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An Evaluation of the Bradford District Health Trainers Programme – Phase 2

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Evaluation report Year 2

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Abbreviations

PCT	**Primary Care Trust**
DOH	**Department of Health**
NICE	**National Institute for Clinical Excellence**
SHT	**Senior Health Trainer**
HT	**Health Trainer**
KI	**Key Informant**
SOA	**Super Output Area**
BEEP	**Bradford Encouraging Exercising People**
IMD	**Indices of Multiple Deprivation**
DNA	**Did Not Arrive**

Executive summary

Introduction

Health trainers are health workers who offer one-to-one support to help individuals make changes to improve their health. The government regards health trainers as being an important mechanism to help tackle health inequalities through improving access to health advice, support and services in disadvantaged communities (Department of Health, 2005). As one of the 12 early adopter sites of the national health trainer programme, Bradford was one of the first places in the country to have health trainers working out in local communities. The early adopter phase was evaluated in 2006 to provide feedback on the development and functioning of the programme and any early outcomes. The evaluation findings indicated that the health trainer role was successful at supporting people to make changes to improve their health. Since the initial evaluation one significant development has been the piloting of the senior health trainer role. Three senior health trainers were recruited in November 2006 and placed in three localities, all areas of disadvantage. Their role was to support the work of health trainers on the ground and to use community development skills to improve access to the health trainer programme. At the time of the second evaluation there were 32 health trainers and 3 senior health trainers working in Bradford providing support to those individuals and communities with greatest health needs.

Evaluation methods (see section 3)

The second phase of the evaluation sought to build on the findings of the first evaluation. The evaluation strategy was developed to provide greater understanding about how and why the programme works in different contexts and settings. An important part of the evaluation was to examine the role of the senior health trainer in these different settings. Evidence was gathered using a number of different methods. This included qualitative interviews that were used to obtain rich, contextual information on the delivery of the health trainer programme in the three different localities, as well as secondary analysis of monitoring data on client characteristics and evidence of success.

Findings – clients (see section 4)

Over the course of the evaluation 20 clients were interviewed about their experience of seeing a health trainer. All clients, without exception, were extremely positive about their health trainers and they would recommend them to anyone wanting to make lifestyle changes. It was important that the venue and time of the health trainer session was convenient for clients and the health trainer programme was free. Health trainers were perceived as different to health professionals because they had the time to work with clients on a one-to-one basis, to listen and to support them in their desire to change. In this way clients were able to establish a meaningful relationship with their health trainer. Health trainers worked with the clients to achieve their goal by agreeing targets and supporting them on their journey. For many clients the issue of how to achieve their goal was equally as important as knowing what to do. Having the

opportunity to talk about a health issue in the context of their own lives was a key factor in addressing how they could make changes.

Findings – service providers (see section 5)

A key component of the evaluation was the interviews with 27 service providers. For the purposes of this report we have defined service providers as health trainers, senior health trainers, key informants from host organisations and project leads, all of whom were interviewed about the development of the health trainer programme. All interviewees recognised that the health trainer programme fills a gap in terms of service provision, since the programme is available for and accessible to everyone, plus health trainers have greater expertise in dealing with lifestyle issues. Health trainers were perceived as facilitators who supported individual clients to make behaviour changes. In addition, they conducted community development work and assisted in raising the profile of the health trainer programme. As with health trainers, senior health trainers played an important role in client behaviour change, but their main role was to support health trainers, project leads and key informants of host organisations. In addition, negotiating and setting up placements was regarded as a key aspect of their role, as was conducting home visits. It was acknowledged that there needed to be clearer boundaries distinguishing the roles of health trainers from those of senior health trainers as key informants from host organisations, in particular, were not always clear about the difference between the role of a senior health trainer and a health trainer. Health trainers are employed on a freelance basis, unlike senior health trainers, which was potentially problematic for the delivery of the health trainer programme in terms of continuity of service. There are a variety of health trainer models in operation with different ways of working but a set of common attributes can be identified characterising successful health trainer placements, regardless of the model employed.

Findings – monitoring data (see section 6)

There has been a great expansion of the Health Trainer Programme since January 2006, increasing from 10 health trainers working in 14 organisations to 32 health trainers having worked in 77 organisations in October 2007. A total of 1064 clients have been seen by health trainers from January 2006 to October 2007. The Health Trainer Programme has been successful in accessing those in deprived areas with 57% of clients living in areas designated the fifth most deprived in England and Wales. The majority of clients were women, although the number of men using the service increased from 17% in year 1 to 23% in year 2. Of the clients who completed their pathway through the Health Trainer Programme, 38% made excellent or good progress towards their health goals. Clients who attended more appointments with their health trainer achieved greater progress.

Summary of evidence (see section 7)

Can health trainers get people to the 'right place', where individuals receive appropriate support to enable them to make positive changes for health?

What emerges strongly from the evaluation is that health trainers do provide the 'right place' for many clients. The qualitative data provide evidence that the programme was valued and this confirms the earlier evaluation results (year 1). Health trainers were seen as offering something distinctive from clinical care and the health trainer-client relationship was frequently described as special. The approach was based on listening, spending time with clients and adopting a caring and non-judgemental attitude. It was evident that there was a very clear understanding of the role and this was seen across all the different stakeholder groups. This should be regarded as a strength of the Bradford programme that the role, remit and ethos are clearly understood and provide a good basis for expansion and marketing. The monitoring data indicate an increasing demand for the service and a significant growth in the number of clients. These findings suggest that the health trainer programme is meeting client needs and plugging a gap in provision.

Does the health trainer programme improve access to health improvement services/activities?

Access to the health trainer programme was a very strong theme in the qualitative interviews and the programme was generally regarded as accessible both in terms of location and service entry points. The fact that the service was free was also an important factor. Ease of access promoted utilisation, particularly where health trainers were visible and operating in familiar locations near to where clients were living or working. The phone help line was also effective as a mechanism to promote access to the programme. The monitoring data indicate that the health trainer programme was having a much greater reach in terms of areas covered, types of host organisation and population groups. It is notable that the proportion of men attending increased in the second year to just under a quarter of all appointments. Similarly 40% of clients were from Black and Ethnic Minority groups, including small numbers of people from minority populations such as Polish. The programme was prioritised in areas of deprivation and the monitoring data show that the programme was extremely successful at being able to target clients from those areas. In addition, the programme continues to be run for clients with specific health and social needs such as mental health and learning disabilities.

How can the senior health trainer role facilitate this process?

The need for a senior health trainer role arose because it was felt that individuals with community development skills and experience were required to develop new settings, to link potential clients to health trainers and to support the work in the localities. The three senior health trainers were in many ways pioneers, developing the new role in response to community and organisational needs. In terms of benefits, the role was seen to provide a vital link between the health trainer programme, run centrally through Bradford Health Development Partnerships (now Public Health Directorate) and the health trainers on the ground. This link is important given the sessional nature of employment, the range of venues and client groups and the flexible, community approach adopted. Senior health trainers have been able to trouble shoot, support health trainers and provide consistency when necessary. They have also been able to

extend the service by offering home visits. The role of the senior health trainer is about providing a seamless service and as such their work may lack visibility. However, more may need to be done to strengthen local links through a community development approach.

Do people make positive changes for health as a result of seeing a Health Trainer?
As in the first evaluation the second evaluation provides further evidence of the effectiveness of the health trainer approach in that health trainers can provide the necessary support to help individuals to make changes. Health trainers were able to support clients when relapse occurred and also provided suggestions for sustaining change. It is notable that some clients talked of beginning to change their lifestyle with reference to severe, complex or intractable problems where they had made little progress in the past.

Key issues for consideration

- Recruitment of health trainers should continue to be based on selection of individuals able to deliver an individualised, client-led, empathic approach. Trying to recruit neighbourhood support directly from targeted communities may not be necessary and there were benefits in health trainers being seen as anonymous and offering a confidential service.

- There is potential to raise the profile of health trainers still further in the localities to increase access. Health trainers need to be comfortable with a proactive way of working, developing relationships in the settings and opening opportunities for clients as situations arise.

- The employment status of health trainers needs further consideration. While freelance working has some merits, it makes it harder to maintain a visible presence, in some host organisations.

- There remains a strong rationale for a joined up approach where health trainers and senior health trainers are highly visible, fully integrated within host organisations and signposting to local organisations. Consideration should be given as to how this can be further developed and sustained in key community organisations.

- The role of the senior health trainer has been trialled over the past year and found to be useful in terms of building up the infrastructure to support the delivery of the programme as consistency and communication are essential. The roles and remit of senior health trainers need to be more clearly defined.

- Setting up placements and developing relationships with host organisations is part of the senior health trainer role. However, consideration should be given to the most appropriate balance of activities between supervision of health trainers and developing links through community development principles.

- The establishment of a monitoring and follow up system is a major achievement, considering the community-based, flexible nature of the programme. The system provides valuable data to track individuals. Some health trainers are working in a more informal way in group settings. This has its challenges for the purposes of monitoring, as processes are set up to monitor individuals, rather than capture community development and group processes. Other methods may need to be used to capture some of this important work with hard to reach groups.

- The contemporary debate about how to monitor complex multiple outcomes is pertinent to the nature of the health trainer programme. Currently, the progress towards individual action plans is the main generic indicator. The programme team may wish to consider measuring a small number of specified outcomes, which, although not relevant to all clients may capture some key indicators of success for the majority.

- There is now a body of local evidence that health trainers help some people make positive changes. In many cases the programme works successfully with groups that are hard to reach or where individuals have had little previous success at making changes. The next stage of strategic development needs to consider how the breadth and depth of the health trainer programme can be developed and where resources would be best targeted. While the programme may produce 'quick wins' for many clients, investment will be required to really expand the use of the health trainer programme as a tool for addressing health inequalities.

Section 1: Introduction

Health trainers are health workers who offer one-to-one support to help individuals make changes to improve their health. They are part of the public health workforce and work in a range of community settings. Health trainers are recruited from local communities and usually do not have professional backgrounds. The rationale is that health trainers will be able to relate to common concerns and offer a service that is accessible for individuals from disadvantaged communities (see Box 1.1).

Box 1.1: Improving health of the community (Department of Health 2004a)

> *"In touch with the realities of the lives of people they work with and with a shared stake in improving the health of the communities that they live in, health trainers will be friendly, approachable, understanding and supportive. Offering practical advice and good connections into the services and support locally, they will become an essential common sense resource in the community to help out with health choice.*
>
> **[Department of Health 2004:103]**

Policy Context

The national Health Trainer programme is still relatively new. The idea was first proposed in Choosing Health (Department of Health, 2004). The national health trainer programme was initiated in 2005 and a draft competency framework was developed by Skills for Health. Twelve early adopter sites were chosen in 2005 and given funding to develop local health trainer pilot programmes and trial the competency framework. Since then the national Health Trainer programme has continued to expand with many more areas developing health trainer services. By March 2007 there were 1200 health trainers trained and in post (Department of Health (2007). As well as the new local programmes run through Primary Care Trusts (PCTs), there has been interest in developing health trainers in other organisations such as Royal Mail and the army (Department of Health, 2007).

It can be noted that while the principles of the new programme are clearly set out and the competency framework in place, PCTs have discretion to develop programmes to fit with local priorities and needs. Consequently there are a whole range of different models in practice, some adopting a holistic approach, others targeted on specific groups or health issues (such as exercise and weight management).

The government visualised health trainers as being an important mechanism to help tackle health inequalities through improving access to health advice, support and services in disadvantaged communities (Department of Health, 2005). Spearhead PCTs were targeted for early implementation of the health trainer programme although

eventually it will be rolled out across the country (Department of Health, 2004b). The programme was also seen as part of workforce development as it was a way of building capacity in public health through providing opportunities for unqualified people to gain skills in public health work. This is linked to the idea of a 'skills escalator' where some health trainers may go onto develop health careers.

Bradford District Health Trainers Programme

As one of the 12 early adopters, Bradford was one of the first places in the country to have health trainers working out in local communities. The new programme was developed through a Partnership Board with the following partners:

- Bradford District PCTs [now Bradford and Airedale teaching PCT]
- Bradford District Health Development Partnerships
- Bradford Metropolitan District Council
- Bradford Vision (LSP)
- Bradford Council for Voluntary Services
- Keighley Voluntary Services
- Confederation of Ethnic Minority Organisations
- Leeds Metropolitan University

Bradford District Health Development Partnerships (now part of the Public Health Directorate) provided management and supervision and a project co-ordinator oversaw implementation. The first cohort of 21 health trainers was recruited in October 2005 and began working in various settings from January 2006. A second cohort was recruited in October 2006. Both cohorts undertook a 15-day training course accredited with the Open College Network to prepare them for the role (Hawkins, 2006). This course reflects the national competency framework for health trainers (Skills for Health, 2006). Health trainers were employed on a sessional basis, a minimum of half a day a week. At the time of this evaluation there were 32 health trainers and 3 senior health trainers working in Bradford. Appendix 1 gives details of the range of settings where health trainers were placed.

Table 1.1: Timeline for Bradford early adopters programme

Health trainers proposed in Choosing Health	November 2004
Funding secured to be an early adopter site Partnership formed	July - September 2005
Project co-ordinator appointed	October 2005
Health trainer recruitment – 1st cohort 21 health trainers recruited	October 2005
Training course	November 2005 – January 2005
First health trainers in practice	January 2006
Health trainer recruitment – 2nd cohort 19 Bradford health trainers recruited	October 2006
Senior health trainers recruited.	October 2006
Second cohort of health trainers placed in practice	January 2007

The priority in Bradford has been to use the health trainer programme to provide support to those individuals and communities with greatest health needs. The health trainer role was seen enabling and supporting, not giving advice, thus reflecting the initial vision (South *et al* 2007). What is termed a 'support and signposting model' was based on the premise that health trainers will be able to tap into existing community health resources (Box 1). The health trainers work with clients using a 'Stages of Change' approach (Prochaska and DiClemente, 1984) to help individuals make and sustain small behaviour changes (see Appendix 1 for the client pathway). The early adopter phase was evaluated in 2006 and the evaluation findings indicated that the health trainer role was successful at supporting people to make changes to improve their health (Appendix 2 Executive Summary).

