



University of Brighton

Evaluation of Health Trainers in West Sussex

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Executive Summary

Introduction and background

The West Sussex Health Trainers service is part of a national programme introduced by the Department of Health in 2006. The aim of the programme is to recruit people from local communities with a good understanding of local issues who can offer tailored advice, motivation and practical support to individuals who want to adopt a healthier lifestyle and act as message bearers between professionals and communities. A national package of accredited training has been developed to support the work of the health trainers and develop their skills as part of the healthcare workforce.

The health trainers in West Sussex work generically in deprived communities in West Sussex, focusing on Local Neighbourhood Improvement areas (LNIAs) and with older people in other areas. They are employed by voluntary sector organisations (VSOs) who have been commissioned by the West Sussex Primary Care Trust (PCT) to deliver the service.

Evaluation Outline

West Sussex PCT commissioned the University of Brighton to conduct an evaluation of the Health Trainers programme. The aims of the evaluation are:

1. To evaluate the ways in which the West Sussex Health Trainers programme can influence health-related behavioural change in targeted deprived areas in West Sussex.
2. To contribute to learning about how health trainers are recruited, trained and supported to enable them to achieve the programme objectives.
3. To contribute learning that will help improve the Health Trainers programme.

Methodology

The evaluation included:

- Analysis of data on the recruitment and training of health trainers;
- Semi-structured interviews with clients, health trainers, their VSO supervisors and the PCT Health Trainer Co-ordinator;
- Survey of applicants and potential applicants;
- Focus groups with health trainers;
- A facilitated workshop for older people's health trainers;
- Analysis of client monitoring data collected for the national evaluation.

Findings

Developing the Health Trainer workforce

The first year of the programme concentrated on the recruitment and training of the health trainers. Recruitment has taken place in two stages across the county. Twenty three health trainers are now working in a variety of community settings in Adur, Bognor, Burgess Hill, Chichester, Crawley, Horsham, Littlehampton and Worthing. Nine of the health trainers work exclusively with older people. The programme aims not only to draw on the 'lay' knowledge of health trainers but also to offer opportunities to develop their skills through training and a level 3 qualification. At the end of the first year the health trainers completed their core training and were working towards accreditation for the City and Guilds Certificate for Health Trainers.

The potential support needs of the health trainers who fit the target profile had not been anticipated and caused some difficulties in resources and management. This highlighted the inherent ambiguities in the Health Trainers programme that attempts to utilise lay knowledge and a 'common sense' approach but within a highly structured framework of a psychological model of behaviour change. The role also requires a certain amount of structured learning, computer literacy and formal paperwork.

Reaching out into the community and recruiting clients

Following the core training, the first year of the programme focused on promoting the service and making the role of the health trainers visible in the community. As a completely new programme a key challenge was getting the service and the role of the health trainers known and understood in the wider community. Getting the right message across was somewhat hampered because of public perceptions of the name 'Health Trainer' and what it implies. Publicity and promotion is likely to play an important part in making the programme known and successful in attracting referrals. There was concern that the promotion of the service at a strategic level had not been well planned and many of the health trainers had felt frustrated and demoralised at not having promotional materials to use in their outreach and development work when they first started.

The client interviews suggested the programme had been unsuccessful in reaching out to those who were not in touch with health care services. Although there had been a steady increase in the number of client referrals in each of the locations, data collected for the national dataset showed that a large majority of clients were looking at issues around diet/exercise and few clients working towards other types of goals. Male clients were also under-represented.

Tensions in defining the Health Trainer role

Clients tended to regard the health trainer role as distinct from those of health 'professionals', in the sense that they were more approachable and easier to relate to and confide in. They valued the more informal, flexible, and person-centred approach and the greater sense of understanding and concern conveyed.

However, there was a notable tension between the 'lay' elements of the client-centred approach, with the 'professional' element of the behaviour change model. This was particularly apparent in relation to the issue around advice/suggestion giving on issues relating to diet and exercise. Although health trainers were trained to avoid giving 'advice', in practice this was often found to be impractical, not least because the imagined 'line' between offering suggestions and giving advice is unclear. If health trainers do give advice or make 'suggestions' in relation to behaviour change, however, the absence of clinical supervision in the role renders this problematic owing in particular to a lack of information concerning the client's medical background. Hence there is limited awareness as to how any suggestions may specifically affect individuals.

Health trainers noted frustration in being unable to use their existing health related knowledge when working with clients. Greater clarity and information on the nature of the health trainer role at the recruitment stage may be required in order to increase understanding in how health trainers' existing skills and experience might be used in delivering the health trainer service.

One size fits all?

Some concerns were raised regarding the appropriateness of the model of behaviour change for different types of clients. In particular health trainers and VSOs working exclusively with older people raised concerns that the issues older people face and ways of engaging with older people were not sufficiently considered within the generic model. They have argued that, while the specific needs of older people, particularly in relation to social isolation and exclusion, do fit within the priorities of the Health Trainer programme, the service needs to be implemented in different ways to ensure the greatest effectiveness. Health trainers felt this may involve exercising some flexibility to use the behaviour change tools in a subtle way, possibly in combination with a community link role. The personal health plans, self-efficacy forms and paperwork were felt to be off-putting for older clients and to possibly lead to disengagement.

Interviews with older clients, however, found a mixed response in relation to the suitability and effectiveness of the model for older people. In some cases the paperwork did not appear to be a barrier and the behaviour change model was understood and considered useful. Some other older people, however, did not identify with the key aspects of the model such as working towards goals. Health

trainers therefore in some cases adopted a different 'befriending' type approach which bore little resemblance with the model of the intervention.

