalities within this county. We invested more in this service then elsewhere in the South Central Region because we wanted to give it the best chance of succeeding. The public health team have invested considerable time, effort and belief in trying to make this initiative work.

The idea behind the service is a good one, it is to employ residents from local communities to contact 'hard to reach' individuals to either 'signpost' them to other services and if possible, to work with them to set a personal plan for health improvement (usually around weight loss, exercising or smoking) and support them as they put the plan into action.

The service was set up to focus on specific deprived wards within Oxford City and Banbury these are Blackbird Leys, Rose Hill & Littlemore and Barton in Oxford City, Neithrop, Grimsbury and Ruscote in Banbury. Around 15 staff have been employed at any one time, mostly part time. Currently there are 11 Health Trainers directly employed by the PCT, making up 6 full time equivalent posts.

Health Trainers are non-clinical staff, therefore cannot give medical advice. They cannot see clients with long term medical conditions or conditions which Health Trainer input may have an adverse impact on, *without gaining consent and specific advice from the client's GP.*

3.2 Service activity

The in-depth review described above included an analysis of the number of clients seen from April 2008 – September 2010 and calculated the costs incurred for the outcomes gained.

A summary of the data collected by the Health Trainers from April 2008 to September 2010 shows that:

- 260 new clients were seen by the service on average in a year. This is a low figure, representing only one new client seen per working day by the combined efforts of all health trainers.
- 150 clients agreed to a targeted health plan on average in the year, most of whom concentrated on losing weight or increasing their physical activity levels. Clients set their own targets for weight loss, with advice from the health trainer. Again, this figure is very low representing 3 health plans agreed by the combined efforts of all health trainers per working week.

- Only one in four clients achieved their health objective. This means that in total only 36 clients on average fully achieved their health objective each year.
- In terms of numbers of individuals achieving their health objectives each year, the data shows that in each year, approximately:

    - only 1 client per year met their 'emotional wellbeing' target
    - only 2 clients per year met their quit-smoking targets
    - only 14 people per year met their exercise targets
    - only 18 individuals per year met their diet/nutrition targets.

Full-service activity data is included in Annex one.

3.3 Service costs

Over one million pounds has been allocated to this initiative over the last 3 years. The budget for the service has been increased year on year as follows:

Financial Year	Budget
2008/09	£307k
2009/10	£341k
2010/11	£369k

These figures exclude any additional costs of managing the service within the central public health team.

The total budget allocated to this service for the period of data collection mentioned above (April 2008 to September 2010 was therefore 832K, excluding any additional costs within the central public health team (307k + £341K + half of £396K).

Over £1,000 of tax-payer's money is budgeted to maintain this service every single day.

3.4 People employed, staff turnover and sickness absence

The total number of staff employed by the Health Trainer initiative since July 2006 is 29. Each member of staff is given basic training for up to 2 months before beginning client work and ongoing training throughout their employment. Fifteen members of staff have left their posts with an average of 17 months service (range 6-27 months). The average length of employment for all members of staff, including those currently in post, is 23 months.
Staff turnover for this staff group has been high compared with elsewhere in the PCT.

Sickness absence rates in this staff group have also been very high. The PCT average for sickness absence is 2.6% and the standard aimed for is 3% or less.
Health trainer sickness absence in 2009/10 was 16%, i.e. 6 times higher than the PCT average, and sickness absence in the current financial year to date is 14%, i.e. 5 times higher than the PCT average. Coupled with turnover and the need for thorough training of new staff, this means that the management input required by this staff group is intensive.

4. Why is it proposed to cease this service? The five reasons are as follows:

4.1 Lack of impact on population health because of the low number of new clients seen
4.2 Poor value for money and return on investment
4.3 High cost and low impact of the service when benchmarked against other services
4.4 Inability to transfer this work to an NHS provider trust as a commissionable service
4.5 The opportunity cost - while the initiative remains, more promising alternatives cannot be fully pursued.