Box 1.2: Bradford health trainers – the support and signposting model

- Clients can self refer or be referred through other services;
- Clients are supported to develop an individualised action plan which could relate to mental, physical or social issues;
- Health trainers work one-to-one with individuals; they enable clients to address issues and find their own solutions and do not give health advice;
- Health trainers signpost people to appropriate local services and can accompany clients to other health improvement services.
- Health trainers work in a range of settings: primary health care, education settings, community projects and services across the district.

A number of issues emerged from the initial phase of programme development and evaluation that led to the programme being modified and new elements included. One significant development was the piloting of a senior health trainer role. Three senior health trainers were recruited in October 2006 and placed in three localities:

- Manningham/Girlington
- Trident area (New Deal for Communities)
- Allerton/Lower Grange

These localities are very diverse but all are areas of disadvantage. The role of the senior health trainer was to support the work of health trainers on the ground and to use community development skills to improve access to the service. This involved building local networks, establishing new settings and recruiting clients. Another modification from the initial phase was the further development of monitoring systems, allowing clients to be followed up at three and six months.

Evaluation – Phase 2

The Centre for Health Promotion Research was commissioned to undertake further evaluation of the Bradford programme. The first evaluation (2006) was completed as the local programme was in its infancy due to the need for early feedback and gave a comprehensive overview incorporating different stakeholder perspectives. The aim of the second phase of the evaluation was to provide greater understanding about how and why the programme works in the different contexts and settings. An important part of the evaluation was to examine the role of the senior health trainer in the three localities.

The objectives that guided the second phase of the evaluation were:

- To evaluate the role of the senior health trainer (SHT) and how SHTs can best support the work of the health trainer programme;
- To assess if the health trainer programme is able to improve access to health improvement services/activities, including for people not normally in contact with health services;
- To capture the perspectives of a range of health trainer clients on the value and relevance of the programme;
- Using in-depth case studies of three localities, to identify the contexts where health trainers can have most impact and the most effective approaches.

The evaluation involved qualitative interviews based around the work in the localities and secondary analysis of monitoring data on client characteristics and health issues. The Centre for Health Promotion Research is a member of Bradford District Health Trainers Partnership and worked in collaboration with the Health Improvement Directorate of the Bradford & Airedale Teaching PCT to undertake the evaluation.

Structure of the report

This report presents the findings from the second phase of the evaluation. Section 2 briefly discusses the evidence base for health trainers and highlights key findings from the previous evaluation. The evaluation methods and approach are described in the following section. Section 4 reports on the findings from the client interviews conducted in the different settings, while section 5 presents the service providers' perspectives including findings from project leads, senior health trainers, health trainers and host organisations. The analysis of the monitoring data is presented in Section 6. The report ends with a synthesis of the evidence and discussion of key issues emerging from the evaluation.

Section 2: Evaluation Base

Health trainers, as indicated earlier, are a new initiative and as such the evidence base has yet to emerge. A national evaluation, which will bring together local evidence and examine issues for delivery and implementation, is in the process of being commissioned. Alongside this evaluation, an effectiveness review of healthy lifestyle advisors is being undertaken which is due to report in 2009.

Generating evidence on health trainers is challenging because of the diversity in practice as a result of local development. It also appears that in some areas, existing schemes have been 're-badged' as health trainers. It will be difficult to draw out robust generalisable evidence given the different target communities, range of models and different settings. Visram and Drinkwater's (2005) review brought together a diverse literature on these types of role and they were able to identify four dimensions: individual / community focus and targeted / generic. Evidently measurement of outcomes will be dependent on the approach and whether primary goals are related to behaviour change or empowerment.

In the local evaluation of the Bradford early adopters programme, we found strong evidence of the success of the programme in 3 three key areas (see Appendix 3):

1. The successful recruitment, preparation and support for health trainers taking on a new role.

2. The development of effective referral processes and placements. It was noted that the programme was successful in attracting Asian women, people with learning disabilities and those with mental health problems. It was less successful in attracting men.

3. Health trainers were able to successfully work with clients to support lifestyle change. Clients identified diverse and complex needs that closely fitted the Choosing Health priorities of weight management, exercise and mental health/wellbeing. Findings from both interviews and monitoring data indicated that health trainers were able to help people make positive changes to their health and move along the cycle of behaviour change.

While the health trainer initiative is new, the underpinning principles are well established. Visram and Drinkwater (2005) reviewed primary research evidence (much drawn from North America) on peer education, lay health advisors and advocates, and also commented on examples of good practice from around the UK. The concept of community health workers or lay health workers is widely adopted in international contexts including developing countries. These models share many similarities with

health trainers. The mechanism is based on the idea that people recruited from local communities will be able to break down barriers to health prevention and care. Nemcek and Sabatier (2003), in a review of evidence from the US, point to the value of community health workers who are 'culturally sensitive and possess strong community rapport'. Indeed, Wilkinson *et al* in their study of health trainer activity in the UK, state, "the majority of health trainers appear to be lay people and people from the very groups that the services aim to target" (2007:33). A Cochrane review (2005) provided some evidence of the effectiveness of lay health worker models in some public health areas such as breastfeeding and immunisation. The review commented that more needed to be known about how lay worker services should be provided and the extent of training required. One suggestion is to utilise the health trainer approach since according to Wilkinson *et al*, "health trainers are becoming credible providers of health care, whilst retaining the advantages of their community orientated approach" (2007:33).

Choosing Health (Department of Health, 2004) set out a broad agenda around the major public health issues in the UK: smoking; obesity; physical activity; alcohol intake; mental health; sexual health and health inequalities. National policy advocates action on health at many levels (Department of Health, 2003). Macro-level social and economic policies addressing the determinants of health are widely regarded as essential to address health inequalities and make progress on health goals. There is, however, evidence that approaches at individual and community level are needed alongside the broader public health agenda. For example, the health improvement programme, Connect 4 Life in Tameside, illustrates the economic benefits of personal lifestyle sessions, sometimes using health trainers. Using a NICE (National Institute for Clinical Excellence) cost effectiveness model to calculate Quality Adjusted Life Years the programme has been able to demonstrate measurable reductions in the number of heart attacks, strokes and even deaths as a result of individual health improvement programmes that target a reduction in smoking, excessive drinking and stress (Tameside and Glossop PCT). Past reviews of evidence on inequalities have concluded that interventions based on changing behavioural risk factors do have value particularly where focused on disadvantaged groups and individuals (Catford, 2002; Gepkens and Gunning-Schepers, 1996). These findings have recently been endorsed by the NICE guidance on behaviour change (2007), which sets out recommendations for individual–level interventions that motivate and support people to set goals, make small changes and cope with relapse. It can be noted that key elements of the Bradford model match the recommendations from NICE in terms of being client-led, setting goals and providing support. Stages of Change, which is used as a basis for the work with clients in Bradford, is a well established framework for supporting behaviour change (Prochaska, Diclemente and Norcross, 1992). It is, for example, used as the basis for the national smoking cessation programme. In addition, further endorsement for the health trainer programme is provided in the recent National Health Trainer Activity Report where it is clearly stated that "health trainers appear to be providing an evidence-based, common sense health resource…supporting clients to change a variety of behaviours, mainly healthy eating, physical activity, and smoking cessation" (2007:33).

Section 3: Evaluation approach and methods

Phase one of the evaluation gave a comprehensive overview of the success of the pilot programme, incorporating a number of different stakeholder perspectives. The second phase of the evaluation explored in more detail how the health trainer programme operates, with a particular focus on how the health trainer role works in different settings.

The main research questions for the evaluation were:

- Can health trainers get people to the 'right place', where individuals receive appropriate support to enable them to make positive changes for health?
- How can the senior health trainer role facilitate this process?
- Does the health trainer programme improve access to health improvement services/activities?
- Do people make positive changes for health as a result of seeing a Health Trainer?

The evaluation approach was chosen to allow evidence to feed into the development of the programme. The evaluation was conducted in collaboration with the Bradford District Health Trainer Partnership and a small evaluation sub-group was set up to oversee the evaluation that included individuals working within the three study localities. Several meetings took place between the research team, project leads and other members of the evaluation sub group, in order to ensure all relevant parties were involved in the planning stage of the evaluation. Interview schedules were also developed in collaboration with the evaluation sub group.

The broad aim of the evaluation was to provide both a comprehensive assessment of progress and also in depth information on specific aspects. Evidence was therefore gathered using a number of different methods. This included quantitative information based on an analysis of monitoring data relating to client characteristics and health issues. In addition, qualitative research methods were used to obtain rich, contextual information on the delivery of the health trainer programme (primarily in three different case study localities).

Monitoring data – Methods and Analysis

Monitoring data is collected routinely about each individual client by their health trainer. Data is collected in two stages. Firstly, a new client information sheet (Appendix 4) is completed and returned to the administrator. Secondly, once the client pathway is completed the record is closed and the remaining data about progress is returned to the programme administrator (Appendix 5). Follow up data from clients is also obtained at 3 and 6 monthly periods. Monitoring data was obtained from the programme team and inputted into Statistical Package for Social Scientists (SPSS). Data was cleaned, coded and analysed to produce descriptive findings. Relationships about client progress towards action plans were analysed using non-parametric methods. In order to assess the client levels of deprivation, Indices of Multiple Deprivation scores and ranks were tagged to postcodes using GEOConvert software.

Examination of case study localities – Methods

An in-depth investigation was undertaken based on a case study approach. Research was carried out in three localities where health trainers and the senior health trainers were working:

- Manningham and Girlington
- Trident/ Little Horton
- Allerton/ Lower Grange

Individual, semi structured interviews were chosen as the most appropriate method to explore the research questions in depth and allow different perspectives and experiences to emerge. In Phase 1 of the evaluation qualitative telephone interviews were used in preference to a postal questionnaire but it remained a challenge to recruit individuals for interview. After discussion with the project leads and evaluation sub group, it was felt that informal face-to-face interviews were the most appropriate choice. The interviews were to be conducted in the settings during the period the health trainer was running sessions. It was hoped that the more informal, opportunistic approach would promote greater participation in the evaluation, particularly from individuals who might be hard-to-reach through traditional research methods. Semi-structured interviews were also undertaken with project leads, senior health trainers, key informants from host organisations and health trainers. Semi-structured interview schedules, an information leaflet and consent forms were developed.

Sampling and recruitment

The aim of the sampling strategy was to obtain views from a range of different stakeholders with some involvement in the programme within the three localities. Initially, the main researcher worked with the senior health trainers to identify a variety of host organisations within the three localities in which to conduct the research, for example, community centres, libraries and medical centres. Once a range of settings had been identified, one-to-one interviews with clients, key informants and health trainers were carried out within these different organisations.

Prior to starting the interviews, as discussed above, the intention was to employ a naturalistic approach for the recruitment of clients. This would involve the researcher being based in the host organisation for half a day and therefore, being 'on hand' to talk to any clients that may be attending a health trainer session and who would be happy to talk about their experience of the service. However, once the research was underway it became clear that such a naturalistic approach to the research was inappropriate given the way in which the health trainer sessions were organised. It was more common for clients to attend health trainer sessions on an appointment basis often using the host organisation simply as a place to meet their health trainer and nothing more. In these instances, the facilities that the organisation provided were not necessarily utilised. For example, in the case of a community centre where various activities took place, clients attended the centre for their appointments with the health trainer but did not engage in other activities that were available. Therefore, the approach to the evaluation and in particular, the recruitment process, had to be altered in order to accommodate this way of working.

As part of the evaluation it was considered important to involve the health trainers in the recruitment process for the interviews. Given that they were the ones who were directly involved with the clients it was necessary to respond to their individual ways of working as much as possible and make use of their expertise in terms of finding clients to participate in the interviews. Therefore, wherever possible, an initial meeting was organised between the researcher and the health trainer teams. This enabled the researcher to outline the evaluation approach and explain how the senior health trainers and health trainers would be involved in the research process. Each member of the health trainer team were given leaflets explaining the evaluation and encouraged to pass these onto their clients where they thought it was appropriate to do so.

In their capacity as gatekeepers the senior health trainers and health trainers recruited clients who had verbally consented to participate in the evaluation. In addition, they assisted with the recruitment of key informants within the different host organisations. Following this, the researcher visited the host organisation for a half-day period in order to interview consenting clients who were attending their health trainer session. Where possible key informants, as well as health trainers, were interviewed during the same visit.

Following the client, key informant and health trainer interviews, senior health trainers and project leads were interviewed collectively as part of a focus group discussion. In addition, each member of the focus group discussion was interviewed on a one-to-one basis.

In total, the sample consisted of: 20 client interviews; 9 health trainer interviews; 11 key informant interviews; 3 senior health trainer interviews and 4 project lead interviews. A team of 3 university researchers conducted all the one-to-one interviews and the focus group discussion. These interview totals represent the point at which 'saturation' was achieved. So, for example, as far as the client interviews were concerned, it was not necessary to interview more than 20 participants because the same issues were being raised repeatedly. Additional recruitment for the interviews would only have been necessary if new themes were continuing to emerge.