Although the evaluation did reveal a need for flexibility in approach with different types of clients, it also highlighted the need for greater sensitivity when assessing clients in terms of identifying whether the health trainer programme would be the most appropriate form of support. In some cases it was clear that (especially for some older people) an alternative service (e.g. a befriending scheme) was in fact required. It was also apparent that some older and younger persons had specialist mental or physical health needs, the support for which was beyond the scope of the health trainer role. The appropriateness of the service was therefore also questionable in such cases.

Partnership working

The PCT and the VSOs have a shared commitment to tackling health inequalities and providing local services to local people. The context in which the PCT and VSOs have developed their partnership has been challenging and complex, requiring relationship building between partners; creating a workforce and delivering a service in diverse communities across the county. Different organisational practices have led to a degree of difficulty around communication. Greater clarity in the division of responsibilities would be helpful, particularly in relation to the health trainers' perceptions about decision-making, accountability and support. The speed at which the programme developed and delays around some aspects impacted negatively on the morale and confidence of the health trainers. However, clear benefits have also been emerging for the VSOs from the Health Trainer programme and any future evaluations might consider including a focus on the outputs from the VSO perspective. These could relate to the ways in which the Health Trainers' service is contributing to capacity building in health promotion in a broad sense within the sector, and the development of volunteering activities that link to the Health Trainer service.

Client outcomes

Interviews with clients indicated that the scheme does have the potential to make a significant positive impact on people's lives. The support seems to have been most effective where the health trainer took a holistic approach through offering practical and emotional support to the individual. The subsequent impact was evident in some cases both in terms of weight loss and in relation to increasing a sense of well-being and improving physical and mental health. The intervention was also found to have a wider impact in relation to a 'ripple effect' of behaviour change upon other family members. Although almost all of the interviewees were seeking support in relation to diet and/or exercise, there were also cases in which the health trainer intervention had also supported clients' recovery from alcoholism and smoking.

Interview data, however, suggested a greater proportion were not fully content with their progress through the intervention than is suggested by statistics collected for the purposes of the national evaluation. Some clients had not achieved changes to the extent they would have liked during the programme. In most of these cases, however, the intervention had been important in enabling them to make a start in making positive changes i.e. putting them 'on the right track', or laying a foundation for change. Several clients spoke of how the intervention had given them the confidence, heightened awareness and techniques to sustain and develop these changes over the longer term. Disruption in frequency of sessions with the health trainer had hindered achieving and maintaining change for several clients, highlighting the need to avoid such interruptions to the intervention where possible. The importance was also highlighted of the need for the transition at the end of the health trainer sessions to be handled carefully and phased gradually. The need in some cases for greater follow-up support was highlighted, in order to give clients a sense of reassurance through the transition to 'going alone'.

Data collected for the national evaluation showed that a large majority of clients were considered to have fully achieved their goals, but this percentage was lower for goals around smoking and alcohol than for diet and exercise. In order to enable effective monitoring of the ongoing effectiveness of the intervention, greater precision and consistency is required in relation to data collection of goal areas and goals achieved and maintained.

Conclusion

By the end of the first year of the programme twenty three health trainers were in post, almost all were working with clients and were expected to achieve the City and Guilds qualification by December 2009. If the aim to recruit people from the local community is to be met, careful consideration of their potential support needs and the implications for management will need to be built into future recruitment. Progress had been made in the partnership work between the PCT and the VSOs, but, communication and the division of responsibilities are areas which could usefully be addressed to generate greater understanding of the respective responsibilities of PCT and VSOs in relation to the health trainers.

The majority of clients interviewed were positive about the support received from health trainers. However, concerns highlighted included issues around the boundaries of the health trainer role in relation to advice-giving and the suitability of the model for some older people and other client groups with specialist needs. In addition there is a need for more adequate follow-up support in some cases and for more comprehensive and consistent data to be gathered in order to enable adequate monitoring of the ongoing effectiveness of the project in relation to behaviour change.

Chapter 1: Introduction

1.1 Background

The Department of Health White Paper *Choosing Health* (DH 2004) set out proposals to support individuals to adopt healthier lifestyles. Following pilot programmes in 88 Spearhead Primary Care Trusts during 2004 / 05, a national programme of health trainers was proposed in *Our Health, Our Care, Our Say* (DH 2006). The proposal was that health trainers would offer tailored advice, motivation and practical support to individuals who want to adopt a healthier lifestyle and act as message bearers between professionals and communities. A national package of accredited training has been developed to support the work of the health trainers and develop their skills as part of the healthcare workforce.

The 5 key priority areas for health improvement identified in *Choosing Health* are:

- Reducing obesity
- Improving sexual health
- Encouraging sensible drinking
- Reducing smoking
- Improving mental health (including reducing social isolation)

It is expected that health trainers will support clients to address these behaviours, and that this will contribute to the over arching agenda of reducing health inequalities by supporting people to maintain good health for longer and reducing demand for health care services.

A key component of the programme is that the health trainers will be recruited from local communities and thus will have a good understanding of the issues facing the people they will be working with:

In keeping with a shift in public health approaches from 'advice on high to support next door', health trainers will be drawn from local communities, understanding the day-to-day concerns and experiences of the people they are supporting on health.

In touch with the realities of the lives of the people they work with and with a shared stake in improving the health of the communities 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 choices.

Choosing Health 2004, p.103)

West Sussex Health Trainers Programme

West Sussex Primary Care Trust (PCT) commissioned Voluntary Sector Organisations (VSOs) to employ local people as health trainers to provide one-to-one, health-related behavioural advice and support to others in their communities. In line with the national programme the West Sussex Health Trainer service aims:

- To reduce health inequalities;
- To target disadvantaged less well-reached (by health and social care services) communities;
- To increase uptake of preventative services;
- To provide opportunities for people to train in the healthcare workforce.

