Health Trainers

Performance Report

2015/16

1. INTRODUCTION

The Health Trainers programme was set up in 2008 in response to the 'Choosing Health' Government White Paper, to introduce a workforce that would support people experiencing the

poorest health to make improvements. Moving away from 'advice from on high' and using a 'support from next door approach', the Health Trainer (HT) service in Leeds, delivered by 3rd sector agency Health for All, has recruited local people with a real insight into the day to day experiences of the target communities. They have been effective in delivering one to one sessions to support lifestyle change and have made a real difference to people's health and wellbeing. Service developments for this year include increases in: male clients referred into the service; self-referrals and improvements to emotional health and wellbeing. Whilst weight management is the main goal clients seek support with, a huge proportion of these clients combine this with a secondary goal of increasing physical activity; this is really encouraging as there's strong scientific evidence that being physically active lowers the risk of many chronic diseases and it can also boost self-esteem, mood, sleep quality and energy, as well as reducing your risk of stress, depression, dementia and Alzheimer's disease (NHS Choices, 2016). This report demonstrates the level of impact the HT service has made and how it has been successful in reaching those living in the most deprived areas of Leeds.

2. COUNT OF NEW CLIENT REFERRALS

Table 1: Number of clients referred into the service

New referrals	Overall			
	2012/13	2013/14	2014/15	2015/16
	771	998	1066	930

3. CLIENT DEMOGRAPHICS

This section provides a series of summary charts that outline the basic demographic profile of new clients referred to the HT service.

3.1 GENDER

- The service remains predominantly accessed by women; this is consistent with the national picture of HT activity.

Table 2: Gender of clients

Gender	Overall							
	2012/13		2013/14		2014/15		2015/16	
	Count	%	Count	%	Count	%	Count	%
Female	579	75.1	686	68.7	761	71.3	656	70.5
Male	192	24.9	312	31.3	306	28.7	274	29.5

3.2 AGE BAND

- The service is predominantly accessed by '36-45' and '46-55' age groups. There has been a significant increase in the number of people aged 65+ referred into the service this year; this may be due to the increase in outreach activity HTs have engaged in, recruiting clients from community venues and places where people congregate.

Table 3: Age of clients

Age	2014/15		2015/16	
	Count	%	Count	%
Declined	2	0.2	3	0.3
<18	5	0.5	4	0.4
18-25	79	7	48	5.1
26-35	190	18	168	18
36-45	230	22	200	21.5
46-55	256	24	216	23.2
56-65	127	12	164	17.6
65+	0	0	127	13.7

3.3 ETHNICITY

- There has been an increase in number of people recruited into the service from 'Asian Indian' backgrounds and 'Other Ethnic Groups' compared to the previous year; 'Any Other Ethnic Group' includes people from any Eastern European background - the recruitment of a Polish speaking HT may explain this growth.