Table 3.1: Interviews completed

Host Organisation	Locality	Interviews
Cafe West	Allerton and Lower Grange	4 clients, 1KI, 1HT
Bradford People First	Manningham and Girlington	1KI, 1HT
Mayfield Centre	Trident	3 clients, 1HT, 1KI
Federation of African & Caribbean Elders, Mary Seacole Centre	Trident	1HT, 1KI
Rhodesway Secondary School	Allerton and Lower Grange	1HT
Community Health Action Project, Woodroyd Children's Centre	Trident	1client
Bradford Foyer	Trident	2 clients, 1HT
Attock Centre	Trident	1HT, 1KI
Allerton Health Centre	Allerton and Lower Grange	1client, 1KI
MASTS Project	Allerton and Lower Grange	1HT, 1KI
Missione Cattolica Italiana	Trident	2 clients, 2 KI
Naye Subah, Quaker House	Trident	1KI
Dixon's CTC College	Trident	1KI
Westbourne Green Community Health Care Centre	Manningham and Girlington	3 clients, 1HT
Allerton Library	Allerton and Lower Grange	4 clients
Whetley Hill Resource Centre	Manningham and Girlington	1KI

HT = Health Trainer
KI = Key Informant

Approach to analysis

For the purposes of analysis, the one-to-one interviews and the focus group discussion were recorded using digital recording equipment. In addition, field notes were taken following each visit to a host organisation. All interviews were fully transcribed by a member of the university research team. Three researchers carried out the qualitative analysis, in order to validate the emerging findings. Transcripts were coded and themes identified, which were then organised into larger categories. Quotations have been used to evidence the evaluation findings. All participants were assured of their confidentiality and therefore, to ensure participants cannot be recognised, all quotations are listed anonymously.

Section 4: Findings – Clients

This section presents the findings from the one-to-one interviews with the clients. The key points from these findings are listed below followed by an explanation of the findings in more detail.

Summary Points

All clients stated that their health trainer experience was a positive one. The main reasons for this were:

- Clients were ready to change
- The venue and the time of the health trainer session was convenient and the health trainer programme was free
- Clients were able to talk one-to-one on a confidential basis and health trainers had the time to listen unlike health professionals
- Health trainers were professional in terms of their knowledge base and conduct
- Clients were able to establish a meaningful relationship with their health trainer
- Health trainers worked with clients to achieve their goal by agreeing targets and supporting them on their journey. Health trainers focused on both the 'what' and 'how'.
- Clients knew their health trainer was always there for them

The detailed findings are grouped according to four main headings, which were identified from the analytic process. The main headings are:

- Referral process/access to a health trainer
- Health trainer role and qualities
- Relationship with the health trainer
- Supporting behaviour change and how this is managed

Each of the headings is now explained in terms of the different themes that emerged.

Referral process / access to a health trainer

There were a variety of ways in which clients found out about the health trainer programme. Health professionals such as dieticians and health visitors referred clients, or clients themselves rang the help line number after seeing the health trainer

programme advertised on a leaflet or poster. However, the interviews revealed that the majority of interviewees found out about the health trainer programme on a more informal basis, for example thorough a friend, a child at school, an open day or a chance meeting whilst attending a community facility. In addition, some clients heard about the health trainer programme directly from the health trainer, as a result of health trainers or senior health trainers doing promotional work. Clients commented on the fact that seeing the health trainer in person and knowing whom they would be meeting before attending a health trainer session was an important factor in determining whether or not they chose to use the service.

> "She was there in person…her being there saying it's me who you're going to see, I'm the health trainer and it could be easier because you at least know who you're going to see…if I'd just read the leaflet I think I would have just walked away".

In terms of accessing a health trainer clients stated that convenience was important. It was easier to see a health trainer if the health trainer ran sessions in their workplace or if health trainers attended community centres, specifically to be 'on hand' should anyone require their services. When asked why they chose to see a health trainer clients said,

> "Because she was here and she was handy".

> "I think it was because (the health trainer) was here and I'd walked past a few times…whereas if I had to go and see somebody and actually make an appointment and go there and build myself up, but here you're just walking past so I just thought go in, it's the easiest thing."

The fact that health trainers were based in an organisation local to where clients lived and in addition, were flexible in terms of scheduling appointments was a significant factor. However, clients did travel beyond their home environment to see a health trainer, either because health trainers were located in centres on route to clients' place of work or there was no health trainer provision in the area where clients lived.

A free service was a positive factor for clients. Many of the clients expected to have to pay to see a health trainer based on their experiences of using other services. Some clients also expected a health trainer to be similar to a personal trainer and whereas such a service was prohibitive because of the cost, the health trainer programme was a free service and therefore, more accessible for a greater number of people.

> "I thought she was going to be like Slimming World. I thought she was just going to say buy this and buy that. I thought it was going to cost me…wherever you go it costs…it's a free service that everybody could go for".

Clients referred to the uptake of the health trainer programme and offered their own suggestions for increasing accessibility to the service and for encouraging people to

utilise what they thought was a valuable and worthwhile provision that all members of a community could benefit from. Increased marketing and a greater presence in the community were seen as being important in order to raise the profile of the health trainer programme and make people aware of its existence. Many clients felt that people did not use the service simply because they had no knowledge of it.

> "Needs to be publicised a bit more…unless you come in here you don't really know…there would be a lot of people who would benefit from coming".

In addition, clients thought that health trainers and host organisations could work together to increase the profile of the health trainer programme, perhaps by having a display or advertising the health trainer service as part of an open day.

Health trainer role and qualities

Regardless of the reasons why clients first decided to see a health trainer, the overriding theme to emerge was that of talking and listening. Whether clients were seeing a health trainer because of issues relating to their physical or mental health they all commented on the fact that a health trainer was someone they could talk to on a one-to-one basis.

> "You have to find someone to talk to…I just probably sat and cried for a few months and I just wanted to talk to someone so it were a blessing really".

> "Just being able to talk to somebody was the best thing".

In addition, they were perceived as being someone who was willing to listen, unconditionally, in a safe and confidential environment. One client summed this up with the following response,

> "This is your own appointment, your own problems, it's confidential and you can say whatever you like and it's just (the health trainer), that's it".

As well as being there to act as a sounding board and provide a listening ear, clients felt that part of the health trainers' role was to give advice, provide information and signpost them onto other services such as Versa (weight management programme), BEEP (Bradford Encouraging Exercising People) and the walking project, as and when appropriate. Health trainers were perceived as having a particular role to perform which was distinctly different to that of other professionals, for example, doctors and nurses, yet they were regarded as professionals in their own right.

> "Knowing that she's (health trainer) got the professional knowledge…it's having the professional there".

The key distinction separating health trainers from other professionals was the time factor, with clients commenting on the fact that health trainers had more time for them. The theme of time is examined in more detail in the following section. This concept of being a 'professional' is an important one because of course underpinning the health trainer programme is the idea that health trainers are not usually from a professional background. Clients regarded health trainers to be of equal standing to other professionals, perceiving them as trained and knowledgeable about their work (but not technical in their use of language) and more so than doctors when it came to lifestyle issues. In addition, they regarded them as professional in terms of their conduct, integrity and the fact that they were non-judgemental. So, health trainers were thought to be both professionals and professional.

> "A doctor goes so far and that is it. If you need to exercise you have to find out yourself…I need somebody that knows…then the health trainer takes over".

Interestingly, concurrent with this was the idea that health trainers were the clients' friends. There were no barriers separating them and clients were able to talk to their health trainer about any issue in an informal setting. However, what was important was that health trainers were willing to go that extra mile just as a friend would.

> "Each time if I rang her she would ring me back. She talked to me…it didn't matter if she was busy or it was a weekend or whatever".

> "She didn't just come as a health trainer, she came as a friend as well".

Clients made a further distinction between the health trainer as a friend and other friends. They appreciated being able to talk to the health trainer as a friend but significantly this friendship with the health trainer was viewed as a completely separate entity in their lives. Indeed, this was given as one of the reasons why clients did feel able to talk to a health trainer. Health trainers were removed from their community and therefore, the risk of confidentiality being breached was not an issue.

> "I couldn't talk to J or the family because they don't want to see you in that state…just someone to talk to outside the family, they aren't involved".

> "An outsider's point of view, somebody who was not related to me, not my family and somebody who was not Asian as well because it's a culture thing…had he been Asian I would have never have walked in here".

Additional characteristics that clients thought were necessary for a health trainer included empathy, patience, support and encouragement.

Relationship with the health trainer

All clients stated that one of the most valuable aspects of seeing a health trainer was that they had been able to build up a relationship with their health trainer. The key factors facilitating this were time and availability. Health trainers, as has been stated previously, were able to and prepared to make time to see clients for as long as was necessary. For the clients this contrasted sharply with their experience of seeing health professionals, who never seemed to have enough time for them. A consequence of this was that there was no opportunity to establish a more meaningful relationship in which clients really felt their needs were being catered for.

Many clients experienced simply being told *what* to do whenever they visited a health professional such as their doctor or community nurse. For example, there were clients who wanted to lose weight and a major theme that came through was that of 'diet sheets'. Diet sheets were perceived as the 'quick fix' answer and yet as one client commented,

> "It's like people don't understand and they just give you a sheet with follow this diet or eat a bit of this and less of that, but there's more to it and how to get to them and how to achieve that…my doctor's excellent but I don't think the doctor could do what (the health trainer) has done…she's helping me how to achieve that, that's the main thing".

For many clients the issue of *how* to achieve their goal was equally as important as knowing *what* to do. Having the opportunity to talk about a health issue in the context of their own life was a key factor in addressing how they could make changes. Not only this but, as a result of having built up a relationship with their health trainer, clients said they felt comfortable talking about other issues besides that which had originally prompted them to see a health trainer. Even though clients approached a health trainer with one particular problem, for example wanting to lose weight, it was not unusual for other issues to surface that were often at the root of the problem, relating to their emotional and mental health for example.

> "I told her how I was fed up with my weight to put it bluntly…I've got other issues really which I did not recently know myself until I started tapping at mental issues".

Another key theme to emerge was that of not wanting to let go of a health trainer. Having established a relationship with their health trainer many clients had come to rely on their health trainer and saw them as a significant person in their lives. In some instances the relationship had developed further into one of dependency largely because of the longevity of service, with a few clients seeing their health trainer for up to a year.

The opportunity to have regular appointments, knowing that the health trainer was only a phone call away and being encouraged to access the health trainer at any time were all factors that promoted feelings of security. The following comments exemplify the depth of feeling that clients had towards their health trainers.

> "It's very important for me to be able to see (the health trainer) I don't know what I'd do without her…it's like she's your soul partner, honestly she is".

> "If (the health trainer) not there then I crack up. Even when she goes on holiday I say, "Oh my God, what are you going on holidays for?"

> "If I didn't have a health trainer I don't know where I'd be".

Continuity was also an important factor. Having built up a relationship and the rapport with their 'own' health trainer, understandably clients did not want to see anyone else because,

> "I know that she knows everything about me and she is the person who has directed me into the right point".

Supporting behaviour change and how this is managed

Clients recognised they had to want to make a change and accordingly it was their responsibility to make the changes happen. However, in order to alter their behaviour they needed to know they had the support of their health trainer.

> "It was all me really but (health trainer) was supporting me but it was for me to actually go out there and do it…I needed that little boost, that little push".

The way in which health trainers supported their clients was important with many clients using the terms motivation and monitoring. Treating clients as individuals, tailoring programmes to their specific needs and giving them different choices were key factors in motivating clients and facilitating behaviour change. Again, time was reiterated as a significant aspect of this process. Phrases such as "small steps", "take one step at a time" and "making those small changes" were often used to manage the behaviour change. Clients spoke of not feeling pressurised by their health trainer to make big changes or to change quickly.

Building up a relationship with their health trainer and knowing the health trainer was there for them helped to reinforce the clients' desire to change. Clients stated that health trainers gave them the confidence to make changes on their own that they would not have necessarily done before and instilled in them the belief that they could indeed

change if they really wanted to. In addition, they spoke of being answerable to a health trainer without feeling judged.

> "Seeing a health trainer you can sense that there is somebody there to help you and somebody will encourage you and if you're not doing as well as you should be she won't be angry or upset with you but she will be there to give you that one little extra push and she will get you there".

Clients referred to targets as an important aspect of the monitoring process. The key theme was working with their health trainer to set those targets. Knowing that there was someone in the background keeping an eye on their progress and who would know whether they had successfully achieved their target was an incentive to change.

> "We've set times to meet every fortnight so she'll be keeping a record of what I've been doing and if I've been meeting those targets that we've set…I know inside me that I'll be speaking with (health trainer) in two weeks so I better do…you have to do because you know that if you don't do it then there'll be problems".

Clients wanted to please their health trainers because the clients were aware that the health trainers had invested time with them and also believed in their ability to change. However, if for any reason they did relapse the clients knew that the health trainers were available to help them.

> "I have to do what I have to do to reach my target but I know that if I do fall back I've got (the health trainer) to rely on and talk to and somebody who can increase my confidence and encourage me. I've got somebody on side".

It was important to be able to dip in and out of the health trainer programme as and when clients felt the need to do so. Some clients were seeing their health trainer on a regular basis and there were others who felt they had reached their targets and were seeing their health trainers less frequently. However, these clients still wanted the reassurance of knowing they could contact their health trainers if necessary. They felt that the health trainer programme should cater for all clients no matter how or when clients chose to use the service.

> "Even if it's only temporary depending on the difficulties. If it's an ongoing thing it might be more useful to see (a health trainer) every few weeks over a longer period of time. Whereas somebody might need to be able to see one to kick start them and get them onto something else…but if there's a safety net that's useful".

All clients, without exception, were extremely positive about their health trainers and they would recommend them to anyone wanting to make lifestyle changes. The following comment is typical of those received in praise of health trainers.

"Everyone who needs to make a change or who wants to set themselves targets, health trainers are just the perfect people to come and see".