The programme has two main components. The first component comprises six whole time equivalent (wte) health trainers working over two years in the north, south-east and south-west regions of West Sussex. These health trainers are employed by VSOs working exclusively with older people. The second component comprises 15 wte health trainers working over three years in the five identified Local Neighbourhood Improvement Areas (LNIAs) in West Sussex (Adur, Bognor, Crawley, Littlehampton and Worthing). These health trainers are employed by generic VSOs and work with any adults within their localities. Health trainers are line managed by supervisors in their VSO organisation but are supported in the training by the PCT Health Trainer Co-ordinator.

The key objectives of the West Sussex Health Trainer programme (as outlined in the service specification) are:

- Ensure health trainers complete the training programme and participate in any ongoing training identified by the Health Trainer Co-ordinator to enable them to carry out their key duties and achieve the required standard to meet the competences outlined for health trainers by Skills for Health;
- Support clients to identify behaviours which have a negative impact on their health, set goals to address these, identify steps towards goals and other supporting services, address any barriers which may prevent achievement, and support clients to recognise success;
- Raise awareness of and stimulate the uptake of the Health Trainer service in local settings by the target groups;
- Deliver health trainer service to successfully work with clients to identify areas of their health that they want to improve, to develop action plans and achieve lifestyle change;
- Identify other services to refer to the Health Trainer service appropriately;
- Manage and support the Health Trainer in their role and in their personal development;

- Collect monitoring information as required by the PCT and Department of Health, including data relating to those working as health trainers and their clients; Participate in the evaluation of the service.

West Sussex PCT commissioned the University of Brighton to conduct an evaluation of the Health Trainers programme. The aims of the evaluation are:

1. To evaluate the ways in which the West Sussex Health Trainers programme can influence health-related behavioural change in targeted deprived areas in West Sussex.
2. To contribute to learning about how health trainers are recruited, trained and supported to enable them to achieve the programme objectives.
3. To contribute learning that will help improve the Health Trainers programme.

1.2 Guide to contents

Originally it was intended that the evaluation would be a two stage process over the course of the first year. During the first six months the recruitment and training of the health trainers would be the focus whilst work with clients would be evaluated during the second half of the year. However, in practice the timescale of the original evaluation did not coincide with the commencement of client work. Therefore an extension to this study looking at the perspective of clients was carried out following the completion of the first part of the study. The findings in this report are therefore divided into two chapters (3 and 4).

Both these chapters aim to contribute to learning that will help improve the Health Trainers' programme. Chapter 3 focuses on the establishment of the programme during its first year by looking at:

- The delivery and implementation of the programme across the partnership;
- The development of the Health Trainer workforce including the recruitment and training of the health trainers, including ongoing support and supervision;
- The issues in practice of implementing the Health Trainer programme including the behaviour change model;
- Perceived differences between the implementation, delivery and role of health trainers working with older people and those working generically.

Chapter 4 of the report focuses on the client perspective (presenting findings from data collected for the extension study between May – September 2009) in order to:

- Assess client outcomes in relation to the potential of the intervention to influence behaviour change in clients in targeted deprived areas of West Sussex;

- Compare the extent to which outcomes were achieved by client group and goal area (with reference to the DH five priority areas for health improvement);
- Identify key elements of the intervention found to be most effective;
- Identify any barriers to successful behaviour change among clients of the programme.

The report is set out as follows:

Chapter 2 sets out the methodologies for both stages of the evaluation;

Chapter 3 presents the findings for the first stage of the evaluation around the implementation and development of the programme in its first year;

Chapter 4 presents the findings from stage 2 of the evaluation which focuses on the client perspective;

Chapter 5 discusses the key issues arising from both parts of the evaluation and makes conclusions and recommendations based on the results identified in chapters 3 and 4.

Chapter 2: Research Methods

2.1 Introduction

In undertaking this evaluation, the following methods of data collection were used in relation to the project:

- Survey of applicants and potential applicants to Health Trainer posts;
- Semi-structured interviews with clients, health trainers, their VSO supervisors and the PCT Health Trainer Co-ordinator;
- Focus groups with health trainers in the second half of the first year;
- A facilitated workshop for older people's health trainers.

In addition to these activities the researcher attended steering group meetings and some training sessions, and analysed secondary data provided by West Sussex PCT and VSO partners.

2.2 Survey

To gather information on the recruitment of the health trainers a survey of applicants and potential applicants was carried out after both rounds of the recruitment. The aim of the survey was to gather information about potential applicants relating to age, gender, ethnicity, highest educational qualification, current work status, number of dependent children, interest in the health trainer post and, where applicable, reasons for not proceeding with the job application. The information was used to assess the extent to which the recruitment strategies were successfully meeting the aim of recruiting health trainers from local communities, and offering opportunities via the health trainer programme to develop a career in health care to people who may have been out of the labour market or with low formal educational qualifications.

Questionnaires and a covering letter were sent out to everyone who had requested an application pack via the VSOs and returned directly to the university researcher (see Appendix 1 and 2). A total of one hundred and six questionnaires were sent out in the first round, thirty three were returned representing 31% response rate. In the second round of recruitment two hundred and four questionnaires were sent out and forty six were returned representing a 23% response rate.

2.3 Semi-structured interviews

2.3.1 Introduction

Semi-structured interviews were carried out in both stages of the research. In stage one, those interviewed included 7 health trainers (i.e. all those from the first round of recruitment), VSO supervisors and the PCT Co-ordinator and one client. The second stage of the evaluation included further interviews with clients. Before conducting interviews, information about the research was explained to the interviewees before participating in the interview with the aid of the information sheet (Appendixes 3, 9, 11 and 14), and interviewees were asked to sign a consent form once it was established the participant was aware and happy about what participation in the interview would entail (Appendix 4). Interview schedules (Appendixes 5, 6, 7 and 12) were used flexibly, i.e. as a prompt sheet rather than a prescriptive list of questions. This method was chosen in order to allow the participant flexibility to raise other matters during the 'conversation', that they may feel were important, whilst at the same time allowing the researcher to focus on key issues relating to the aims and objectives of the project. The duration of interviews ranged from around 20-60 minutes. Interviews were recorded (with interviewee's consent) with assurance that comments would be treated confidentially and with anonymity should they be referred to in the report. Digital recordings were later downloaded onto a password protected computer, transcribed and analysed with the support of the Nvivo8 computer software package.