Chart 1: Ethnicity breakdown of clients

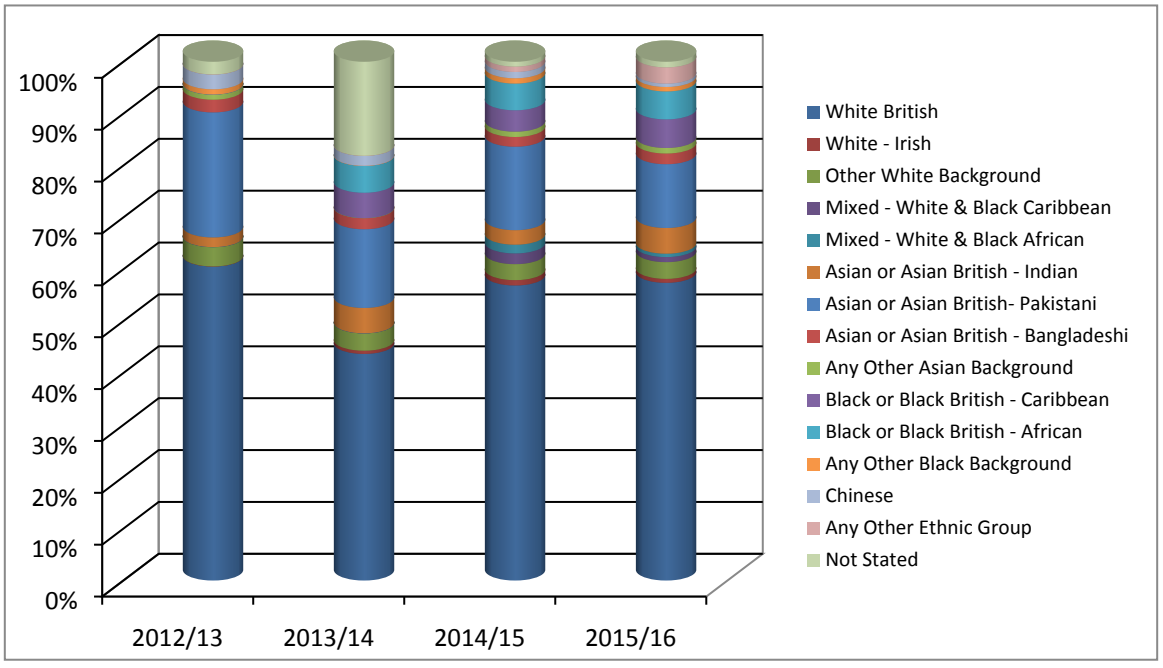

Table 4: Ethnicity breakdown of clients

Ethnicity	2012/13		2013/14		2014/15		2015/16	
	Count	%	Count	%	Count	%	Count	%
A: White - British	422	54.7	429	43.0	608	57.0	532	57.2
B: White - Irish	0	0	6	0.6	11	1.0	7	0.8
C: Other White Background	26	3.4	33	3.3	33	3.1	30	3.2
D: Mixed - White and Black Caribbean	0	0	0	0	22	2.1	9	1.0
E: Mixed - White and Black African	0	0	0	0	18	1.7	6	0.6
H: Asian or Asian British - Indian	13	1.7	48	4.8	30	2.8	46	4.9
I: Asian or Asian British - Pakistani	168	21.8	149	14.9	172	16.1	114	12.2
J: Asian or Asian British - Bangladeshi	17	2.2	21	2.1	20	1.9	19	2.0
K: Any Other Asian Background	7	0.9	0	0	11	1.0	10	1.0
L: Black or Black British - Caribbean	0	0	48	4.8	44	4.1	51	5.5
M: Black or Black British - African	0	0	51	5.1	55	5.2	50	5.4
N: Any Other Black Background	81	10.5	0	0	8	0.8	8	0.9
O: Chinese	20	2.6	19	1.9	13	1.2	6	0.6
P: Any Other Ethnic Group	0	0	0	0	11	1.0	29	3.1
Z: Not Stated	17	2.2	178	17.8	10	0.9	13	1.4

3.4 DEPRIVATION STATUS QUINTILES

- 82% of clients are from Quintile 1 and 2 areas; these clients fall into one or more of the following indicators* for the 20% deprivation threshold:

- Income
- Employment
- Health Deprivation & Disability
- Education, Skills & Training
- Barriers to Housing & Services
- Crime
- Living Environment

*[Deprivation data is based on indices of deprivation and grid-link which can be found from the following links:
http://www.communities.gov.uk/communities/neighbourhoodrenewal/deprivation/deprivation07/
http://nww.connectingforhealth.nhs.uk/nacs/downloads/officenatstats]

Table 5: Postcode deprivation status of clients

Postcode Deprivation Status	2013/14		2014/15		2015/16	
	Count	%	Count	%	Count	%
No fixed abode	0	0	1	1	0	0
Not recognised	14	1	27	2.5	27	2.9
Quintile 1 - Most deprived	755	76	749	70.3	630	67.7
Quintile 2	122	12	146	13.7	132	14.2
Quintile 3	39	4	64	6	56	6.0
Quintile 4	56	6	66	6.2	56	6.0

Quintile 5 - Least deprived	12	1	13	1.2	29	3.1

3.5 HOW HEARD ABOUT THE SERVICE

- Referral by GP practices forms the significant majority of referrals. There has been a significant increase in the number of people referred into the service via an existing client/word of mouth and family member or friend; this is an indication that the HT service has offered a good quality intervention where people have recommended the service to others.