Theses five reasons are explored in detail below

4.1 Lack of Impact on Population Health in Deprived Parts of Oxford City and Banbury -Low Number of new clients seen

The main points are:

Only 250 new clients per year were reached by this service on average.
This is a very small number by any standards.
This equates to only one new service contact generated by around 11 health trainers every working day.

Of these an even smaller number agreed a health plan (150 per year on average), and of these only tiny numbers of people achieved their own personal targets per year (2 smoking quitters, 14 meeting exercise targets and 18 achieving weight loss targets on average per year).

The inescapable conclusion is that the impact of this initiative on the health of the population has been very slight indeed, particularly when it is recalled that the point of the service is to prevent premature death in adults.

4.2 Poor value for money and return on investment

An analysis of the cost effectiveness of this initiative shows that the cost to the taxpayer from April 2008 to September 2010 was on average:

- **£1,300 per new client contacted**, whether or not a favourable result was achieved. (£832k / 640 clients)
- **£2,200 per individual health plan produced**, whether or not the targets in the plan were met.(£832k / 372 health plans)
- **£9,300 per individual for successfully giving up smoking** for 4 weeks (£832k / 89 total successful health plans delivered)
- **£9,300 per individual for meeting any agreed exercise target**
- **£9,300 per individual for successfully meeting any agreed dietary or weight loss target**
- It is not known whether or not these benefits were maintained.

These figures can only be described as extraordinarily expensive and demonstrate exceptionally poor value for money.

4.3 High Cost and Low Impact of Service Shown by Benchmarking and Comparative Data

Although it is difficult to find exact comparisons, but looking at the costs of other types of health service contacts from a range of sources gives stark results:

- £27 per standard GP consultation.
- £11 per adult health check carried out by outreach nurses in an Oxfordshire pilot project
- Health and Social Care advisor employed by the local authority £31 per hour, which might be the time spent with one client.
- For £228 a child can receive the full childhood vaccination regime
- For £741 an elderly person can receive cataract surgery.

Perhaps the best comparison is with the public health team's own Oxfordshire Stop-Smoking service which helps people stop smoking for **£145 per smoking quitter, and achieves 3,300 smoking quitters per year.** (ie reaching around 13 times more people than the health trainer initiative). This service is also specifically targeted at hard-to-reach groups. **This service is a staggering 64 times more cost-effective that the health trainer initiative.** (£145 per quitter compared with £9,300)

4.4 Inability to Be Able to Transfer This Service to a Provider Trust

As mentioned above, services directly provided by the Public Health team are currently being transferred to provider trusts. Services can only be accepted by provider trusts where due diligence checks show the service is viable and specified outcomes can delivered. In addition, the PCT as commissioner has to state its willingness to continue to commission these services for a number of years to provide stability.
With regard to the Health Trainer Service, effectiveness and good value for money cannot be demonstrated, and thus it would be impossible for the PCT to guarantee future commissioning of this service.
This is a further indication that **the service is not viable within the current operating principles of the NHS - it is simply not commissionable in its present form, nor can realistic changes be envisaged that would make it commissionable in the future.**

4.5 The opportunity cost - while this initiative remains, more promising alternatives cannot be fully pursued.

Section 8 sets out the other initiatives which have either begun or are proposed to substitute or replace this initiative. These cannot be pursued fully while this initiative remains.

5. Are Similar Steps Being Taken Elsewhere?

The Health Trainer Service in Milton Keynes has recently been decommissioned by the PCT. This was contracted out to a provider organisation and the contract has not been re-tendered.

6. What is the Likely Impact of ceasing this service on the population and how can the impact be mitigated?

The coverage of the health trainer initiative (which sees on average 250 new clients per year and agrees only 150 health plans) is very small indeed compared with the total adult population of the target population. This means that the impact on any section of the population is very small. When it is also taken into account that only around 36 clients per year meet their agreed targets, the impact of the service falls from being very small to being extremely small.

An Equality Impact Assessment has shown that the impact on individual vulnerable groups of ceasing this service, including ethnic minority groups, will be slight because of:

- the small number of new clients contacted and the even smaller number of those successfully meeting their own targets
- poor evidence of cost-effectiveness among those who were contacted
- other services (existing and new) which will mitigate any potential impact (described below).