Section 5: Findings – Service providers

This section presents the findings from the one-to-one interviews with the health trainers, senior health trainers, project leads and key informants from the host organisations (referred to collectively as service providers). In addition, it includes information from the group discussion involving senior health trainers and project leads. This collective term was used to maintain the anonymity of those interviewed and to represent key points along the pathway of service delivery. A summary of these findings is listed below followed by an explanation of the findings in more detail.

Summary points

Roles and qualities

Health trainers:

- Support clients to make behaviour changes
- Conduct community development work
- Assist in raising the profile of the health trainer programme

Senior health trainers:

- Support/supervise health trainers and support project leads and key informants of host organisations
- Conduct community development and outreach work
- Problem-solve and deal with sensitive issues
- Conduct home visits

Structure of the health trainer programme

- The freelance model can be problematic for the delivery of the health trainer programme
- There need to be clearer boundaries distinguishing the roles of health trainers from those of senior health trainers so all parties are aware of the difference
- A supportive infrastructure was recognised and valued
- There are a variety of health trainer models in operation with different ways of working
- A set of common attributes exists characterising successful health trainer placements

Advantages of the health trainer programme

- Health trainers fill a gap in terms of service provision
- Health trainers have greater expertise in dealing with lifestyle issues
- The health trainer programme is available for and accessible to all

The detailed findings are grouped according to 4 main headings, which were identified from the analytic process. The main headings are:

- Roles and qualities
- Structure of the health trainer programme
- Advantages of the health trainer programme
- Development of the health trainer programme

Each of the headings is now explained in terms of the different themes that emerged.

Roles and qualities

All participants were asked about the role of service providers within the health trainer programme, including their individual role as well as the role of their colleagues and partners. The roles and qualities of the health trainers and senior health trainers emerged as dominant themes and are now each examined in turn.

(1) Health trainers

In response to questioning about what service providers saw as the role of health trainers the key themes to emerge were those of behaviour change and one-to-one ways of working. Health trainers were perceived as facilitators who supported individual clients to make behaviour changes. Rather than offering advice, working in partnership with clients and encouraging clients to set their own targets, were regarded as important facets of the health trainers' role. The following comment is typical of the responses given.

> "I see the role of the health trainer as being one-to-one support for people who are trying to change something about their lifestyle…I don't see them as giving advice or anything. I think it's about a joint partnership between the client and the health trainer. It's about getting to the point where the individual wants to be" (project lead).

Another factor that was highlighted within the health trainer role was a willingness to carry out community development work and assist in raising the profile of the health trainer programme. In addition, there were other characteristics that were regarded as necessary, including a willingness to talk with people, being a good listener, being empathetic and non-judgemental and possessing flexibility, particularly in relation to the different ways of working.

> "A person comes in and they're identifying their needs and expressing where they are within the cycle of change and then you're on that journey with them to

give them the support, the encouragement and the motivation towards the changes that they want to make" (health trainer).

(2) Senior health trainers

When service providers were asked about the role of the senior health trainer the main theme to emerge was that of support. Health trainers and project leads referred to the various forms of support that senior health trainers gave to the health trainer programme, whether it was in relation to personal development or service delivery. This included offering direct support to health trainers and management, attending presentations, networking, liaising with host organisations and establishing links with health professionals.

> "Although in the job description it wasn't a supervisory role, but we've seen that we're doing that a lot more…I've seen the role as may be mentoring…supporting the health trainers in their role for them to develop and what needs to be put in place such as training" (senior health trainer).

> "I look at them as developing areas. I think they're there to support the health trainers, being more experienced health trainers and being that link between the health trainer and the placements, doing more of the setting up of the placements…but they're also a massive support to me in that there is that middle person now who can better explain things to a health trainer on a one-to-one basis" (project lead).

Other aspects of the senior health trainer role were emphasised, including previous experience of community development and outreach work, together with an understanding of the community in which the senior health trainers and health trainers were working. In particular, knowing where to access information, identifying gaps in service provision and building up a directory of services in the local area were all-important aspects highlighted within their role.

When asked about the difference between a senior health trainer and a health trainer the one clear distinction was that senior health trainers were permitted to make home visits. Senior health trainers were also regarded as having more experience to deal with any problems that arose. Often they were the first point of contact for health trainers faced with difficult issues, especially those of a sensitive nature. However, some service providers commented on the lack of experience of senior health trainers and thought that a prerequisite of the role of senior health trainers should be to gain experience initially as a health trainer. In addition, key informants from host organisations were not always clear about the difference between a senior health trainer and a health trainer.

Negotiating and setting up placements was regarded as a key aspect of the senior health trainer role. Senior health trainers were responsible for making contact and establishing relationships with key people whom the health trainer programme had previously been

unaware of. The consequence of this was a greater number of placements in all areas, not just in the three evaluation localities. In this respect the role of the senior health trainer and health trainer was regarded as similar. Health trainers were active in initiating health trainer activity and were responsible for setting up new placements and recruiting clients.

> "There are a lot of areas that the senior health trainers do that we do as well. There is a lot of overlap. Then again the senior health trainers have got their own placement so they go out and do the health trainer's role as well so they do a bit of our job…senior health trainers do more of community development work but then again our job involves a lot of community work as well so I don't think there are that many things to separate us really" (health trainer).

Box 2: Role of senior health trainer

- Mentor health trainers
- Support/supervise health trainers
- Support project leads
- Liaise with key informants of host organisations
- Carry out community development and out reach work
- Solve problems and deal with sensitive issues
- Conduct home visits
- Support clients to make behaviour changes
- Raise the profile of the health trainer programme

Structure of the health trainer programme

A three-tiered structure exists in terms of delivery of the health trainer programme comprising project leads, senior health trainers and health trainers. When this structure was explored two main themes emerged, employment and working relationships. Each of these is now examined.

Employment

Senior health trainers and health trainers work on a different basis and this has an impact on the delivery of the health trainer programme. It was felt that senior health trainers, who are employed rather than health trainers who work on a freelance basis, have increased security and provide the health trainer programme with greater consistency and continuity. Responses from health trainers varied in terms of those who were happy to work on a sessional basis and those who stated they would prefer to be employed.

An important concern to emerge was that of health trainers having more autonomy and being in a position to decide exactly when they wanted to work. Although an advantage for the health trainers, this could potentially create problems for others involved in the health trainer programme, not least for the clients. This flexible way of working also had an impact on the host organisation particularly if communication strategies between the health trainer and the host organisation were not well established. In these instances the host organisation was not always clear about when a health trainer would be available and seemingly, this had an adverse effect on the referral process.

Working relationships within the health trainer programme

Both senior health trainers and health trainers stated that there needed to be clearer boundaries regarding the role of the senior health trainers. Health trainers commented on the fact that they were unsure what the exact role of the senior health trainer was and according to the senior health trainers their role had evolved from the original job description. Spending time with health trainers in host organisations and at locality meetings was a key area where senior health trainers had to concentrate their efforts. It was important for them to do this in order to achieve respect, build up trust and establish a rapport between themselves and the health trainers.

In order to ensure effective working relationships within the health trainer programme, service providers regarded a supportive infrastructure as essential. This was felt to be particularly important given the evolving nature of the health trainer programme and the varying experiences of the health trainers, in terms of what they brought to the programme and their expectations. Senior health trainers and health trainers commented on the support they received from the project leads and it was clear that this constituted an invaluable element of the health trainer programme which many had come to rely on.

> "I don't think you could do it without full project support and seniors…somebody is always there on the end of a telephone and somebody will always follow up and somebody will find you the information and make the links so I think it's really important" (project lead).

Working relationships within the localities and placements

Different ways of working were identified between the facilitators of the health trainer programme and the host organisations. These were dependent on the needs of the community and the individual strategies of the health trainers and senior health trainers. In terms of setting up a placement and the recruitment of clients there were three main approaches:

1. The health trainers themselves identified the need for a health trainer within a particular organisation and clients were then recruited, largely through health trainers employing a proactive approach to working.

2. Key informants within particular host organisations expressed the need for a health trainer and clients were then referred through the organisations themselves.

3. Placements were established as a result of client recruitment based on strategic marketing. Marketing strategies included flyers, open days, newsletters, word-of-mouth and being present at key locations in the community.

In addition, recruitment occurred as a result of telephoning the health trainer programme helpline. See section on Monitoring Data.

A variety of models were identified that exemplified the different ways in which the health trainers worked with the host organisations; each model was successful in terms of meeting the needs of the clients. There were three main models. Firstly, that where the host organisation was used as a venue only and clients were seen on an appointment basis. Secondly, that where health trainers worked with established social groups, for example, the Italian Mission. In this case the health trainer attended the group sessions held for women at the Italian Mission and was on-hand to provide a one-to-one service for clients as and when they needed it. A further model was that where clients were able to see a health trainer as part of a small group, for example Café West. The personal skills of the health trainers were perceived as largely responsible for ensuring a particular model worked and the placement was successful. Health trainers were seen as being able to work with whichever model was most appropriate and respond accordingly to the needs of their clients.

> "She works in about five or six different places but they all work. So it's a lot to do with the qualities and skills of the person. She's in a health centre, she's in a community centre, she's in a gym and she's in a school and she's in a resource centre and they all work because she understands what she does" (project lead).

Even allowing for the fact that there were a variety of models it was still possible to identify common characteristics that contributed towards a successful health trainer placement. The main characteristics that emerged included the following. Service providers, including project leads, senior health trainers and health trainers, thought that health trainers needed to be located within an organisation located in a super output area that afforded clients easy access. It was preferable for the setting to be anonymous, in the sense that service providers believed clients were more likely to come and see a health trainer if the setting was not associated directly with health. However, the organisation had to be familiar to clients in order to ensure they would feel comfortable, for example a community centre in the area where clients lived. In addition, it was felt that the organisation should be welcoming and receptive to clients

with no limits imposed by the organisation on the number of clients using the service. Service providers highlighted the importance of a meeting place that facilitated one-to-one interactions; it was imperative that this room enabled clients and health trainers to talk in private. For security reasons it was essential that all venues where health trainers and clients met were staffed, particularly outside of normal working hours.

Box 3: Features of successful health trainer placements

Easily accessible for clients, including access at weekends and on an evening
Free service
Sited within a host organisation located in a super output area
Approachable environment
An anonymous setting
A setting familiar to clients
Located in a host organisation with no 'conditions' attached
Comfortable meeting place that is private and facilitates one-to-one interaction
Assured confidentiality
Safe and secure at all times
Host organisation is receptive to the health trainer programme and does impose no limitations
Open regular communication between the host organisation and the health trainer
Commitment from the host organisation and the health trainer
Partnership working

There were clear themes that emerged in relation to building up a successful relationship between the host organisation and the health trainer programme, regardless of the model and the setting. The first point of contact was regarded as important with good communication skills and approachability identified as necessary attributes of the health trainer and senior health trainer. Clear boundaries were thought to be necessary including ensuring the host organisation and the health trainer were both aware of each other's roles and expectations. Most importantly, a commitment from all members, both from those within the organisation as well as the health trainers, was regarded as imperative if the placement was to be a success. It was acknowledged that establishing a relationship within different organisations takes time and requires effort, but working in partnership to achieve the common aim of a successful placement was a theme that was constantly reiterated.

> "As time went on the people began to realise that we are not there to step on people's toes, we are there to add onto their service. Every organisation is

important, we are very important and we have worked very hard to build this up" (health trainer).

Primarily, interaction and integration were identified as fundamental processes. Key informants from some host organisations commented on how important it was to have the health trainer programme on board as part of a fully integrated service that they were able to offer their clients. As well as being able to simply say that they were offering the health trainer programme, key informants expected to interact with the health trainer regularly, but most importantly they wanted to work in a reciprocal way where both the host organisation and the health trainer operated as a team to satisfy the needs of their clients.

> "Health trainers have to take a partnership approach, I don't think they would work exclusively on their own, if they tried to promote the services purely on their own I don't think they would manage. They would need to work very closely with the organisations from where they are actually delivering the service… I think if you have got strong relationship you can go out there and you can recruit members of the community together" (key informant).

Key informants thought that establishing a good working relationship between the organisation and the health trainer was essential in terms of the success of the programme long term. It was important to work together, to share skills and resources and collaborate in order to overcome any barriers within the community. Two barriers that were highlighted included the difficulty of accessing people who were not already in contact with services, in other words those who were hard to reach, plus the difficulty of establishing the health trainer programme in an area that had poor networks and little existing provision. Service providers in general commented on the fact that community development work could be problematic for all concerned, which is why it was important for health trainers, senior health trainers and key informants within host organisations ideally to work together, sharing expertise and recognising one another's experience.

Advantages of the health trainer programme

Service providers spoke of the advantages of the health trainer programme and many were able to cite the benefits of the service for clients. Clearly, the health trainer programme had made a huge impact on the lives of some client groups as well as having a demonstrable effect on certain host organisations.

In terms of the advantages of the health trainer programme the responses from the service providers largely echoed those of the clients. However, it is important to reiterate the main findings as evidenced from the service providers' perspectives. The main issues that were identified included the following; health trainers having more time to spend with clients, a greater expertise in relation to lifestyle issues and a more holistic way of working with clients.

> "To be able to refer…where there may not be a medical condition at all…there are social issues and lifestyle issues; they (GPs) simply haven't got the time or necessarily the expertise to deal with…then you have this person (health trainer) who has a holistic approach saying this is all your lifestyle, this is all your habits and they are actually related to each other" (key informant).

The health trainer programme was continually emphasised as a complementary service and it represented another option for health professionals to signpost clients. Although concentrating on hard to reach clients, service providers believed the health trainer programme should be available for everyone. Even in those organisations where a particular population group was targeted key informants stated that their doors were always open for anyone who wanted to use the health trainer programme. They were keen to improve inequalities and encourage all users.