Table 6: Breakdown of how clients heard about the service

How heard about the service	2014/15		2015/16	
	Count	%	Count	%
Diabetes Nurse	29	2.8	45	4.8
Existing Client, Word Of Mouth	0	0	33	3.6
Family Outreach Worker	2	0.2	0	0
Friend or Family Member	0	0	11	1.2
GP practice	913	88.12	761	81.8
Interserve Department for Work & Pensions	2	0.2	0	0
Poster / Leaflet	0	0	24	2.6
Primary Care Mental Health Team	5	0.5	0	0
Self	69	6.7	0	0
Through other Health Improvement Services	16	1.6	31	3.3
Through Outreach Work	6	0.6	25	2.7

4 ASSESSMENT OVERVIEW

This section reviews the assessment process, focussing on the primary issue and outcomes of those carrying out Personal Health Plans (PHPs) for client assessments added in financial year 2015/16.

4.1 EMPLOYMENT STATUS

- 'Additional Personal Information' is a non-mandatory field. The service has improved its data collection process as the 'not recorded' count is significantly lower than the previous year.

Table 7: Additional personal information about clients

Additional Personal Information	2014/15		2015/16	
	Count	%	Count	%
Not recorded	107	10.0	7	0.8
Employed full time	240	22.5	201	21.6
Employed part time	104	9.8	106	11.4
Full time carer	17	2.0	11	1.2
Looking after home or family full time	149	14.0	131	14.1
Ex offender	3	0.3	0	0
Other	5	0.5	10	1.1
Permanently sick/disabled	75	7.0	94	10.1
Response declined	1	1	0	0
Retired	160	15.0	158	17.0
Self-employed	15	1.4	23	2.5
Student	26	2.4	18	1.9
Unemployed	159	15.0	167	18.0

Volunteer	5	0.5	4	0.4

4.2 PRIMARY GOAL

- A 'primary' goal refers to the main issue logged at initial assessment when a client sets a PHP. A 'secondary' goal refers to additional issues that a client wishes to pick up in their PHP, but did not identify this at initial assessment; it is quite common for a client to explore dual goals, once trust and rapport has been built. The dual goals are largely a combination of 'diet/weight management with exercise' and 'diet/weight management with mental health/emotional wellbeing' but the system has not been able to capture the data in this manner.
- Reasons for why a primary goal was not recorded are also provided.
- The most popular topic area clients present with as their primary issue at a first meeting is weight management followed by diet. When looking at secondary issues, exercise is also a popular topic area.
- The number of clients who identified general wellbeing and mental health as a secondary goal has increased significantly from the previous year; this is an indication that HTs have been effective in reaching the core issue and moving clients beyond the presenting issue. Smoking is another area that has increased as a secondary issue.

Table 8: Primary and secondary goals of clients who set a Personal Health Plan

Health Topic/Goal	2014/15		2015/16	
	Primary Goal (number of clients)	Secondary Goal (number of clients)	Primary Goal (number of clients)	Secondary Goal (number of clients)
Accessing Community Services	0	2	2	34
Advocacy & Legal Advice	0	0	1	3
Alcohol	11	34	4	21
Autoimmune Conditions/ Diabetes	0	0	2	17
Blood Pressure	0	1	1	32
Depression	0	1	6	61
Diabetes Prevention	0	0	17	62
Diet	206	433	272	570
Employment	0	0	1	6
Exercise	40	504	56	420
Family Issues	0	0	1	0
Feeling Low	0	0	1	0
Financial	0	4	0	4
General Health	0	16	28	212
General Wellbeing	2	2	13	216
Isolation	0	0	2	14