7. What is the Likely Impact of ceasing this service on staff and how can the impact be mitigated?

The formal proposal to cease this service was set out as part of a wider PCT Staff Consultation document issued on January 19th 2011. No action was taken apart from to consult with staff and inform affected staff groups that they were 'affected by change' - a technical Human Resources term meaning that proposals are under discussion which may affect individual posts.

Staff-side unions were engaged in this consultation through the usual formal and informal channels. It is anticipated that union representatives will brief the Health Overview and Scrutiny Committee on their specific concerns. The consultation document was launched at a staff meeting, and following this, within the Public Health Directorate, meetings with all staff groups affected by change were held on 20 and 21 January, including Health Trainers. This was followed up by detailed meetings with all individuals involved to ensure understanding of how they may be affected by change, options for national and local redundancy schemes, offers of suitable alternative employment and redeployment support plus their option to respond to the consultation.

During this staff consultation, it became clear that it would be beneficial to seek the opinion of the Health Overview and Scrutiny Committee (HOSC) on this issue, and so the PCT requested HOSC to scrutinise the issue and give their opinion and advice as soon as practicable.

It was proposed to staff-side representatives that the Health Trainer initiative should be formally taken out of the PCT staff consultation at this point so as to allow unfettered debate at HOSC. This was agreed to, and so the present position is that the Health Trainer initiative is suspended from the PCT consultation pending the discussion with HOSC.

Depending on the opinion and advice of HOSC, the next steps will be negotiated in the usual way through the PCT's Staff Partnership Forum. Whatever the outcome, the PCT will safeguard the legal rights of its staff.

At no time have any Health Trainers been formally put 'at risk' of redundancy, although if the service were to cease, it would clearly be disingenuous to guarantee that they would not be affected as individuals.

Whatever the outcome, the staff employed as Health Trainers have all received extensive training including qualification at level 3 City and Guilds as part of their training. Their range of competences and experience gained is applicable to a range of roles.

8. What Services are Proposed to Substitute for or Replace this Initiative?

Examples of existing; new and potential services (with approximate investment) that will be in place to minimise the very small impact of this proposal are set out below:

Services Recently put in place

- The Family Intervention Project which teams up the staff of Children and Young Peoples' Services with Community Nurses and the Criminal Justice System to target our most needy families. This initiative is showing very good return on investment in Oxford with savings of £59K on average for the 28 families engaged so far. The idea is to be of benefit to adults as well as children. We are seeking to invest further in this service.

Existing services which support lifestyle change

- Oxfordshire Smoking Advice Service and other stop smoking services £525Kpa
- Slimming on referral service for Primary Care £85Kpa
- Exercise on Referral (PCT contribution) £10Kpa

Existing services targeted at vulnerable groups

- Interpretation Services £125Kpa
- Health Advocacy Service which aims specifically to improve access to NHS services for a range of Black and Minority Ethnic communities in areas of social deprivation £160Kpa
- We have also recently managed to maintain the 'Benefits in Practice' (BIP) scheme in deprived areas despite funding cuts from other agencies - this scheme places Citizens Advice Bureau benefits advisors in General Practice to help the worst-off access the benefits to which they are entitled. Cost to the PCT of maintaining BIP in the city is £20K pa

New Services:

- Benefits in practice (Banbury) as part of the Public Health review we reallocated investments on Benefits in practice and will be setting up a service in Banbury 13.5Kpa

- The new NHS Health Checks programme which aims to help prevent heart disease, stroke, diabetes and kidney disease. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions, will be invited (once every five years) to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes and will be given support and advice to help them reduce or manage that risk. NHS Health Checks will start being offered in Oxfordshire in 2011/12 with full roll-out planned for 2012/13. The estimated cost of providing this service is £225K per year, based on information on costs we have gathered from pilots.

Potential New services

- The Department of Health are expected to produce documents on the future direction for Obesity and physical activity together with more guidance on the Public Health Responsibility Deal in Spring 2011. These documents together with information on local needs will steer our commissioning plans for the future.