> "It's whoever, at the centre there is no bars…in having the health trainer here, they can still pop in, the doors are open to everybody…I don't see why I should stop them, everyone has the right to use it" (key informant).

For host organisations the benefits of the health trainer programme were numerous. Health trainers were credited with having increased the number of service users within organisations as a result of clients having seen a health trainer. Health trainers, as well as filling a gap in terms of service provision, were also aware of other services that were available within organisations. Consequently, they were in a position to signpost clients and if necessary, were able to accompany clients to other internal and external services, something that health professionals were unable to do. As a result of the work of health trainers more clients were using other services on offer in organisations and therefore, increasing the profile of the organisation within the community.

> "They've been to see the health trainer, they've not known we existed in the first place because a lot of people still don't know we're here, but they come to see the health trainer and they see what else we do and tapped into other services" (key informant).

Service providers regarded health trainers as having greater flexibility, adaptability and mobility. All three factors meant health trainers were more accessible in the community. As a result they were perceived as being able to monitor clients more closely than other health professionals and "keep in touch" with clients' progress. In addition, the fact that senior health trainers and health trainers were based in different areas and within a wider range of organisations meant a greater number of clients, particularly those who were hard to reach, were being targeted.

Development of the health trainer programme

The final section within the service providers' findings centres on recent and future developments within the health trainer programme. The main theme to emerge was that of the impact of the senior health trainer on the health trainer programme as a whole. In particular, senior health trainers were credited with having increased accessibility to health trainer services by opening up more placements and generally, raising the profile of the health trainer programme throughout the region. However, some service providers thought senior health trainers needed to be more fully integrated in terms of their involvement with host organisations. In addition, key informants thought they should be more embedded in the culture of different organisations.

> "We view any additional services that we can provide to this population…as being very useful. The trick is…to like embed them in the culture of what we are doing" (key informant).

Senior health trainers were said to be responsible for the programme becoming more professional in its approach as a consequence of them being employed and therefore, having a greater presence. Since senior health trainers had come into post new systems and strategies had been developed in response to clients and service providers needs. These included home visits and an out-of-hours service.

Many service providers commented on the nature of the senior health trainer role and referred to the fact that it had been evolving and was continuing to do so.

> "They have to be able to raise the profile of the service. They need to be able to tackle the other things that we ask them to become involved with. What we're trying to do is focus on their strengths…what we've done is experiment with the senior health trainers' job description and learned what's needed" (project lead).

As a result service providers felt that the role of the senior health trainer had changed. It was regarded as being less about management and working in localities and more about supervision, in the sense that senior health trainers were required to spend a greater proportion of their time supervising health trainers.

As far as the future development of the health trainer programme was concerned the issues that were highlighted focused on developing the depth and breadth of service. A greater effort was required to increase the uptake in existing organisations as well as promote the service across a wider area. It was acknowledged that more planning needed to occur in order to develop a greater intelligence and understanding of people's needs in different areas, particularly those in less developed areas, so that health trainer models could be established that met people's needs. Instead of being reactive the health trainer programme needed to be more proactive to avoid duplication and gaps in service.

Service providers thought the health trainer structure would be improved by employing health trainers rather than health trainers working on a freelance basis. Key informants stated that health trainers would be able to reach out to more people in need if they were employed on different terms. Health trainers would be able to spend more time in different organisations and because of their increased presence they were more likely to be recognised as an integral and indispensable service in much the same way as other services.

Many service providers thought the health trainer programme would benefit from a more structured training strategy, to follow on from the initial training, one that was ongoing and constantly updating individuals' skills[1]. Health trainers felt they needed training that targeted specific areas of concern and increased their experience of health related issues.

Promotion and publicity were highlighted as areas for improvement. Service providers acknowledged that more could be done to raise the profile of the health trainer programme and therefore, increase client uptake. The perception was that promotion needed to be part of a continuous and planned strategy in order to ensure that the focus was not simply directed at recruiting new clients and setting up further placements. A constant reminder of the existence of the health trainer programme was required using a planned and focused promotional campaign.

[1]The Health Trainer Programme provides a training programme and since health trainers started in January 2006 meetings have been held every 6 weeks to pick up any outstanding training issues

Section 6: Monitoring data

Introduction

This sub-section has been compiled using the monitoring data collected routinely by health trainers for each client. The data was collected between 17 January 2006 and 22 October 2007 by 32 health trainers including 3 senior health trainers in 77 different locations. A total of 1064 clients were seen by health trainers during this time period.

Summary Points

- There has been a large expansion of the health trainer programme since January 2006 from 10 different health trainers in 14 organisations, to 32 health trainers working in 77 locations in October 2007. A total of 1064 clients were seen by health trainers during this time period.
- Client outcomes were measured in terms of progress towards action plans and goals set. Of the clients that worked on action plans, 70% made progress towards their goals.
- Health trainers provided an efficient mechanism to direct clients to other appropriate services. Ten percent of clients were signposted to other services after one consultation. This is a useful outcome for clients and addresses one of the central functions of health trainers.
- Signposting in general has increased from 36% in year 1 to 50% in year 2.
- The more appointments a client attended with a health trainer, the greater the progress towards action plans and goals.
- The service was able to respond to the needs of the diverse client base both in terms of ethnicity and age. The majority of clients were women, although there was a proportional increase in the numbers of men being referred to health trainers from 17% in year 1 to 23% in year 2.
- Community groups and general practice were key gatekeepers of the service reflecting the important role of the host organisations in promotion of the programme.
- The health trainer programme was successful in reaching out to those living in areas of deprivation. Fifty-seven percent of clients were living in Super Outputs Areas (SOAs) in the top twenty percent most deprived areas in England.

Table 6.1 Characteristics of clients using the Health Trainer Programme.

Characteristic	N= 1064
Gender n (%)	
Female	818 (77)
Male	243 (23)
Age n (%)	
Under 18	34 (3)
18-25	87 (8)
26-35	218 (21)
36-45	239 (23)
46-59	259 (34)
60-74	155 (15)
75+	44 (4)
Ethnicity n (%)	
British	638 (60)
Pakistani	274 (26)
Indian	40 (4)
Other	103 (10)

Percentages rounded to nearest whole number
Totals may not be 100% due to rounding

The majority of the clients attracted to the service were women but the proportions of men accessing health trainers has grown from 17% to 23% in year 2 of the programme.

The age structure of the clients referred to the programme reflects Bradford's broader population profile demonstrating the ability of the service to meet the needs of a wide age range of clients.

Health trainers continue to engage an ethnically diverse client group, reflecting the ethnic mix of Bradford. The service is able to meet the needs of a changing population profile, for example, Eastern European and Chinese clients, albeit in small numbers but demonstrating the responsiveness of the programme.

Marketing and Referrals

Getting clients into the service is an important component of the process. The health trainer programme used a variety of techniques to market the service and attract clients. Both senior health trainers and health trainers have attended a wide variety of events to promote the service to a) develop new placement locations or b) encourage recruitment of clients into existing locations. Since January 2007 to October 2007 they have attended 175 different events.

Table 6.2. Finding out about the Health Trainer Programme

Marketing method	Community Centre	Flyer	GP	Practice Nurse	Group or Event	Bradford Council	Newsletter	Press and Radio	Others
Number (%)	168 (21)	105 (13)	88 (11)	78 (10)	58 (7)	51 (6)	24 (3)	21 (3)	194 (25)

Community centres and health care professionals working in primary care were the most frequently reported methods of hearing about health trainers. This is likely to reflect the important role of the host organisations, in which health trainers are based, promoting the service.

Referrals were made mainly by the clients themselves, accounting for 70% (n= 741) of the total referrals. Health care professionals were important gatekeepers of the service responsible for referring 187 (18%) clients to health trainers. The central helpline was used as part of the process for referral for 51% clients.

Client contact with the health trainer

The monitoring data includes both clients who have completed their pathway through the health trainer process and those who are still actively working toward their health goals. For completeness this information is clearly reported in the following paragraphs.

Service use

Table 6.3 Number of appointments with health trainer

Number of appointments	1	2	3	4	5	6	7-10	11-15	16-32	Missing data
Number (%)	210 (30)	99 (14)	95 (13)	57 (8)	50 (7)	44 (6)	71 (10)	30 (4)	9 (1)	32 (5)

365 clients were still actively working with HTs and have been excluded from this table
The amount of contact with health trainers varied tremendously amongst clients. Nearly one third (n=210) attended one consultation, but of these 76 (11%) were appropriately signposted to other service/s. The average number of consultations was 3.86 per client.

Occasionally clients saw health trainers more than six times, although gender, age, ethnic group, language of consultation, or complexity of health issues could not predict numbers of consultations attended.

Health Issues

The programme is designed so that clients can discuss any health issue in the broadest sense of health. As expected a great variety of health issues were considered when developing the client action plans. The majority of clients (75%) did not focus on one issue but worked on multiple issues for example smoking & stress relief and weight loss & meeting people.

The table below provides information about how many clients reported each health issue.

Table 6.4 Health issues considered by clients with health trainers

Health issue	Weight Management	Healthy Eating	Fitness & Activity	Anxiety /Stress	Social Emotiona Issues	Smoking	Confidence/ Self esteem	Relationship /Family	Physical	Alcohol	Missing
No of clients (%)	588 (55)	478 (45)	427 (40)	222 (21)	167 (16)	131 (12)	89 (8)	77 (7)	61 (6)	29 (3)	24 (2)

By far the most frequently reported issues were diet and physical activity, primarily for the purpose of weight management. Many clients considered their health holistically, without separating physical health from mental health issues.

No differences or patterns of types of health issue could be found by gender, age or ethnicity. For example, men were just as likely as women to report social/emotional issues.

Progress towards Health Action Plans

Due to the complexity and diversity of health outcomes that clients could achieve within the health trainer programme, all clients were asked to record progress towards their individual health actions plans as part of the monitoring processes. It is important to note that the data contains still active clients n= 365 (34% of the total) who are not yet ready to assess their progress towards their health goals. These clients have been removed from the analysis to measure client achievement accurately.

Table 6.5 Progress on action plans

Progress on Action Plans	Excellent progress	Good progress	Limited Progress	No progress	Missing data
Number of clients (%)	57 (10)	160 (28)	213 (38)	132 (23)	61 (11)

*Excludes 76 clients who were signposted after 1 consultation
#Excludes 365 active clients

Thirty-eight percent of clients had made excellent or good progress towards their health goals, compared to 17% in year 1 of the programme. Ten percent of clients were signposted to other appropriate services after one consultation with a health trainer and did not make action plans with a health trainer. Twenty-three percent of clients had made no progress toward their health goals. No specific factors for example age, gender, health issues were related to this lack of progress.

Progress towards health action plans revealed that good or excellent progress was related to the number of appointments attended with a health trainer. (rho= +0.63 p= 0.01). The more appointments a client attended the greater the progress towards health goals.

6.5 Signposting to other services

An important function of health trainers is to signpost clients to other useful services. The amount of signposting in year 2 of the evaluation has increased from 36% to 50% of clients directed to others services. The most common services to which clients were directed are shown below in Table 6.6

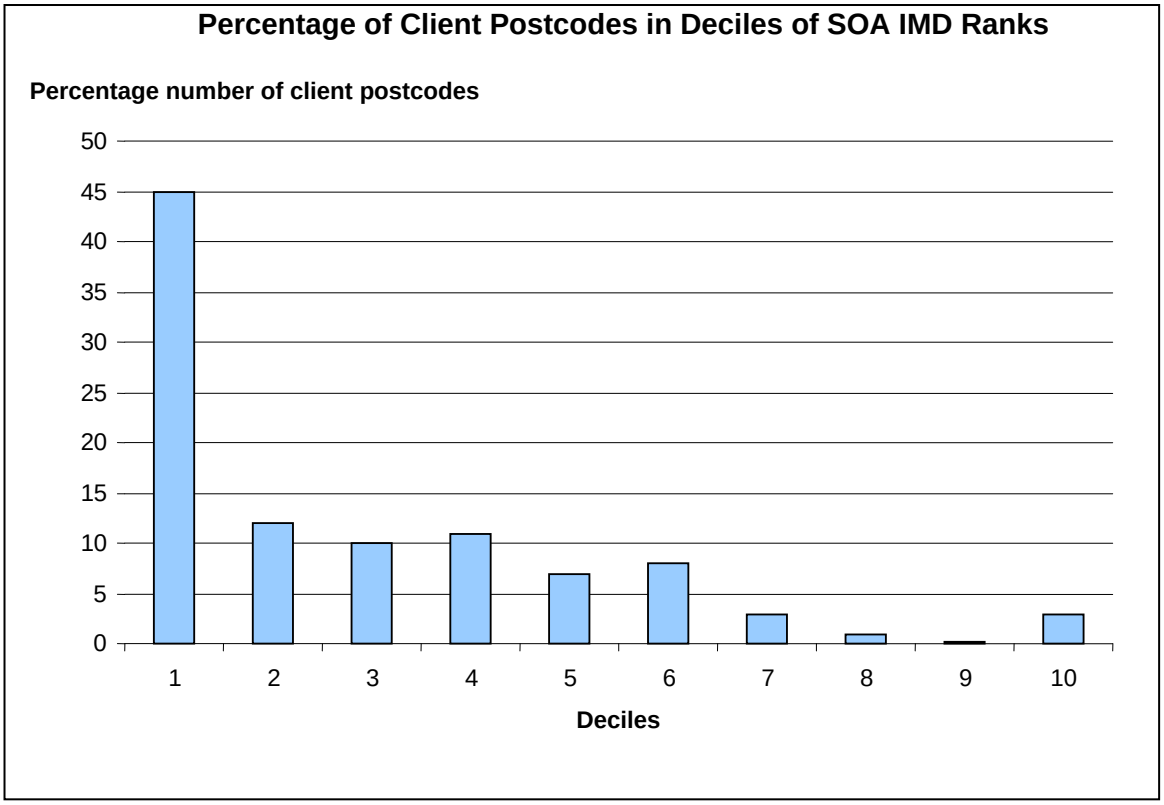
Table 6.6 Types of services signposted to clients

Service Signposted	BEEP	Community Group	Walking Group	Healthwise	Smoking cessation	GP	Other
Number (%)	131 (24)	66 (12)	53 (10)	45 (8)	44 (8)	31 (6)	164 (31)

The type of community groups were largely unspecified within the monitoring data but it is evident that exercise and healthy eating were the main services mentioned by health trainers as useful for their clients. There is quite a large gap between the numbers of clients stating particular health issue/s and the number of clients signposted to those health related services. For example, 131 clients stated smoking as an important health issue for action planning although 44 clients were signposted to smoking cessation services. This may reflect that clients may have previously tried other types of services and who wish to continue working with their health trainer and do not want be referred on. Importantly, given the importance of mental health needs identified by clients there was little evidence of signposting to these types of services. This may reflect the lack of services available for health trainers to refer on and reluctance of clients to be referred. However it is important to note that some of the more physically outcome-based services may also provide opportunities for emotional & social support and stress relief.
Of the clients who were signposted to other agencies, 89 (17%) were accompanied by a health trainer in order to overcome any nervousness about attending alone.