2.3.2 Health trainers, VSO supervisors and the PCT Co-ordinator

After the first round of recruitment semi-structured interviews were held with the 7 health trainers, their VSO supervisors and the PCT Co-ordinator to gather data on the training process. The interviews explored the experience of the training from the perspectives of the health trainers, the VSO supervisors and the PCT Co-ordinator. The data gathered was fed back to the PCT to help develop the second round of training and reflect on how the training meets the needs of the newly recruited health trainers. Towards the end of the first year of the programme semi-structured telephone interviews were also carried out with the VSO supervisors. These explored the main issues and challenges during the first year from the VSO's perspectives and the extent to which the health trainer programme had met the organisation's expectations.

2.3.3 Clients

The original evaluation proposed to evaluate work with clients during the second half of the year. However, the timescale did not coincide with the commencement of client work and towards the end of the first year there were only a small number of clients being seen. The health trainers who were currently seeing clients were asked

to inform their clients about the evaluation and seek the client's consent using a consent slip attached to a form designed for the purposes of the data collected by West Sussex PCT (Appendix 10). Health trainers were then to pass on their details to the university researcher who would then contact the client directly. However, within the timescale only one client was identified in this way and a semi-structured interview with that person was subsequently carried out.

In stage 2 of the evaluation, further clients were identified using the consent card method described above and through a follow-up form e-mailed to VSO supervisors, which also requested additional on client numbers, goal areas and number of sessions clients had completed (Appendix 16). 20 clients participated in this part of the study, which equated to 8% of total clients since December 2008 (as recorded by health trainers at the time of the evaluation). This was in order for the researcher to be able to select clients who had completed all or most sessions (as these clients would be better able to reflect upon their experiences across the course of seeing a health trainer). The data obtained from health trainer supervisors on number of clients and numbers giving and refusing consent is presented for each Voluntary Sector Organisation (VSO) in Table 1 below, alongside the numbers finally interviewed. On receipt of client names the next step was to contact these clients by post with a letter (Appendix 12) and information sheet, explaining the research in more detail. The same clients were then contacted by phone approximately one week later. Some clients were not contactable by phone, despite phoning several times at different times of day. Where the client was available and willing to participate, interviews were then arranged at a time and location convenient to them. In 17 cases these took place at the interviewee's home, in two cases at the interviewee's workplace and in one case at the premises of the VSO host organisation. The flow chart in Figure 1 below, illustrates the process through which these clients were selected for interview.

Findings from these interviews are presented in Chapter 4. At the end of these interviews, participants were also asked to complete a short questionnaire (Appendix 15). In some cases this was self-completed and in others, where more appropriate (e.g. the client had sight or literacy problems) the researcher asked the questions verbally and completed the form on behalf of the client. The purpose of the questionnaire was to find out some basic socio-economic information about the clients participating in the programme.

Figure 1: Flow chart showing the client sample selection process (stage 2 of evaluation)