Whatever the outcome, these investments signal the need for a change of tack reflecting our learning from the Health Trainer initiative. In future we would propose to commission services from existing or new service providers rather than provide services in-house ourselves.

Our overall aim will be to shift the large blocks of money spent on generic services in our county each year so that they better meet the needs of deprived communities whether urban or rural. The public sector spends over £2billion on services in Oxfordshire each year. We believe that by specifying contracts more tightly around health improvement and health inequalities, we can influence this spending to achieve a greater benefit to the population. In this way we believe we can influence the spending many millions of pounds of public money rather using our current management effort on running small services ourselves which may not give good value.

This work will be overseen by the Public Health Transition Group mentioned above and we welcome and invite full HOSC participation in this work.

9. What Consultation Has Taken Place and Why has Formal Public Consultation Not Taken Place?

The following groups have been consulted or will have been consulted by the time of the HOSC meeting:

- The Public Health Transition Group
- The PCT Executive and Board
- The PCT's staff partnership forum
- The health trainers, collectively and individually
- Individual County and District Councillors in the areas where the initiative is targeted and elsewhere
- The LINk Steering Group on the 2nd of March 2011
- The Joint Health Overview and Scrutiny Committee on the 10th of March 2011.

At the HOSC meeting, we would wish to reach a view of how best to apply the paragraph below to this proposal:

"Each local NHS body has a duty to consult the local overview and scrutiny committee(s) on any proposals it may have under consideration for any substantial development of the health service in the area of the committees' local authorities, or on any proposal to make any substantial variation in the provision of such service(s)".

Looking at the data, our own view is that this proposal does not constitute a substantial variation in service provision because:

- The numbers of people affected are by the initiative in total are very small indeed with annual average figures of 36 successful plans achieved out of a total around 150 plans and 260 new contacts.

- The initiative is not effective - it simply does not make a discernible impact on mortality in socially deprived communities

- The initiative is very far from being cost effective: our conclusion is that taxpayer's money is not well invested here. Alternative approaches show greater potential for success.

- The Equality Impact Assessment for this proposal does not point to a specific community group to be consulted with. The conclusion is that ceasing the service would not have a differential impact on any particular group of people, including black and ethnic minority communities.

Our conclusion therefore is that, on balance, the public interest would be best served by ceasing this service on the basis of the information in front of us and to use the experience gained to develop alternatives which are more likely to be effective. We do not believe that wider consultation would be helpful in this case. We ask for the opinion and advice of the Health Overview and Scrutiny Committee on this matter.

10. What Next Steps are Proposed and What Is the Joint Health Overview and Scrutiny Committee Requested To Do?

In the light of this information, as Director of Public Health, I am compelled to conclude that the only logical step is to propose ceasing the Health Trainer initiative. This is a difficult proposal to make as my team and I have initiated, developed and championed this initiative over a number of years. Nonetheless, the facts will not be denied, we must provide the public with the very best services they deserve and I conclude that this service cannot realistically be changed or modified to be cost effective. The main reasons are summarised again here:

- **Lack of Impact on Population Health: we will not reduce inequalities in mortality through this initiative**
- **Low Numbers of new patients seen, low numbers of health plans produced and poor effectiveness of those plans** (36 successful plans on average per year)
- **Very poor value for money and return on investment** (£9,300 per successful plan)

- **High cost and low impact of the service when benchmarked against other services** (£9,300 per successful plan compared with £145 per quitter from the Oxfordshire Stop Smoking Service)
- **Inability to transfer this work to an NHS provider trust as a commissionable service**
- **The opportunity cost - while the initiative remains, more promising alternatives cannot be fully pursued.**

The Health Overview and Scrutiny Committee are there therefore respectfully asked to:

- **Debate this issue and give a general opinion and advice based on the content of this paper and other presentations received at HOSC**

- **Support the conclusion that the best way forward is to cease this initiative and to pursue alternative service models as the way forward.**

Jonathan McWilliam - Director of Public Health for Oxfordshire
Jackie Wilderspin - Assistant Director of Public Health
Shakiba Habibula - Deputy Director of Public Health
Val Messenger - Deputy Director of Public Health

February 2011

Supplementary Information: Frequently Asked Questions

1. Is this change prompted by the need to cut NHS budgets?
No. This change is prompted by a comprehensive analysis of the effectiveness and value for money in Public Health services. Although it is consulted upon within a PCT document which does seek savings, this proposal is not motivated by a need to make financial savings.