Health Trainer Programme Reach.

The health trainer programme was successful in reaching out to those living in areas of deprivation. The graph below shows the number of postcodes of clients in each deprivation decile (10%) band. The top ten percent most deprived areas in England are in band 1 and the bottom ten percent are in band 10.



Forty-five percent of the clients accessing health trainers, lived in areas of Bradford classified in the top ten percent (band 1) of deprived areas in England. A small percentage of clients were living in relative affluence but this may be a result of health trainers undertaking targeted work with excluded groups, including those with severe physical impairment , people with enduring mental illness and those with learning difficulties.

The map in Appendix 8 also shows that the locations where health trainers are based match well with areas of deprivation.

Section 7: Discussion of evidence

In this section of the report the results are discussed in relation to the four main evaluation questions and the original objectives. Points for consideration pertaining to future service development are highlighted. The limitations of the evaluation are discussed and the strength of evidence assessed. The different elements of the local programme are considered in relation to the role of the health trainer in providing support, the role of the SHT, access to health improvement services and service outcomes (lifestyle change).

Can health trainers get people to the 'right place', where individuals receive appropriate support to enable them to make positive changes for health?

The national health trainer programme is based on the notion that individuals may require additional support in order to make and sustain lifestyle changes leading to health improvement. The health trainers' role is both about providing direct support and low-level advice to clients and also helping clients make the transition to other services and health activities. In Bradford this model has been termed a 'support and signposting model'. What emerges strongly from the evaluation is that health trainers do provide the 'right place' for many clients. While those involved in interviews may report higher levels of satisfaction than others, nonetheless the views expressed were universally positive. The qualitative data provide evidence that the programme was valued and this confirms the earlier evaluation results (year 1). Health trainers were seen as offering something distinctive from clinical care and the health trainer-client relationship was frequently described as special. The approach was based on listening, spending time with clients and adopting a caring and non-judgemental attitude. It was evident that there was a very clear understanding of the role and this was seen across all the different stakeholder groups. It should be regarded as a strength of the Bradford programme that the role, remit and ethos is clearly understood. This solid understanding, to paraphrase "it does what it says on the tin", provides a good basis for expansion and marketing.

The monitoring data indicate an increasing demand for the service and the significant growth in number of clients. These findings suggest that the health trainer programme is meeting client needs and plugging a gap in provision. There was also an increase in signposting which can be regarded as an outcome of the programme. The interview data provide an insight into why the service appears to be meeting needs. A short blast of information of 'what to do' about lifestyle was generally seen as unhelpful in comparison to the health trainers who offered support over time and promoted understanding of 'how to make a change'. Factors such as the service being client-led, offering personalised support and responding to the social context were identified as significant.

Trust and confidentiality were also seen as important. The vision set out in 'Choosing Health' was that of neighbourhood support from 'next door'. However, some clients valued the service being delivered by a trusted person who was not from their immediate community. Health trainers can respond flexibly to client needs and the number and timing of appointments varies considerably. While some clients clearly valued the ability to access their health trainer and receive reassurance over time, there is potential for clients to become dependent in some cases. Signposting may be less successful in these circumstances. On the other hand the analysis of the monitoring data shows that a greater number of attendances was associated with greater progress towards action plans and goals.

Points for consideration

- Health trainers in Bradford have a clear role and the principles of the approach are understood and valued. This is a good basis for promotion and marketing to different groups including NHS staff.

- Recruitment of health trainers should continue to be based on selection of individuals able to deliver an individualised, client-led, empathic approach. Trying to recruit neighbourhood support directly from targeted communities may not be necessary and there were benefits in health trainers being seen as anonymous and offering a confidential service.

Does the health trainer programme improve access to health improvement services/activities?

The question of access can be considered both in relation to **access to health trainers** as a resource for health improvement and health trainers improving **access to other local services**. Access to the health trainer programme was a very strong theme in the qualitative interviews and the programme was generally regarded as accessible both in terms of location and service entry points. The fact that the service was free was also a factor. Ease of access promoted utilisation particularly where health trainers were visible, operating in familiar locations near to where clients were living or working. These factors and the flexibility of the service appeared to reduce barriers to appointments. The phone help line was also effective as a mechanism to promote access to the programme. The monitoring data indicate that the health trainer programme was having much greater reach in terms of areas covered, types of host organisation (and therefore service users) and population groups. It is notable that the proportion of men attending increased in the second year to just under a quarter of all appointments. Similarly 40% of clients were from Black and Ethnic Minority groups, including small numbers of people

from minority populations such as Polish. The programme was prioritised in areas of deprivation and the monitoring data show that the programme was extremely successful at being able to target clients from those areas. In addition, the programme continues to be run for clients with specific health and social needs such as mental health and learning disabilities.

Understandably, given the newness of the programme, there is scope for further marketing and publicity. Many clients reported finding out in an ad hoc fashion, more by accident than design. While this may be indicative of information cascade in the localities, clearly many potential clients may simply not be aware. The results suggest there is the potential for greater health trainer presence in the targeted communities. One major barrier to this is the employment status of health trainers. The sessional work, as and when needed, means that the programme is not always able to sustain a consistent presence in host organisations and locations. The monitoring data indicate that while a huge number of locations have opened up from 16 in year 1 to 77 currently, some are only seeing a few clients. The locality focus is one strategy for increasing presence, but there may need to be further consolidation, ensuring the programme is really visible in settings where health trainers can work effectively.

The original vision for the Bradford model was based on a joined up approach which acknowledged the wealth of community-based organisations. There was potential for health trainers to enhance the work of host organisations by increasing referral, at the same time as receiving referrals from the host organisations. This model appeared to be working in some organisations in the first phase; however, these results suggest that this model is still confined to a small number of settings. Where such a joined up approach works, it works well and is mutually beneficial to host organisations, health trainers and clients in terms of ease of access. More frequently the health trainer programme was using organisations as a venue only. This may be a function of the stage of development, as partnership working takes investment over time and many of the venues are still relatively new. In Allerton, where there is a less well-developed community infrastructure, the priority for the health trainer programme was to establish some bases. It may also be a reflection on the relative priorities of host organisations.

Points for consideration

- There is potential to raise the profile of health trainers still further in the localities to increase access. Health trainers need to be comfortable with a proactive way of working, developing relationships in the settings and opening opportunities for clients as situations arise.

- The employment status of health trainers needs further consideration. While sessional working has some merits, the perception is that it also makes it harder to maintain a visible presence.

- Where appropriate there remains a strong rationale for a joined up approach where health trainers and senior health trainers are highly visible, fully integrated within host organisations and signposting to local organisations. Consideration should be given as to how this can be further developed and sustained in key community organisations.

How can the senior health trainer role facilitate this process?

The senior health trainer role has been developed and tested over the past year. The need for this new type of post arose because it was felt that individuals with community development skills and experience were required to develop new settings, to link potential clients to health trainers and to support the work in the localities. Three localities were chosen where the senior health trainers would work and develop local links. The three senior health trainers were in many ways pioneers, developing the new role in response to community and organisational needs. A number of issues emerged from the evaluation. In terms of benefits, the role was seen to provide a vital link between the health trainer programme, run centrally through Bradford Health development Partnerships (now Public Health Directorate) and the health trainers on the ground. This link is important given the sessional nature of employment, the range of venues and client groups and the flexible, community approach adopted. Senior health trainers have been able to trouble shoot, support health trainers and provide consistency when necessary. They have also been able to extend the service by offering home visits. One theme to emerge was the gradual shift to a supervisory role. This caused tensions on occasions. There is also confusion over the senior health trainer role and at times it was seen to overlap with the role of health trainers where health trainers are confident to operate at a high level, using their skills and experience to develop work and links. There are some indications that having senior health trainers has led to the expansion of the health trainer service, and some examples where a joined up approach has been developed in community settings but it is difficult to say how large the influence was. The role of the senior health trainer is about providing a seamless service and as such

their work may lack visibility; however, more may need to be done to strengthen local links through a community development approach[2].

Points for consideration

- The role of the senior health trainer has been trialled over the past year and found to be useful in terms of building up the infrastructure to support the delivery of the programme as consistency and communication are essential. The roles and remit of senior health trainers need to be more clearly defined.

- Setting up placements and developing relationships with host organisations is part of the senior health trainer role. However, consideration should be given to the most appropriate balance of activities between supervision of health trainers and supporting the development of links through community development principles. Currently some organisations have no knowledge of senior health trainers and therefore the potential to embed the health trainer programme and strengthen external links in these cases is dependent on the health trainer.

Do people make positive changes for health as a result of seeing a Health Trainer?

As in the first evaluation there is good evidence that health trainers can provide the necessary support to help individuals to make changes. The interviews with current clients illuminate this process. The concept of being ready to make a change and then changing in small steps fits with the Stages of Change model. Health trainers were able to support clients when relapse occurred and also provided suggestions for sustaining change. It is notable that some clients talked of beginning to change their lifestyle with reference to severe, complex or intractable problems where they had made little progress in the past. The results on outcomes are also supported by interview data from the service providers, again a theme that health trainers do achieve changes with those in need. Client outcomes were measured in terms of progress towards action plans and goals set. Of the clients that had completed their pathway through the Health Trainer Programme, 38% of clients had made excellent or good progress. The majority of clients were working on lifestyle issues related to the Choosing Health priorities. The second evaluation therefore provides further evidence of the effectiveness of the health trainer approach. There is, of course, acknowledgment that behaviour change approaches are

[2] It was originally envisaged that SHTs would be part of locality teams but this has not been possible because reorganisation of the PCT has meant locality teams have not been

unlikely to be effective without addressing the structural determinants of health through policies and population approaches.

Points for consideration

- The establishment of a monitoring and follow up system is a major achievement, considering the community-based, flexible nature of the programme. The system provides valuable data and provides a mechanism to track clients and collect follow up data. Some health trainers are working in more informal way in group settings. This has it challenges for the purposes of monitoring, as processes are set up to track individuals, rather than capture community development and group processes. Other methods may need to be used to capture some of this important work with hard to reach groups.

- The contemporary debate about how to monitor complex multiple outcomes is pertinent to the nature of the health trainer programme. Currently, the progress towards individual action plans is the main generic indicator. The programme team may wish to consider measuring a small number of specified outcomes, which, although not relevant to all clients may capture some key indicators of success for the majority. Clearly weight, physical activity and anxiety/stress would capture important outcomes. There are some more generic measures of holistic health that may prove useful for this task. This will add considerably to the amount of time clients and health trainers spend collecting data. However, in the long term this may strengthen the evidence base for the programme.

- There is now a body of local evidence that health trainers help some people make positive changes. In many cases the programme works successfully with groups that are hard to reach or where individuals have had little previous success at making changes. The next stage of strategic development needs to consider how the breadth and depth of the health trainer programme can be developed and where resources would be best targeted. While the programme may produce 'quick wins' for many clients, investment will be required to really expand the use of the health trainer programme as a tool for addressing health inequalities.

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Appendix 1 Host organisations interviewed for the evaluation

Host Organisation	Locality
Cafe West	Allerton and Lower Grange
Bradford People First	Manningham and Girlington
Mayfield Centre	Trident
Federation of African & Caribbean Elders, Mary Seacole Centre	Trident
Rhodesway Secondary School	Allerton and Lower Grange
Community Health Action Project, Woodroyd Children's Centre	Trident
Bradford Foyer	Trident
Attock Centre	Trident
Allerton Health Centre	Allerton and Lower Grange
MASTS Project	Allerton and Lower Grange
Missione Cattolica Italiana	Trident
Naye Subah, Quaker House	Trident
Dixon's CTC College	Trident
Westbourne Green Community Health Care Centre	Manningham and Girlington
Allerton Library	Allerton and Lower Grange
Whetley Hill Resource Centre	Manningham and Girlington

Appendix 2 Seeing a health trainer – a client's pathway through the process

Client "is ready to make a change"
The client is a contemplator on the cycle of change.