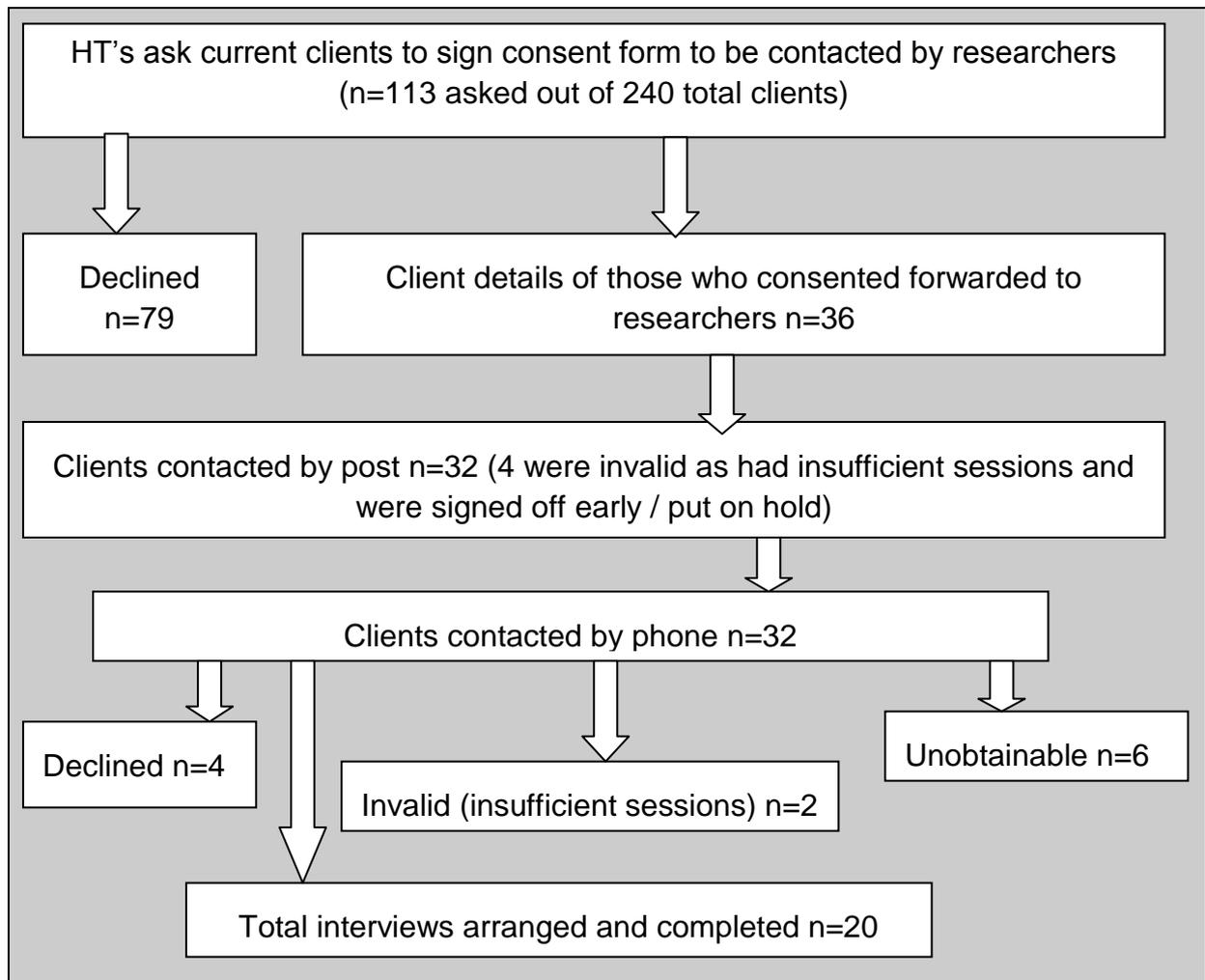


Table 1: Client data provided by Health Trainers (May-June 2009), and final number interviewed by VSO

| Org/area | Total clients* | Current clients | Given consent | Declined consent | Undecided /not asked | Interviewed |
|---|----------------|-----------------|---------------|------------------|----------------------|-------------|
| Adur | 30 | 12 | 5 | 23 | 2 | 3 |
| Crawley | 34 | 10 | 8 | 10 | 16 | 4 |
| Bognor and Littlehampton | 38 | 26 | 3 | 23 | 12 | 3 |
| Worthing | 22 | 10 | 5 | 5 | 12 | 3 |
| Mid Sussex, and Chichester – older people | 50 | 25 | 8 | 18 | 24 | 5 |
| Worthing – older people | 66 | 19 | 5 | 0 | 61 | 2 |
| Total | 240 | 114 | 34 | 79 | 127 | 20 |

* seen since December 2008

NB 'consent' = initial consent to be contacted by the researchers rather than consent to be interviewed.

As outlined in the extension proposal, the researchers aimed to recruit participants from all the host organisations across West Sussex (which was achieved: see Table 2 above) and at a minimum to include clients with certain criteria as detailed below. All these criteria were met in the interview sample:

- an older person from a more deprived area (i.e. Crawley, Bognor, Littlehampton);
- an older person from a more affluent area (i.e. Chichester, Burgess Hill, Horsham);
- a client linked to an older people's VSO in Worthing (since this Health Trainer programme has been running for longer);
- a client from a minority ethnic group;
- younger people with concerns about weight and/or diet.

Further information about the characteristics of the sample can be found in section 4.1.2 which presents data from the questionnaire with clients. 4.1.1 includes some profile data of all clients in West Sussex, collated by health trainers for the purposes of the national evaluation, and provided to the researcher by West Sussex PCT.

2.4 Focus groups

In the second half of the first year, after the second round of health trainers had completed their training, a series of focus groups were carried out. All the health trainers were invited to take part in their learning sets and were given information sheets and consent forms (See Appendix 4 and 9). In total fourteen health trainers took part. The focus groups explored health trainer's perspectives on their own professional development and their progress towards the qualification and their initial experiences of working with the behaviour change model with clients. With the consent of the participants the focus groups were recorded and then downloaded and transcribed as previously described for the interviews.

2.5 The workshop

A facilitated workshop was held with the older people's health trainers some months after they had completed the core training by which time most of the eight were working with clients (See Appendix 8). The aim of the workshop was to identify the types of issues that older people present and the ways in which the Health Trainers service can be delivered effectively to older people. The issues raised also have implications for the content and delivery of the training and promotion of the Health Trainer service.

Discussions in the workshop explored:

- How and why older people's needs may be different;
- What particular things need to be taken into account when working with older people;
- What are the barriers for engaging older people and how to reach them;
- How do the older people's health trainers perceive themselves as different to generic health trainers?

Chapter 3: Findings from Part 1: Implementation and development

3.1 Introduction

This chapter presents findings from data collection in stage 1 of the evaluation which included the use of interviews, focus groups, a survey and a workshop with a range of participants. These findings focus on issues concerning the implementation and early development of the programme.

3.2 Developing the Health Trainer workforce

This section looks at developing the Health Trainer workforce. It covers the recruitment processes during the first year of the programme; the training of the health trainers; the preparation for accreditation for the City and Guilds Certificate for Health Trainers; the future development of the health trainers and summarises issues that need to be addressed.

3.2.1 Recruitment of Health Trainers

The 'ideal type' of Health Trainer envisaged in *Choosing Health* is someone who has local knowledge of the needs and issues in their own communities, who will be able to reach out to people not usually in contact with services and use 'common sense' in a friendly and approachable way. The programme aims to not only draw on the 'lay' knowledge of health trainers but to also offer opportunities to develop their skills through training and a level 3 qualification. There is therefore an assumption that health trainers may be people with little or no formal educational qualifications but who will have personal skills and the ability to establish good relationships with those using the system. West Sussex PCT recognised that to ensure that health trainers are drawn from local communities, innovative and creative recruitment strategies would be necessary.