Long Term Condition	0	0	4	45
Mental Health	10	54	13	62
Pain Management	0	0	5	34
Pre diabetes	5	0	1	0
Retired	0	0	0	5
Sleep	0	0	0	13
Smoking	1	19	1	31
Social Interaction/Integration	0	0	0	12
Volunteering	0	0	1	2
Weight Management	595	137	383	482
Welfare/Benefits Advice	0	0	0	4

4.3 PERSONAL HEALTH PLAN OUTCOME

Clients develop personal health plan's (PHP) with the support of a Health Trainer, identifying health issues and setting small goals; diary charts are in place to help monitor activities. The PHP is discussed at subsequent meetings to review progress and identify motivators and barriers to behaviour change.

- 870 clients set a PHP and of these clients 788 carried out activity against their plan. 96.6% of clients that completed their PHPs either achieved or part achieved their goal(s). An 'achieved' outcome status refers to people who set a primary goal, or a primary goal with one or more secondary/additional goals and achieved 100% completion. On average, clients set 3-4 goals each. A typical example is a person setting 'weight management' as their primary goal with additional goals to include increasing physical activity levels and improving confidence and self-esteem.
- A 'part achieved' outcome status refers to people who achieve less than 100% of their PHP goal(s).
- 'Not achieved' status refers to clients not achieving any activity against their goal.
- 'Outcome Unknown' represents a combination of clients left 'active' within the system who started their intervention in 2015/16 but had not finished at the time of reporting and clients who DNA any point after 2 sessions with a HT and do not complete a full intervention.

Table 9: Client's Personal Health Plan Outcome's

PHP Outcome	2014/15		2015/16	
	Count	%	Count	%
Achieved	322	41.5	280	35.5
Part Achieved	217	28.0	203	25.8
Not Achieved	44	5.7	17	2.2
Outcome Unknown	193	24.9	288	36.5

4.4 SIGNPOSTING, PHP REFERRALS BREAKDOWN & BUDDYING

For clients not wishing to set a PHP, others services are recommended and the client is signposted on (Table 10). For others who proceed with a PHP but require support from other services, HTs proactively refer clients on (Table 11); where confidence is low, some clients are accompanied to a new service/activity (Table 12).

Table 10: Number of clients signposted to other services

Signposting Breakdown (this is where no further HT service interaction occurs after 1st appt)	2014/15		2015/16	
	Count	%	Count	%
Active Women	1	2.08	3	13.6
Adult Weight Management Service	10	20.8	0	0
Benefits	4	8.32	3	13.6
Counselling	0	0	2	9.1
GP	1	2.08	0	0
Gym	2	4.17	3	13.6
Leeds City Council service	1	2.08	0	0
Leeds Lets Get Active	16	33.28	2	9.1
Leeds Smoking Service	5	10.4	3	13.6
Local Community Group	1	2.08	2	9.1
Local Exercise Group	4	8.32	3	13.6
NHS Health Check	2	4.17	0	0
Positive Care Programme	1	2.08	0	0
Xpert Patients Programme	0	48	1	4.6

Table 11: Number of clients referred to other services whilst still engaging in HT intervention

PHP Referral Breakdown (referrals as part of a continued HT service interaction)	2014/15	2015/16
	Count	Count
Active Women	8	5
Adult Weight Management Service	14	6
Alcohol Addiction Service	6	0
Bodyline	149	120
Bereavement Counselling	1	2
CAB	1	1
Change for Life	0	5
College / University	0	1
Counselling	8	5
Dentist	0	1
Domestic Violence	1	0
Food Banks	0	13
IAPT	9	8
Leeds Card	2	2
Leeds City Council services	10	5
Leeds Let's Get Active	52	53
Leeds Smoking Services	5	12

Local Community Course	3	18
Local Community Group	20	35
Local Cookery	3	5
Local Cookery Class	15	8
Ministry of Food	11	12
NHS Health Check	1	18
One Stop Shop	1	2
Positive Care Programme	4	3
Primary Care Mental Health Team	7	3
Private Gym	9	6
Walking Group	13	12
Watch It	0	2
Xpert Patients Programme	3	2