Client calls the health trainer helpline on 01274 223926 for more information. **The role of the health trainer is explained.**

Details are taken from the client in order to match up health trainers and clients in terms of locality, language, gender, ethnic group etc.,
The health trainer support worker calls the health trainer to pass on the client details.
The health trainer calls the client **and an appointment is made**
OR
Client contacts the health trainer directly for more information
The role of the health trainer is explained
An appointment is made

Stage 1
The purpose of the first session is to collect some basic information about the client and to determine the client's priorities & needs.
On the basis of the information presented the client may go on to develop a health goal and health action plan.
OR
If the client identifies needs outside of the boundaries of the health trainer's role the client will be given information about other services, organisations or agencies that may be able to help.
The health trainer may offer to accompany clients to other services if necessary.

Stage 2
Having established priorities the client is encouraged to define a SMART health goal with the support of the health trainer.

Stage 3
A health action plan is agreed between client and health trainer. The health action plan provides detailed steps which will be taken to achieve the health goal. It details what action will be taken, by whom, where and when.

Stage4
The health trainer and client meet on subsequent occasions to review progress made in following the health action plan.
To identify obstacles and difficulties and to find ways to overcome them.
To recognise success and find ways to build on success.

In summary
Client contemplates making a change
Priorities are identified
A SMART behaviour change goal is agreed with a very clear RESULT
A health action plan is produced
Progress is reviewed
Client is encouraged and supported to achieve their goal.

Appendix 3 An evaluation of the Bradford District Health Trainers programme – An early adopter site (South *et al* 2006)

Executive Summary (Phase One)

Introduction

The Bradford Health Trainers Programme is one of the first in the UK to be operational. Since January 2006 17 health trainers, recruited from local communities, have been providing one to one support to people wishing to make positive health changes. The concept of health trainers was introduced in Choosing Health (DOH, 2004) and in July 2005 Bradford was chosen as one of 12 early adopter sites to trial the idea. A range of partners including local government, four PCTs, and voluntary organisations contributed to the project, with Bradford District Health Development Partnerships (BDHDP – a district wide PCT service) taking the lead role. The Bradford Health Trainers Programme is part of the national programme and the intention is that every NHS PCT will eventually offer a health trainer service.

Evaluation methods (see section 2)

The evaluation strategy was developed to provide feedback on the development and functioning of the programme and any early outcomes. Data collection methods included:

- A group interview with project leads and a learning event with key stakeholders
- Focus groups and feedback forms from the health trainers
- Telephone interviews with placement organisations
- Telephone interviews and monitoring data from the clients
-

The evaluation took place early in the programme's operation. As such, some issues raised reflect the stage of the programme's development and could have altered since then.

Findings: The development of the Health Trainers Programme (see section 3)

BDHDP was able to rapidly develop the programme due to their previous experience of training community members and their long track record of partnership working. The recruitment of a project co-ordinator was critical as was the active involvement of the partnership board in offering expertise and links to community and health organisations.

The first cohort of health trainers were successfully recruited and trained on an accredited course developed by BDHDP. People were recruited on the basis of their ability to connect with target communities as well as their suitability to become a health trainer. The 21 recruits were a good mix of gender, ethnicity and age – partly attributed to being employed on a sessional basis. Their enthusiasm helped drive the project forward and the fact they were lay people rather than professionals was

perceived positively. Some members of the Partnership Board highlighted that clarity over how health trainers fitted into the wider health community was critical as they moved into practice.

Findings: Working as a health trainer (see section 4)

The health trainers were clear that their role was to listen, support and signpost to local services but not to provide medical advice. Clients had come to see them to address many diverse issues ranging from physical health reasons to mental health and social needs – they were seen to often initially attend for one issue but others frequently emerged. The importance of focusing on small steps was stressed. It was felt that increased flexibility in terms of appointment times and being able to see clients in their homes would be beneficial. The health trainers had used many methods to reach clients but for some this had been frustrating. Reaching men was found to be particularly difficult. However it was recognised that raising awareness of the service and community development were critical parts of the role. Some health trainers reported that health professionals in their placements were less clear about their role (causing tension in some cases) and a small number of clients had also expressed some confusion. On a personal level the health trainers had found the training course challenging yet rewarding, nearly all reported increased confidence and a sense of fulfilment with their new role.

Findings: Working in practice, interviews with placement organisations (see section 5)

Health trainers were placed in 26 different organisations including GP surgeries, extended schools, healthy living initiatives and support services. The placements' involvement varied from providing a location to working closely together. In general having a health trainer was perceived positively, with the ability to provide one to one support to complement existing services being particularly valued. Local knowledge and community experience was seen as important but there were examples of placement organisations being able to successfully facilitate links if a health trainer was new to the area. Feedback to the placement organisations was highlighted as important.

Findings: What did the clients think? (see section 6)

Monitoring data were collected on 121 clients although 24 were DNAs. 83% were female with the most numerous age groups being 46-59 and 26-35. 47% classified themselves as White/White British and 30% as Asian British/ Asian Pakistani. Clients had found out about the service via a flyer, a GP or a community centre. Out of the 97 clients who attended at least once, over two thirds saw the health trainer three or more times. A great variety of health issues were considered with 86% mentioning more than one. The most common were weight management, healthy eating, and fitness & activity followed by stress, emotional issues, anxiety and social issues. 21% of clients who attended at least once had made good progress or met their targets whilst 37% had made some and 11% had made none. 44 were signposted to other services. Reasons for

not keeping to an appointment were generally unknown but where they were included not being ready to make a behaviour change, illness or forgetting.

22 clients were followed up by interview. The number of appointments attended ranged from one to six. Clients had found out about the service from a range of sources including health professionals, community groups and the health trainer themselves. 17 out of 22 clients set a health action plan. The most common health issues addressed were losing weight, improving diet or increasing exercise levels but wanting to de-stress, gain confidence and make friends also featured. Most mentioned more than one issue. 16 were signposted to other services.

Before seeing a health trainer most clients were at the contemplation stage of the behaviour change cycle. After seeing a health trainer 15 had moved forward on this cycle and the most common stage was that of maintenance. All but four of the clients interviewed had done something differently since seeing a health trainer, such as making dietary changes or taking more exercise. Most felt they had made some progress towards meeting their goal or had achieved it whilst six felt they had not. In addition, 17 clients felt they had benefited in other ways from seeing a health trainer, often citing having someone to talk to (this was particularly the case for Asian women who were able to speak to someone in their first language). Ten also said it had benefited their friends or family and about half planned to make future changes. Satisfaction with the service was high with the appointment length (an hour) and the support provided by the health trainer perceived particularly positively. Suggested improvements related to the services they were referred to (some said a suitable service was not available) and the times of the appointment (in particular evening appointments were wanted). Nearly all (20) said they would use the service again and recommend it to others.

Summary of evidence (see section 7)

Have health trainers been successfully recruited, prepared and supported in their new role?

The recruitment process resulted in adequate suitable applicants and the first cohort reflected the diversity of Bradford communities. The training course prepared the health trainers well and there was a high level of satisfaction with it, although increased emphasis on community development and promoting the programme was requested. Ongoing support and mentoring was seen as important; this is currently being addressed.

Has there been development of effective referral processes?

The number of clients seen by health trainers rapidly exceeded the original targets. The programme has been successful in attracting Asian women, people with learning disabilities and those with mental health problems. It has been less successful so far in attracting men. Inevitably some placements have proved more successful than others – a key facilitating factor was the placement organisation taking an active role in promoting the service amongst their service users / members.

Have service users been able to successfully work with clients to support lifestyle change?

A wide range of diverse and complex needs were identified by clients closely fitting the Choosing Health priorities of weight management and mental health/wellbeing. This evaluation points to this programme being able to help people make positive changes to their health and helping them move along the cycle of behaviour change. Many behaviour changes were cited by clients and there were also signs of a ripple effect out to clients' families.

Has the local Partnership provided the necessary support to initiate and deliver the pilot?

An involved, active partnership board, a project co-ordinator and the experience of BDHTP have proven critical in the success of delivering this programme. A possible area for improvement is the more active involvement of some of the placement organisations.

Key issues for consideration (see section 8)

- There is a need for more promotion and publicity about the *role of the health trainer* and how it fits within the wider health community. This will assist both clients and stakeholders who may have less clarity over the role than those directly involved.
- Having *increased skills to work with communities* has been identified as desirable. This needs to be done in a way that does not deter non-professional people from being health trainers. It is thought that the role of a senior health trainer (currently being developed in Bradford) will assist in this.
- L*ocal knowledge*. In Bradford, health trainers did not always `work in their own communities but this was not necessarily an issue, particularly where the placement organisations were actively engaging in the health trainer's induction.
- *Reaching the hard to reach* is key to tackling inequalities. It is vital that health trainers are able to work with clients who may not already be in touch with other services (and in particular men). Further research is needed on how this can be achieved.
- The need for increased *flexibility* emerged; in particular more evening work and other methods of working (e.g. using email / visiting people at home).
- This evaluation identified how important *feedback and monitoring* were to ensuring the development both of the Health Trainer Programme but also other local services.
- The issue of *how health trainers fit into existing provision* was highlighted. Health trainers offer something distinct to clients (namely one to one support and time from a lay person).

To conclude, the Bradford Health Trainers Programme has been rapidly and successfully piloted. Some issues for consideration have been highlighted, namely to ensure that the hard to reach are brought into the programme and that placement organisations are fully involved. However it is clear that the programme has worked well in a variety of settings, with many clients able to make health behaviour changes.
Choosing Health 2004

Appendix 4: Client participant information sheet

New Client Information

Week Commencing:
Name:
Venue:
Room Cost:
Session times (in hours) per week:

Date of first appointment	Client Code or DNA	M	F	Age Range	Ethnicity	Health Change	Referral Source	Post Code	Client's Tel No's

ONLY REQUIRE YOU TO CODE CLIENTS THAT YOU HAVE ACTUALLY HAD AN APPOINTMENT WITH I.E. THEY HAVE BEEN TO SEE YOU OR YOU HAVE HAD AN APPOINTMENT OVER THE PHONE. IF A CLIENT DOES NOT ATTEND THEIR FIRST APPOINTMENT WITH YOU PUT DNA IN THE CLIENT CODE COLUMN.

What is the demand like at your venue? High ☐ Medium ☐ Low ☐

Any other comments about the venue?

Ethnicity
1 = White British, 2 = White Irish, 3 = White other, 4 = Eastern European, 5 = Mixed White/Asian, 6 = Mixed White/Black Caribbean, 7 = Mixed White/Black African, 8 = Any other mixed background, 9 = Asian/British Asian-Indian, 10 = Asian/British Asian Pakistani, 11 = Asian/British Asian-Bangladeshi, 12 = Any other Asian Background, 13 = Black/Black British-Caribbean, 14 = Black/Black British African, 15 = Any other Black background, 16 = Chinese,17 = Any other ethnic group, 18 = Not stated
Health Change
1 = Smoking, 2 = Alcohol, 3 = Healthy eating, 4 = Weight, 5 = Social/Emotional, 6 = Stress/Anxiety/Depression, 7 = Relationships, 8 = Isolated/lonely, 9 = Confidence/self esteem, 10 = Family, 11 = Fitness/activity, 12 = Physical, 13 = Sexual

Appendix 5 Client progress sheet for monitoring data

Client Summary Sheet

I understand that anything I say to the Health Trainer will be treated in the strictest confidence and only shared, if for legal reasons it is felt necessary to do so. I also understand that the information may be used to help evaluate the work to see how worthwhile it has been. Therefore, I agree that my details can be monitored, but my confidentiality will be maintained **at all times**, and my name will not be mentioned in any reports etc.

Client name……Code…….

Address……..

……..

Postcode……..

Telephone number……

Please tick which of the following groups you belong to:

Gender: Male ☐ Female ☐

Age: Under 18 ☐ 18 – 25 ☐ 26 – 35 ☐ 36 – 45 ☐ 46 – 59 ☐

60 - 74 ☐ 75+ ☐

Ethnicity:

White-British ☐ White-Irish ☐ White-Other ☐ Eastern European ☐

Mixed White/Asian ☐ Mixed White/Black Caribbean ☐

Mixed White/Black African ☐ Any other mixed background ☐

Asian/British Asian-Indian ☐ Asian/British Asian Pakistani ☐

Asian/British Asian-Bangladeshi ☐ Any other Asian Background ☐

Black/Black British-Caribbean ☐ Black/Black British African ☐

Any other Black background ☐ Chinese ☐

Any other ethnic group ☐ Not stated ☐

Long term health condition/disability or suffer from a Chronic disease (if yes please indicate what) **Yes** ☐ **No** ☐

Angina ☐

Asthma ☐

Coronary Heart Disease ☐

Depression ☐

Diabetes ☐

High Blood Pressure ☐

High Cholesterol ☐

Rheumatoid arthritis ☐

Stroke ☐

Other ☐
(please give details)
……

Client signature.....Date.....

1. Client code.....

2. Name of Health Trainer.....

3. Type of Referral

Self-referral ☐ **Health professional** ☐

Other ☐ ☐
(if other please indicate where from)…….

4. How did the client find out about the service?

Community centre ☐ **Newsletter** ☐

GP ☐ **(please indicate which newsletter) ……..**

Practice Nurse ☐ **Press** ☐

Dietician ☐ **Radio** ☐

NHS Direct ☐ **Flyer** ☐

Other (please specify) ☐ **Group or Event** ☐

…… ……. Please comment on type of event ……

5. Did the client use the Health Trainer central helpline number YES ☐ **NO** ☐

6. Starting date of appointments……..

7. Date of last appointment.....

8. Total number of appointments attended……

9. Number of appointments lost to DNA's (did not attends) ……

10. Which venue did you see the client at?.....

11. What were the key issues you worked on with the client?
(Tick up to 3 boxes)

Smoking ☐ **Alcohol** ☐ **Healthy eating** ☐ **Weight** ☐

Social/Emotional ☐ **Stress/Anxiety/Depression** ☐ **Relationships** ☐

Isolated/lonely ☐ **Confidence/self esteem** ☐ **Family** ☐

Fitness/activity ☐ **Physical** ☐ **Sexual** ☐

Other (please indicate what issues worked on)……..