Health Trainers should be drawn from, have knowledge of and be representative of local communities. Creative recruitment strategies will need to be employed to ensure that Health Trainers are drawn from these target groups. 2007 Service Specification (Section 3 Services Delivery Requirement)

During the first six months of the programme two rounds of recruitment were carried out. It was agreed by the PCT and VSO partners to split the recruitment across the county and to concentrate the first round in the north – Crawley, Mid Sussex and Horsham, and the second on the coastal strip – Adur, Bognor, Chichester, Littlehampton and Worthing. This related to capacity issues and the difficulties of

delivering the training to one large group (potentially between 30 to 40 people if all posts had been recruited on a part time basis). A range of methods were used to advertise the posts including the local press, the organisations' websites, exhibitions in local town halls, open days and through the VSOs networks and existing staff. The extent to which the recruitment strategies were successful in attracting the 'target' people to apply is not easily assessed. However, a survey of those who requested job application packs suggested that the posts had generated a lot of interest from people who were already in work and highly qualified. The questionnaire was sent to all those who had expressed an interest in the posts and included respondents who had applied for the posts as well as those who subsequently decided not to apply. In relation to current work status fifty four (out of a total of seventy nine) respondents already had jobs and ten described themselves as unemployed. Of those not registered unemployed or working, three were carers, five were doing voluntary work and three described themselves as retired (see Table 2).

Table 2: Current work status of potential applicants

| Current work status | Male | Female | Total |
|---------------------|------|--------|-------|
| Full time work | 3 | 18 | 21 |
| Part time work | 3 | 30 | 33 |
| Carer | 0 | 3 | 3 |
| Voluntary work | 1 | 4 | 5 |
| Unemployed | 1 | 9 | 10 |
| Retired | 1 | 2 | 3 |
| Other | 1 | 3 | 4 |
| Total | 10 | 69 | 79 |

In relation to education, fifty two percent of respondents held qualifications above level 2 and twenty seven percent had higher education qualifications (five up to masters level)

Table 3: Educational qualifications of potential applicants

| Highest educational qualification | Male | Female | Total |
|--|------|--------|-------|
| No formal education | 1 | 5 | 6 |
| Secondary (GCSE / O level /CSE | 3 | 12 | 15 |
| Secondary plus(AS / A level /BTEC) | 0 | 11 | 11 |
| NVQ level 2 | 2 | 3 | 5 |
| NVQ level 3 | 1 | 4 | 5 |
| NVQ level 4 | 0 | 4 | 4 |
| Vocational (City & Guilds, RGN / professional) | 1 | 9 | 10 |
| Degree | 0 | 17 | 17 |
| Masters | 2 | 3 | 5 |
| Not known | 0 | 1 | 1 |
| Total | 10 | 69 | 79 |

Some applicants who fitted the ideal profile, in terms of links to community and levels of formal education, had shown on their application forms how they met the criteria in the person specification. However, others were clearly deterred from applying and feedback suggested this related to lack of self-confidence.

Not all the posts were filled and in one location, where there was some concern that the recruitment did not penetrate locally, one post was left vacant and a different recruitment strategy developed. Over a two month period interest was generated in the post through the VSO's own contacts and networks and via word of mouth. This yielded eight applications and all applicants were interviewed and one subsequently appointed.

The first two rounds of recruitment were carried out jointly between the VSO partners. This had advantages in terms of pooling resources but was problematic in terms of highlighting local connections and led to some confusion among applicants. Future recruitment is unlikely to be carried out on such a large scale and this may provide further opportunities for more targeted local recruitment.

The experience from the first round of recruitment suggested that there is a tension between the desire to offer opportunities to those with little previous work experience or educational qualifications and the level of support such people may require, both in making an application and delivering the service. The VSO supervisors have raised concerns about whether they could realistically provide the amount of support needed for those who fall within the target group. The initial support and supervision needed by the first group of health trainers far exceeded what was originally anticipated. To address the higher than anticipated support needs and the pressure

on the workload of the VSO supervisors it was decided in the second round of recruitment that each organisation would appoint a senior health trainer to assist in managing and supporting the other health trainers.

A similar issue which may impact on attracting the 'ideal type' to Health Trainer posts relates to hours of work. Whilst there was a desire to offer flexible hours and part-time posts, in practice the impact of these on the amount of management and supervision hours, and the implications for the workload of supervisor needs to be more carefully considered.

Twenty three people were appointed to posts in the two recruitment rounds based in the following locations:

Table 4: Appointed posts by location

| Location | Full-time | Part-time | Total (no of people) |
|---------------|------------------------------|------------------------------|----------------------|
| Adur | 2 generic | | 2 |
| Bognor | 3 generic | 1 older people | 4 |
| Burgess Hill | | 1 older people | 1 |
| Chichester | | 1 older people | 1 |
| Crawley | 2 generic 1 older people | 1 generic | 5 |
| Horsham | | 1 older people | 1 |
| Littlehampton | 2 generic | 1 older people | 4 |
| Worthing | 2 generic 1 older people* | 2 generic 2 older people* | 7 |
| Total | 13 | 10 | 23 |

*Two older people's health trainers were already in post when the programme was put into operation across the county.

A further two people were recruited (and undertook the training) and subsequently left.

Those currently working as health trainers comprise:

Table 5: Appointed posts by gender

| | Older people's health trainers | Generic health trainers | Total |
|--------|--------------------------------|-------------------------|-------|
| Female | 6 | 11 | 17 |
| Male | 3 | 3 | 6 |
| Total | 9 | 14 | 23 |

The health trainers who have been recruited have a range of existing skills and experience which had attracted them to the role. On describing what interested them about becoming a health trainer, common factors which emerged included:

- Experience of working with people in some way, from hairdressing to nursing. Some had experience of care work or had worked with groups, such as older people, those with mental health issues or learning difficulties and in advice-giving roles;
- An interest in health issues and the fact that the Health Trainer role related to health and healthy lifestyles;
- A desire to help people and make a difference to people's lives;
- An opportunity to gain a qualification in a new direction and develop a new career;
- An opportunity to use existing skills in a different way.

3.2.2 Training

Choosing Health recognised that the health trainers would require training to be able to support clients in making lifestyle changes. This is articulated in more detail in *Our Health, Our Care, Our Say* (DH 2006) as acquiring skills in psychological behaviour change techniques:

Through induction training for all new staff, undergraduate courses and continuing professional development we will equip all frontline staff to recognise the opportunities for health promotion and improvement, and use skills in health psychology to help people change their lifestyles.