2. Was the data collected fairly given factors in 2010 such as the swine flu pandemic?
The data was averaged over the period April 2008 to September 2010. This sort of fluctuation in activity would not affect the conclusions in this paper.

3. Why weren't the health trainer team allowed to work with under 18 year olds?
The aim of the service is to reduce the gap in life expectancy, therefore the target population is those at risk of premature death. This means targeting clients aged 40-60 with risky lifestyles and behaviours. Spending time with under 18s would have reduced cost effectiveness even further.

4. Why weren't health trainers allowed to do group work?
The health trainers do carry out some group work but the main aim was to use the initiative as a way of recruiting individual clients who are hard to reach. From the outset the aim has been to help individuals to change behaviour and reduce risk of premature death. Group work alone will not deliver this.

Much of the client work shows that people have complex issues. Group work may only give general information and the aim of the service is to give specific and appropriate support to individuals.

5. You weren't measuring the right things in your review. You have ignored the qualitative aspects, quality of life, confidence and self esteem issues and feedback that clients have given.

The cost effectiveness calculation has to be based on measureable outcomes such as significant weight loss (e.g. 5% of body weight), smoking cessation or self reporting of meeting a specific goal. Additional factors based on subjective assessments e.g. self confidence may or may not improve, and they are of value to clients, but they will not reduce premature death and that is the point of the service.

Individual clients will of course report good successes from the service, but we need to measure the impact of the service as a whole if we are to improve the population's health.

6. Aren't we missing some other important outcomes such as work on mental wellbeing?

In two and a half years only 6 people were seen by the service with improving mental wellbeing as their primary goal, I.e. around 2-3 people per year. Of these 6, only 2 achieved their goals i.e. less than one person per year. There may well have been other benefits to mental health and self-esteem, through contact with this service and these are welcomed, but these were not the primary point of this initiative.

7. Why can't you just reduce the size of the service rather than ceasing it completely?

Why didn't you engage the team and ask for their ideas in making improvements?

The real problem lies in the basic design of the service. We judge that whether this initiative were larger or smaller it would not produce effective results nor could it give a good return on investment. We conclude that this service model will not reduce premature death whatever its detailed size or shape. This issue isn't about making adjustments to a service that almost works, the facts show that the service is very far from working.

A very rough estimate may help to illustrate the point here: to become viable and commissionable, the service would probably have to achieve successful outcomes for its clients at a cost of around, say, £300 per successful plan delivered. On present performance this would require an increase of 30 fold in recruitment of new clients per health trainer which is clearly unachievable for this service model.

8. Were staff not told there was a problem?

All team members knew the importance of demonstrating the effectiveness of the service through regular data collection. Each month staff had to send monthly reports about clients and outcomes. They were not given individual targets but were aware that the number of clients mattered.

Individual staff have received regular one to one reviews of performance.

The results of the review of services undertaken in the Public Health department were fed back to staff. As pointed out above, we believe that the solution cannot

lie in making adjustments to the service model, the problem lies within the service model itself.

9. Isn't there national concern to protect Public Health posts at present?

Ministers are concerned that very specialist public health skills are not lost before Public Health England is formed. This applies only to those who have completed specialist training at consultant level. It does not apply at all to middle managers or health trainers. Health Trainers do not have the specialist public health skills that ministers have voiced concern about losing.