12. Did the client set a Behaviour Change Goal/Health Action Plan? YES ☐ **NO** ☐

13. Did the client make any progress in achieving their goal/Health Action Plan?

No progress ☐

Limited progress on health action plan target(s)/goal ☐

Good progress on the Health Action plan target(s)/goal ☐

Health Action Plan target(s) /goal met ☐

Client signposted to other agency **YES** ☐ **NO** ☐
(If YES please indicate which agency below)

- **Stop Smoking Service** ☐ **Community group** ☐
- **Walking for health group** ☐ **GP** ☐
- **Health wise** ☐
- **Other (please specify ……**

14. Accompanied visits **YES** ☐ **NO** ☐

Accompanied client one to one **YES** ☐ **NO** ☐

Accompanied client as part of a group visit **YES** ☐ **NO** ☐
(e.g. taking more than 1 client to same visit)

If you have answered yes to any of the above please give details and specify where:……..

…….

15. Any other special circumstances
(if yes please indicate what) **Yes** ☐ **No** ☐

Carer ☐ **Learning disability** ☐ **Bereavement** ☐

Single Parent ☐ **Mental Health Service User** ☐ **Physical Disability** ☐

Unemployed ☐ **Refugees/Asylum Seekers**

Other ☐ **(please give details) ……**

16. What language was used with the client? ……

On completion of a series of appointments forms should be returned to the Health Trainer Co-ordinator

Monitoring of Follow up calls/appointments at 3 months

Client Code.....

Client contacted by phone: Yes ☐ No ☐ Unable to contact ☐

If no client contacted by letter: Yes ☐ No ☐

Please indicate how your client has done in terms of achieving and maintaining their goal/action plan:

Met and maintained their goal ☐

Made good progress ☐

Made limited progress ☐

Unable to maintain change ☐

If the client was signposted to another organisation or agency was this beneficial to the client?

Yes ☐ No ☐

Any other relevant feedback from the client.....

.....
.....

Was a follow up session provided by Health Trainer? Yes ☐ No ☐

What type of follow up did the client request?

Appointment ☐ Telephone appointment ☐

Information ☐ Other (please specify) ☐

(NB If the client decides to have additional sessions with the health trainer you will need to set up a client file using Part 2 of paperwork in Client Summary Sheet (HT5). Set up the file using the same client code. This will allow us to monitor the client's ongoing progress.)

On completion of this form please return to Carolyn Ignaciuk

Monitoring of Follow up calls/appointments at 6 months

Client Code.....

Client contacted by phone: Yes ☐ No ☐ Unable to contact ☐

If no client contacted by letter: Yes ☐ No ☐

Please indicate how your client has done in terms of achieving and maintaining their goal/action plan:

Met and maintained their goal ☐

Made good progress ☐

Made limited progress ☐

Unable to maintain change ☐

If the client was signposted to another organisation or agency was this beneficial to the client?

Yes ☐ No ☐

Any other relevant feedback from the client.....

.....
.....

Was a follow up session provided by Health Trainer? Yes ☐ No ☐

What type of follow up did the client request?

Appointment ☐ Telephone appointment ☐

Information ☐ Other (please specify) ☐

(NB If the client decides to have additional sessions with the health trainer you will need to set up a client file using Part 2 of paperwork in Client Summary Sheet (HT5). Set up the file using the same client code. This will allow us to monitor the client's ongoing progress.)

On completion of this form please return to Carolyn Ignaciuk

Appendix 6 Client information sheet for monitoring data

An Evaluation of the Bradford Health Trainer Programme- PHASE 2

Participant Information

Health Trainers offer support to people wanting to improve their health. An initial evaluation of the Health Trainer Programme in Bradford has been carried out by Leeds Metropolitan University. This showed that the Health Trainer role is a successful method for supporting people to make changes to improve their health. The second phase of the evaluation aims to examine the **development of the Health Trainer Programme in various organisations within three different localities.**

What will the evaluation do?

We want to find out in more detail how well the service is working in different organisations. This means spending some time in the organisations and talking to people who use the Health Trainer Programme, as well as those who provide the service. A member of the research team will visit the organisation and check that you are willing to be asked some questions about the Health Trainer Programme.

Taking part is always voluntary; you can refuse at any time.

What will happen if I take part?

We will have an informal chat about the Health Trainer Programme. This should take about 30 minutes. We want to know about the type of support the Health Trainer Programme provides and whether it is meeting people's needs, including those of the client and the organisation. The conversation will be recorded to help with accuracy but we will check you are okay with that first. Recordings will be destroyed as soon as notes have been taken. All information will be stored safely and only the researchers at the University will have access to it. Anything you say is strictly confidential. This means that your name will not be used at any point. Any comments, quotes or experiences used in reports will be anonymous.

What will happen to the information?

The information will be used to provide feedback on the Health Trainer Programme. The findings will be fed back to the Department of Health, the NHS in Bradford and other interested organisations and individuals. A short summary sheet will be distributed to everyone taking part.

The Evaluation Team

The evaluation team is based in the Centre for Health Promotion Research at Leeds Metropolitan University. The team members are: Nicky Kime, Jane South, Marianne Kennedy and Diane Lowcock

We hope you feel you can contribute to this evaluation. Your support will help us develop the Health Trainer Programme to best meet people's needs. If you have any questions please contact us using the details overleaf.

If you would like to receive a copy of the evaluation report please fill in your details below and post to:

Nicky Kime
Centre for Health Promotion Research
Faculty of Health
Leeds Metropolitan University
Queens Square House
Leeds
LS1 3HE
□ I would like to receive a copy of the evaluation report into the Bradford Health Trainer Programme.

Your Contact Details
Name: …….
Address: …….
…….
…….
…….
Postcode: ……..

Contacts for further information about the Evaluation Project:

Jane South

Senior lecturer

Centre for Health Promotion Research

Faculty of Health

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Or if you would like more information on the Health Trainer Programme please call the helpline on:
01274 223926

Appendix 7 Interview schedules

Evaluation of the Bradford Health Trainer Programme- Phase 2

Client Interview schedule

The intention is to interview clients using a narrative, 'story-telling' approach. It is hoped that this will provide a greater insight into clients' experiences of using Health Trainers. In addition, such an approach allows clients to take the lead and tell their personal story (guided by 'probes') rather than researchers dictating the course of the interview through a more formal set of questions. The questions provide an indication of the areas that will be addressed in the interview; the exact wording of the questions may change depending on the client.

The following interview schedule will be piloted with clients in order to determine the appropriateness of the language, ease of understanding, etc. It is recognised that the exact phraseology used will vary according to the client.

It would be useful to have some background information on the client before the interview begins, for example, the length of time the client has been enrolled on the Health Trainer Programme (HTP), whether or not it is their first visit to see a HT, etc. This is in order that the researcher has an idea of how to 'pitch' the questions.

I'd like to know about your experience of using a HT. Can you tell me about this?

Probing questions:

Accessing HTP

What made you choose to see a HT in the first place? *[Check out the decision-making process that led the client to the HT, their awareness of the HTP, the support/encouragement they received from others]*

Why a HT and not someone else?

How did you come to see (name of HT)?

Support that the HTP provides

What about the support you're getting from your HT?

What type of support, can you tell me more about this?

Is the support you're getting from you HT different from the support you can get elsewhere?

Is there any support you'd like from your HT that you're not getting at the moment?

Has the HT talked to you about going anywhere else? Tell me about this.

Value of HTP

How important is it for you to be able to see a HT?

What are the benefits of being able to see a HT?

What about for people in your community, is it useful to have a HT based here?

What else is happening around here? Tell me about what's going on.

Are you going to any other group/activity locally?

Expectations of the HTP

Is seeing a HT like what you expected it to be?

What ideas did you have about HTs before?

What about now, have your ideas changed?

How do you think your experience of seeing a HT could be improved?

Is there anything else you'd like to say about your experience of using a HT?

Evaluation of the Bradford Health Trainer Programme- Phase 2

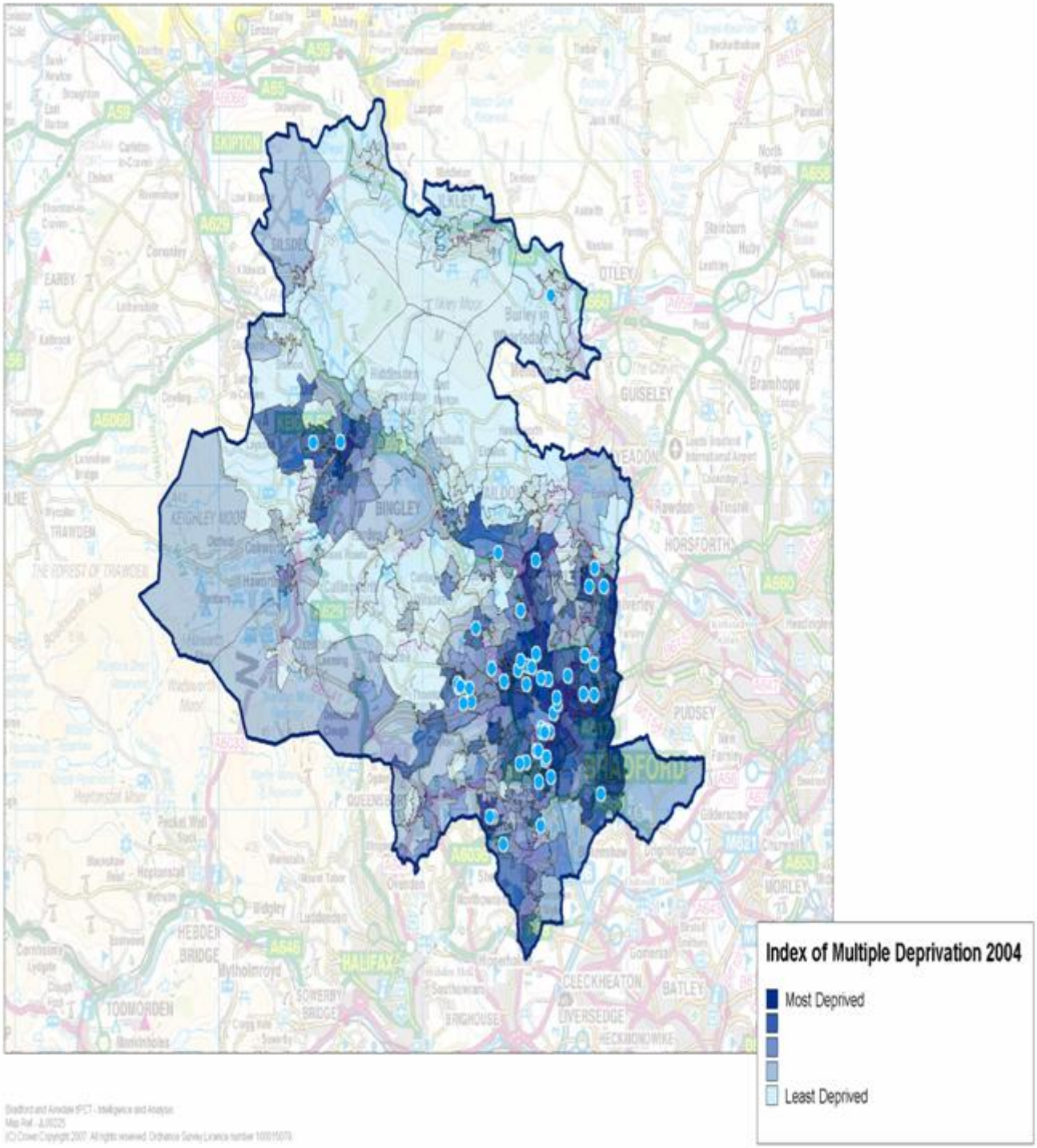
Interview schedule for Key Informants (KIs), Senior Health Trainer's (SHTs) and Health Trainers (HTs) (D4)

The following questions are to be asked of KIs, SHTs and HTs. The interview schedule is an indication of possible questions. The exact questions asked and wording of questions will depend on the circumstances of individual settings.

Questions about the Health Trainer Programme (HTP) and the support available
Tell me about your experience of having a HT here?
How was the HTP set up here? How does it operate now?
What is it about the HTP that is unique and makes people want to use it?
Can you tell me about the extent of service provision in this community/area?
What support do HTs give to enable clients to use these or services in other areas?
How accessible is the HTP for people in this community? What makes the HTP accessible?

Questions about the expectations of the HTP
Tell me about the ways in which the HTP and the organisation interact.
How does the HTP fit in with what the organisation is trying to achieve?
What else is going on within the organisation besides the HTP?
What has been the impact of the HTP on the organisation, positive or negative?

Questions about the role of the HTP
How important do you think it is to have a HTP based here? *Why do you think this?*
Who do you think mainly benefits from the HTP? *Why?*
What are the benefits of the HTP?
What are the disadvantages of the HTP?

Questions about the role of the SHT
What do you see as the role of the SHT?
SHT only: What do you think is different between the role of the HT and that of the SHT?
SHT only: How has your role developed since you've been in post?
What do you see as the future role of the SHT in the Health Trainer Programme?
Tell me about the links that have developed between SHTs, the organisation, etc.
What does the SHT do when there are gaps in the Health Trainer Programme, for example when a HT is on maternity/long-term sickness?
How does the SHT manage the situations where there are gaps in local provision?
In what ways do you think the SHTs could be more effective within the Health Trainer Programme as a whole?

Appendix 8 Map of Health Trainer location in Bradford by deprivation