Table 12: Number of clients accompanied to other services

Activity/group client was accompanied to	2015/16
	Count
Community Group Activity	14
Gym/Bodyline	35
Local Exercise Class	22
Super Market	3
Swimming	1
Walk/Park	29

- Referral to 'Food Banks' is a newly recorded activity for 15/16, reflecting the reality of the clients HTs work with.
- If at an eligible age, clients were told about the NHS Health Check and where appropriate, supported to book an appointment; 18 people booked a Health Check meeting as part of the HT intervention.
- Access to the Leeds City Council's Bodyline scheme continues to be a popular offer amongst HT clients, along with Leeds Let's Get Active.

5 KEY HEALTH GAIN and CLINICAL OUTCOMES

This section is designed to review the change outcomes achieved by clients carrying out Health Trainer Personal Health Plans in 2015/16.

5.1 PERSONAL HEALTH PLAN RESULTS

- The data in these charts relates to outcomes where there was either a primary goal or a combination of a primary goal with secondary/additional goals. It is difficult to make direct comparisons due to the overlap between goals as explained in Section 3.4.
- The 'BMI Change', 'Weight = KG Change' and 'Post Baseline Weight KG Change' charts represent weight changes for all clients regardless of their primary goal. It is not just data for

clients seeking a weight loss; it includes clients who wish to gain weight or choosing to be more active or have a healthier diet. It also includes clients with 2 or more weights recorded but didn't complete their PHP for a variety of reasons. The most significant change in weight is for clients losing 1 - 5 kgs of weight, totalling 340 people (67.1%). There were a total of 1253 general health outcomes reported including improvements in long term conditions; this total exceeds the total number of clients seen by the service as clients often report multiple outcomes.

Table 13: Count of BMI difference achieved amongst clients (based on pre and post HT intervention measures)

BMI Change (Difference)	2014/15		2015/16	
	Count	%	Count	%
Not recorded	23	7.6	22	4.3
-15 to -10	0	0	1	0.2
-10 to -5	11	3.6	9	1.8
-5 to -1	134	44.2	199	39.3
-1 to 0	76	25.1	141	27.8
0	43	14.2	112	22.0
0 to 1	11	3.6	18	3.6
1 to 5	5	1.7	5	1.0
Total	303	100%	507	100%

Table 14: Count of Weight (KG) difference achieved amongst clients (based on pre and post HT intervention measures)

Weight = KG Change (Difference)	2014/15		2015/16	
	Count	%	Count	%
Not recorded	10	3.3	16	3.2
-60 to -55	0	0	1	0.2
-40 to -35	0	0	1	0.2
-30 to -25	1	0.3	1	0.2
-25 to -20	1	0.3	3	0.6
-20 to -15	6	2.0	3	0.6
-15 to -10	17	5.6	17	3.4
-10 to -5	40	13.2	63	12.4
-5 to -1	142	46.9	213	42.0
-1 to 0	23	7.6	57	11.2
0	47	15.5	108	21.3
0 to 1	5	1.7	12	2.4
1 to 5	8	2.6	12	2.4
5 to 10	3	1.0	0	0
Total	305	100	507	100

Table 15: Percentage weight (KG) difference achieved amongst clients (based on pre and post HT intervention measures)

Post Baseline Weight KG Change (Percentage)	2014/15		2015/16	
	Count	%	Count	%
Not recorded	10	3.1	16	2.96
-60% to -55%	0	0	1	0.18
-40% to -35%	0	0	1	0.18
-30% to -25%	1	0.3	1	0.18
-25% to -20%	1	0.3	3	0.55
-20% to -15%	2	0.6	3	0.55
-15% to -10%	15	5.0	17	3.14
-10% to -5%	60	18.8	63	11.6
-5% to -3%	72	23.0	141	26.1
-3% to -1%	78	24.4	116	21.4
-1% to 0%	15	4.7	35	6.47
0	47	15.0	108	20.0
0 to 1%	6	1.9	12	2.22
1% to 3%	7	2.2	16	2.96
3% to 5%	1	0.3	8	1.48
5% to 10%	3	0.9	0	0