Our Health, Our Care, Our Say, p.124

Health trainers were initially conceptualised in *Choosing Health* as those already active in their communities who would be able to draw on local knowledge and common sense to offer advice and links to other services. But by the time *Our Health, Our Care Our Say* was published the role had evolved into one requiring explicit use of psychological behaviour change and motivational techniques. The national *Improving Health: Changing Behaviour NHS Health Trainer Handbook*

(Michie et al 2006) which underpins the role of the health trainer describes the role as:

The role of the Health Trainer encompasses much more than advice and support. It involves training people in skills to actively set their own behavioural goals and manage their own behaviour and, more broadly events and circumstances in their lives they would like to change.

Improving Health: Changing Behaviour NHS Health Trainer Handbook, p.5

A series of competences were developed by Skills for Health and the British Psychological Society which set out what a health trainer needs to know and do once fully qualified. These are assessed through a nationally recognised City and Guilds level 3 Certificate for Health Trainers.

In West Sussex the training and development of the necessary skills is carried out in a number of stages:

- Delivery of the core Health Trainer training;
- Assessment and sign-off by the Health Trainer Co-ordinator as able to practice;
- Completion of assignments for City and Guilds Level 3 Certificate for Health Trainers;
- IT training on inputting data for the national dataset;
- Bespoke core training and other local, 'bolt on' training options identified by co-ordinator, health trainers or supervisors.

In the first year of the programme core training was delivered to health trainers in two intakes by the Health Trainer Co-ordinator who was employed by West Sussex PCT. The training sessions were delivered over nine days and followed the Health Trainers' Training Pack: A toolkit for Developing Core Competences.

On completion of the core training health trainers were assessed by the Health Trainer Co-ordinator through an assessed role play. This was used to assess if the health trainer had sufficient understanding to begin working with clients and to identify any further training needs. The core training and evidence from working with clients form a portfolio of assignments for the City and Guilds qualification which demonstrates the Health Trainer has the required standard of competence to satisfy the Health Trainer Competences set out by Skills for Health. It was anticipated that around half of the trainers will have submitted their assignments for assessment by August 2009 and the remaining half by December 2009.

To support the health trainers achieving the accreditation, geographically based Action Learning Sets were set up to work towards the City and Guilds qualification,

with support for completing the assignments from the Health Trainer Co-ordinator. These groups were meeting fortnightly. Monthly support groups were meeting for ongoing support and clinical supervision specific to client work. In addition, at the request of the health trainers and VSO supervisors, bolt-on training on specific issues were provided, such as working with vulnerable adults, smoking cessation and lone working.

Health trainers have been expected to collect information on the assessment and progress of their clients and to input this data for national dataset being used to measure the outcomes of the Health Trainers programme nationally. Some of this information was made available to the researchers and is presented in section 4.1.1.

The first cohort of health trainers were interviewed after their core training and all the health trainers took part in focus groups between six and four months after core training to reflect on their ongoing development as health trainers. In addition the Health Trainer Co-ordinator was interviewed twice to reflect on training issues from the PCT perspective. The following issues emerged from an analysis of these interviews.

There were a number of practical and logistical issues relating to training two fairly large groups which needed to be addressed. Firstly, geographical distances across the county meant that health trainers would have to travel quite long distances and this impacted on their available hours and for some, on caring responsibilities. To try and accommodate this, training sessions were held at different venues across the county so that travelling distances were spread among the health trainers. There was a difficulty in accessing suitable training venues and there was an ongoing problem of finding a large enough venue for IT training. This contributed to the delay in running the dataset training. These issues are unlikely to arise again to the same extent as it is not envisaged that the core training will be run in the same way. The ongoing learning sets and support groups have been set up geographically so that health trainers do not travel across the county for these meetings.

Secondly, each cohort comprised people with different levels of skills and knowledge. This meant that within each group there were different learning styles and levels of learning support required. This raised the issue of how to implement the training programme to meet diverse needs. Those with higher skills experienced difficulty adjusting to a lower level and those who are not used to a structured learning environment or working towards a qualification struggled to keep up. The range of levels within the cohorts has meant that health trainers had different expectations of the training and the qualification. Those who already had higher educational qualifications found it difficult to adjust to working for a level 3 qualification.

At the other end of the scale, those with no prior qualifications or experience of working towards a qualification found the training and assignments more difficult than they expected from the information they had that attracted them to the Health Trainer role. One explained:

[...] the terminology they're using and how they're wording it, so if you are looking in this role as the Health Trainer role, ordinary everyday neighbours, you try getting them to get their heads around this ... they're just going to run a mile. If I'd known about this I wouldn't do the job, I really wouldn't. That's the City and Guilds stuff, I wouldn't do it.

Many health trainers commented that they had not really understood the role or what was expected of them until they had had the core training. Two of the recruited health trainers (one from each cohort) resigned after the core training. One, who was a qualified counsellor had expected more of an advisory role and felt the health trainer role would involve working at a level lower than her existing counselling skills. The other, who had been out of the workforce for 12 years, needed more support particularly with confidence and self esteem. This again illustrates the tension in the aim of recruiting those with little or no formal educational qualifications and what this might entail in reality.

There were clearly other learning support needs within the group as four health trainers informed the researcher that they have dyslexia. English is not the first language of three of the health trainers and one had explained that she had difficulty understanding the language and the written material in the training. At least one of the health trainers, who fitted the target profile, felt their learning support needs had not been understood or met:

I think it's too hard. Considering no experience necessary and they said to me... I said I was dyslexic, I can't learn, oh no you'll ride through it; I couldn't understand a single word. I sat there and I went oh there we go, I just didn't understand one word of what they were saying to me. All the jargon...