Annex 1

Health Trainer Activity Data from 01.04.2008 to 03.09.2010

Gender	Count
Male	234
Female	413
Total	647

Ethnicity	Count
A: White - British	430
B: White - Irish	7
C: Other White Background	11
D: Mixed - White and Black Caribbean	6
E: Mixed - White and Black African	3
G: Mixed - Any Other Mixed Background	5
H: Asian or Asian British - Indian	36
I: Asian or Asian British - Pakistani	74
J: Asian or Asian British - Bangladeshi	4
K: Any Other Asian Background	3
L: Black or Black British - Caribbean	12
M: Black or Black British - African	10
O: Chinese	1
P: Any Other Ethnic Group	3
Z: Not Stated	42
	647

Comment: the table above shows that the ethnic minority groups contacted reflect the composition of the populations targeted by the health trainer service.

Heath Trainers Clients Progress against PHP											
	CVD	General Practice	Health Promotion Event	Health Visitor	Other	Pharmacy (non CVD)	Phone	Poster/Card	Referred from HT champion	Self	Total
Not required	46	2	163	1	4	0	3	0	1	55	275
Not recorded	0	3	3	1	9	0	0	5	0	1	22
ACHIEVED	3	13	21	1	10	2	3	3	1	33	90
NOT ACHIEVED	3	10	20	1	10	5	2	12	1	41	105
PART ACHIEVED	6	13	42	2	8	5	5	4	0	61	146
Total	58	41	249	6	41	12	13	24	3	191	638

HT Clients Progress against PHP											
	CVD	General Practice	Health Promotion Event	Health Visitor	Other	Pharmacy (non CVD)	Phone	Poster/Card	Referred from HT champion	Self	Total
Eligible did not want to proceed			1		1					1	3
Proceed to PHP	12	39	86	5	42	12	11	24	2	139	**372**
Eligible service mot wanted					1						1
Info Only	44	1	158	1			2			43	**249**
Not Eligible			1								1
Recommended to Primary Care										6	6
Referred to accredited			2								2

Health Trainer											
Signpost Only	2	1	1							1	5
Total	58	41	249	6	44	12	13	24	2	190	**639**

Comment: The above table shows that of the 639 clients seen over 29 months, 249 received information only (signposting), and 372 went on to make personal health plans (PHPs).
Approximate annual averages for these figures are 260 new clients seen and 150 health plans made.

HT Clients Progress against Primary Issue												
	Alcohol		Diet		Emotional Wellbeing		Exercise		Smoking		Total	
	Client	%	Client	%	Client	%	Client	%	Client	%	Client	%
Not Required	-	-	-	-	-	-	-	-	-	-		
Not recorded	-	-	18	10%	-	-	3	2%	1	4%	22	
ACHIEVED	**4**	**57%**	**45**	**25%**	**2**	**33%**	**34**	**23%**	**4**	**17%**	**89**	
NOT ACHIEVED	1	14%	59	32.5%	-	-	33	23%	11	46%	104	
PART ACHIEVED	2	29%	59	32.5%	4	66%	75	52%	8	33%	148	
TOTAL	**7**	**100%**	**181**	**100%**	**6**	**100%**	**145**	**100%**	**24**	**100%**	**363**	

Comment: The table above gives the hard outcome data for the health trainer initiative.
Over 29 months, 363 people made health plans, of whom 89 achieved their primary goal (a success rate of about 1 in 4).
The bottom row shows that the majority of plans were about diet and exercise, with far smaller numbers focussing on alcohol, emotional wellbeing and smoking.
The central row in bold labelled 'achieved' is telling - this shows the numbers of actual individuals who met their targets over the 29 months ie 4 people for alcohol, 45 for diet and so on.
This gives annual success figures for individuals as follows:

- **Alcohol: between 1 and 2 people were successful per year (4 divided by 29 months x 12)**
- **Diet: between 18 and 19 people were successful per year**
- **Emotional Wellbeing: about one person per year was successful.**
- **Exercise: about 14 people per year were successful**
- **Smoking: between 1 and 2 people per year were successful.**

	Diet & Exercise	
	Client	%
Not Required	21	6%
Not recorded	-	-
ACHIEVED	79	24%
NOT ACHIEVED	92	28%
PART ACHIEVED	134	42%
TOTAL	326	100%