Table 16: Key changes made by clients to support healthier diet

Diet Change	2014/15	2015/16
	Count	Count
Complete a food diary	255	431
Eat breakfast regularly	99	105
Eat more regular meals	132	140
Eat healthier carbohydrates	28	54
Reduce evening food intake	19	30
Reduction in portion size by one quarter (25%)	124	210

Table 17: Increase in fruit and veg intake amongst clients

Increased Fruit and Veg intake by	2014/15	2015/16
	Count	Count
1 portion	70	106
2 portions	66	69
3 portions	79	159
4 portions	14	39
5 portions	76	85
Total	305	458

Table 18: Reduction in alcohol intake amongst clients

Reduced Alcohol Intake by	2014/15	2015/16
	Count	Count
More than half	33	17
Quit	5	1

Reduce binge drinking	6	6
To 4 units or less daily	1	4

Table 19: Increase in physical activity levels amongst clients

Increased Light Exercise by	2014/15	2015/16
	Count	Count
10 minutes per week	10	29
20 minutes per week	17	31
30 minutes per week	18	20
40 minutes per week	62	129
Increased Moderate to Vigorous Exercise level		
to 1 hour gym session	142	224
to 1 x 30 minute sessions per week	62	109
to 2 x 30 minute sessions per week	24	13
to 4 x 30 minute sessions per week	12	24
to 3 x 30 minute sessions per week	3	8

Table 20: Changes that support positive emotional well being

Emotional Wellbeing	2014/15	2015/16
	Count	Count
Reduced anxiety	2	14
Reduced depression	10	13
Reduced isolation	3	18
Reduced stress	18	9
Improved management of Chronic Pain	4	4
Improved family relations	22	11
Improved sleep quality	4	10

Table 21: Client reported change to well-being (in percentage) measured through the World Health Organisation (WHO-5) Well-being Scale

WHO Results – Change (Difference) in percentage	Count	%
0	152	31.0
1 to 5	46	9.4
5 to 10	48	9.8
10 to 15	49	10
15 to 20	87	17.8
20 to 25	25	5.1
25 to 30	12	2.4
30 to 35	24	4.9
35 to 40	25	5.1
40 to 45	8	1.6
45 to 50	4	0.8
50 to 55	2	0.4
55 to 60	3	0.6
60 +	5	1.0

The WHO-5 Well-being Index is a short questionnaire covering 5 positively worded items, related to positive mood (good spirits, relaxation), vitality (being active and waking up fresh and rested), and general interests (being interested in things). It has shown to be a reliable measure of emotional functioning and a good screener for depression. Evidence suggests in order to monitor possible changes in well-being, a 10% difference can be regarded as a significant change. Table 21 shows that 49.7% of clients achieved 10% or more difference change in wellbeing.

Table 22: Clients self-reported improvements to health and Long Term Conditions

Improvement in Health and Long Term Conditions	2015/16	
	Count	%
Ability to engage in physical activity	210	16.8
Arthritis	22	1.8
Asthma	18	1.4
Blood Pressure	61	4.9
Blood Sugar	44	3.5
Confidence	205	16.4
Depression	104	8.3
Employment prospects	3	0.2
Mood	250	20.0
Less out of breath	154	12.3
Mobility	144	11.49
No longer Pre- Diabetic	38	3.0
Total	1253	100

5.2 CLINICAL OUTCOMES

- HbA1c readings were extracted for patients from 8 GP practices in the South and East Leeds locality who had fully completed their PHP and achieved a reduction in their body weight; pre and post HbA1c readings were only available for 41 clients and all data was retrieved from the respective GP clinical systems.
- 52.6% of clients who were at high risk of diabetes pre HT intervention went on to report a reading of below 42mmol/mol at the end of their intervention, which meant they were no longer pre diabetic.
- For clients who were diabetic pre HT intervention and still reported a reading of 48+ mmol/mol post intervention, 50% achieved a 5.1 to 10% reduction in their HbA1c level. This is really positive as **'people with diabetes who reduce their HbA1c by even 1% can cut their risk of dying within 5 years by 50%'**, according to Swedish research presented at the annual meeting of the European Association for the Study of Diabetes, Sept 2012.

Table 23: Changes in HbA1c levels for non-diabetic clients

		POST HT INTERVENTION OUTCOMES		
HbA1c level	No. of clients	No of people reducing 1% to 3% of their HbA1c level	No of people reducing 3.1% to 5% of their HbA1c level	No of people reducing 5.1% to 7% of their HbA1c level
41 and below (non diabetic)	4	1	2	1

Table 24: Changes in HbA1c levels for clients at high risk of developing diabetes

		POST HT INTERVENTION OUTCOMES		
HbA1c level	No. of clients	No. of clients who have achieved a reading below 42 mmol/mol	No of people who are still 'high risk' but achieved 1% to 5% reduction in their HbA1c level	No of people who are still 'high risk' but achieved 5.1% to 10% reduction in their HbA1c level
42 – 47mmol/mol 'at high risk of developing diabetes'	19	10	5	4

Table 25: Changes in HbA1c levels for diabetic clients

		POST HT INTERVENTION OUTCOMES						
HbA1c level	No. of clients	Clients who achieved a reading below 42 mmol/mol (non diabetic)	Clients who have achieved a reading between 42-47 (pre diabetic) range	Clients who are still diabetic but achieved 1% to 5% reduction in HbA1c	Clients who are still diabetic but achieved 5.1% to 10% in HbA1c	Clients who are still diabetic but achieved 10.1% to 15% reduction in HbA1c	Clients who are still diabetic but achieved 15.1% to 20% reduction in HbA1c	Clients who are still diabetic but achieved 20%+ reduction in HbA1c
48+ diabetic	18	1	1	2	9	2	2	1

6 MAINTAINING CHANGE

This section focuses on the review of maintenance checks for those clients that part or fully achieved their Personal Health Plan. Maintenance checks are simple checks carried out at 3 and 6 month interval's post HT intervention (client sign off).

6.1 CHANGE MAINTAINED RESULTS

Many clients are non-contactable post intervention due to a number of reasons; HTs have reported 'client changed mobile number' as one of the main reasons. A total of 186 clients who were contactable 3 months after their HT intervention reported that they had maintained their behaviours. A total of 201 people reported that they had maintained their behaviours 6 months post intervention (total number reporting at the 6 month interval exceeds the total reporting at the 3 month interval as they are not necessarily the same people responding to the follow up. It is important to note that this is not a complete picture of success achieved, as clients setting their PHP late in the year 2015/16 will not report their outcomes in the same financial year. The table below captures the number of outcomes reported by clients as maintained at 3 and 6 moths post intervention (collective total); this is a 108% positive increase in behaviours maintained from the previous year.

Table 26: Client reported outcomes maintained 3 and 6 months post intervention on follow up

Outcomes maintained at 3 and 6 months post intervention	2014/15	2015/16
	Count	Count
Completed Counselling session	4	16
Drinking less alcohol	21	65
Exercise more intensively	81	142
Family members eating healthier	68	147
Family members more active	27	92
Feeling better and healthier	95	277
Friend or neighbour more active	18	59
Friend or neighbour eating healthier	24	48
Healthy eating	195	328
Improved skin condition	18	49
Improvement in mood	84	18
Increased self-confidence and self esteem	63	147
Joined gym	20	47
Joined local social activity class	19	37
Less out of breath	92	177
Lost more weight	35	114
Maintained weight loss	75	155
Not smoking	3	6
Reduced joint and body pain	35	70
Walk up hills	12	62

Total	**989**	**2056**

7 CASE STUDIES

Case Study 1

Client is a 38 year old white British male, referred by the IAPT service. He suffers from mental health problems but his primary issue was weight management and to gain a better understanding of a healthy diet.

The client completed a food diary of everything he ate and drank for every session; he appeared to consume large amounts of the same thing – for example, dinner would consist of 12 fish fingers and a 500g tub of ice-cream or a whole chicken. Using the eat well plate as a guide, I explained the importance and benefits of eating a balanced meal including fruits, vegetables and carbohydrates and reducing sugary and high fat foods.

The client did not use a cooker because of his mental health problems, so we looked at alternative ways he could cook a balanced meal. I was able to teach him how to use the microwave properly and how to store food. The client began to buy fresh food, and was confident in storing away food that he could cook another day. The client had very low confidence and found it challenging to make such big changes in his life; he was progressively changing the way he thought about food and learning new skills.

The client learnt how to prepare meals requiring minimal cooking skills and introduced fruit and vegetables to his diet; he rarely consumed any previously. He began eating a portion of fruit with every meal to achieve his 5-a-day. He began to eat a varied diet and was excited about trying new snacks including sweetcorn, sweet potato, carrots and hummus.

As his confidence grew, we talked about goals around improving his social life. He began to meet with his friends and access activities but this was gradual; he tried out a few things until he found what worked for him. We celebrated his achievements which further built his confidence to achieve more.

The client has now started to eat a healthier balanced diet and trying out more new foods. He goes out a lot more and is also part of a community walking group that he attends weekly - he appears much happier than when he first came to see me. In our earlier meetings I suggested the Ministry Of Food project but the client declined this offer as he struggled with meeting new people. By the end of the intervention the client was accessing Ministry of Food which is a major achievement.

By the last session the client had achieved a weight loss of 1stone 1lb and was now physically active, eating a healthier more balanced and varied diet, socialising more and engaging with other health improvement services.

Case Study 2

In January 2015 I worked with a client who initially came to see me for healthy eating and to lose weight. After a few sessions, the client was enthused about making changes and we started to work on goals to improve her physical activity levels.

The client was interested in attending a Zumba class but had never been to an exercise class and was anxious about going so I offered to go along with her. She really enjoyed the session and wanted to go again and asked if I could support her again.

Another client I was seeing who lived in the same neighbourhood had also expressed an interest in doing some kind of exercise class but had no confidence and did not want to go on her own. I made arrangements and organised for the three of us to meet up and go together.

These two clients have continued to go to the Zumba class regularly and meet for coffee mornings and have become really good friends. They even started walking with a walking group in Middleton.

As a result of the HT sessions, these two clients are now attending Zumba class together which has helped them to become more active and confident and reduced their isolation and meet others socially. Both clients commented at the end of their intervention, "buddying up with each other has improved our motivation to become more healthier!"

8 CONCLUSIONS

The service reports modest outcomes for this year and continues to reach out to people who suffer the poorest health in the city. HTs have accessed enhanced coaching skills training delivered through Public Health, which equips them with further tools and techniques to offer a coaching approach in their conversations with clients, putting the health issues or concerns of the client within the context of their lives. This unique approach, where HTs work with individuals to develop rapport and trust and delve deeper into the presenting issues may explain the surge in activity around supporting the emotional health and well-being needs of clients this year.

The service has recently embarked on a pilot programme working with prisoners at Her Majesty's Prison Armley to offer support around resettlement and help prepare them for life after prison. The objective is to help prisoner's develop life skills, access other support services and advice, learn new skills through volunteering and get involved in things that help create stability and prevent re-offending. This work is an exciting opportunity to continue to invest in those most vulnerable to poor health and offer an holistic approach to improving their health and wellbeing.

The introduction of social prescribing services funded through different CCGs in Leeds has been really positive and HTs are utilising this resource to signpost on clients who require less support to realise their goals.

For 2016/17 the service hopes to increase activities around buddying clients and encouraging the formation of groups as described in case Study 2, where clients support one another and maximise the potential for sustainable behaviour change.