Because at the interview they said oh you'll be given loads of support, there'll be loads of training, and I expected it to be like four days working, one day training, where you do it for like a year, where before you actually go out and see people you actually are qualified to talk to someone about to motivate them, not over a short space, what we've done. I needed more, I wanted more and I expected more

Completing the assignments for the City and Guilds qualification appeared to be particularly daunting and overwhelming for those health trainers with learning support needs, as one of them explained:

I accept learning on the job, I thought that was the training, that was learning on the job, but not this, this is terrifying for somebody like me and it's, you know, yeah, I love the thought in about the eight months ... I could have a City and Guilds, yeah I'd be quite proud of that, but nobody has a clue of the torture I'm going through to try and get it. And ask for support and help – where's the time? There isn't the time there available and I can't keep encroaching on my colleague to support and help me.

One consequence of the range of skills and support needs with the current cohort is that the Health Trainer Co-ordinator is spending more time than anticipated on the training and assessment. Although further resources have been put in place, this has impacted on other areas of her role such as promoting the health trainer service with health professionals.

Generally, the health trainers felt the training had clarified their role and that they had gained a better understanding of what is expected of them. Some commented that they found the training very intensive and had not covered some areas in very much detail. One particular issue that many of the health trainers mentioned was feeling that they had not acquired sufficient knowledge about health issues and that this would hamper them in carrying out their role. They felt the lack of knowledge would put them at a disadvantage with their clients:

When people do start talking to you about their health problems and you're kind of staring back at them thinking 'I haven't got a clue about what that illness is' kind of thing.

And again we don't really have understanding... well we went on a course again just to you know, gain the basic knowledge about mental health problems and we don't really know in depth what's anxiety or you know, self-harming ... and I certainly have had clients that have you know, confessed to attempts at suicide or feeling very stressed and depressed and as untrained counsellors and as an untrained professional I don't feel equipped.

Some of the health trainers also felt this limited their capacity to develop a more rounded knowledge base. There was a feeling that they were not given more health based training in case it compromised their health trainer role, as one health trainer put it:

But you do get a sense of fear from the NHS that if you are given too much information you're not going to understand your role as Health Trainer. I do understand my role as Health Trainer and I do understand it is not one to advise but for me, for my own personal development I'd like to do other things but I can also understand therefore well that's not your job, why would you need to know. But it is useful as well and I think as a human being you want to know new information.

This raises the questions of how clearly the boundaries of the Health Trainer's role (specifically in relation to 'health') are understood by the health trainers, and how the Health Trainer's role is perceived both by the public and by other health professionals. This will be discussed in more detail in a later section.

Another area that some of the health trainers felt was not given enough attention during the training related to collecting data on their clients which will be used in the national dataset. Although separate computer training on inputting the data will be carried out, there was some concern about how to ensure the information required for the dataset could best be gathered during the initial sessions with the client. Many felt that dealing with the paperwork would impact on the process of building rapport with the client:

I think there's one mistake that I feel the training didn't sufficiently cover and that was the bureaucracy and the forms and the detail of the forms, so a lot of the training was very good on you know, building up rapport and a lot of the issues you'd be dealing with and that the work actually involves. So again, I found that a bit of when you actually started seeing the client it was quite hard because the bureaucracy hadn't really been factored into the training.

This raises a further question of whether this is in fact primarily a training issue or a reflection of an inherent ambiguity in the role and expectations of health trainers as the friendly, approachable community member, different from other health professionals. Many of the health trainers felt uncomfortable with the form filling and suggested that it goes against the spirit of the programme and is not well-suited to their understanding of a 'person-centred' approach.

they make a lot of importance on the paperwork and the computer and at my interview I said I'm not a paperwork person I really don't want this job if it's a paperwork orientated job and I came away from the training thinking that's exactly what it is.

This concern was echoed by some VSO supervisors who questioned whether collecting information is covered in enough detail during the core training. It may be difficult for health trainers to learn how to use the paperwork confidently so that they

can ask questions and take notes during the client interaction which they will later input on the computer. Some VSO supervisors thought this aspect needed considerable care, both in the way it is carried out during the client interaction, and in any materials used, such as personal health plans. There was concern that these could potentially compromise their own particular VSO identity and ways of working with clients if they came across as 'too statutory sector'.

3.2.3 Accreditation and future development

At the time of the focus groups both cohorts of health trainers were working on the assignments for the City and Guild's qualification. Many of the health trainers commented that it was very time consuming and felt it took them away from doing their job. Some had mixed feelings about the value of doing the qualification; although they accepted they had to do it, they questioned whether it would be useful in the future:

The City and Guilds is a recognised qualification but for me I'm wondering is it...well it's too low level for them to actually be a relevant and decent and realistic step up into a role that I really want to go into. But how much of a gap is it going to be... well because I know what I'm interested in thereafter this role but City and Guilds, I mean I don't know, is it going to make any impact at all into what, you know into that, probably not.

As well as aiming to address health behaviour with individuals on a one to one basis the other key aspect of the Health Trainers' initiative is to provide opportunities for the health trainers themselves to develop a career in health:

This new type of role will provide opportunities for local people to take the first step on a 'Skills Escalator' to improve and develop their skills through the National Qualifications Framework by developing skills for health improvement, prevention and behavioural change. It will extend opportunities to people currently providing advice and support in their local community who may not otherwise have considered a career in the NHS or the public sector. It will also increase opportunities for employment and development in the local community, enabling people to develop a role in providing advice to their community while developing their own understanding of health and community issues. *Choosing Health*, p.112

The health trainers were asked to reflect on their own development and where the health trainer role and qualification might lead. Many did want to develop their skills in particular areas, such as nutrition and exercise. However, they were, at this stage, not clear where the health trainer role sits within the NHS structure and as a new role how far the qualification would be recognised as these two comments from health trainers illustrate:

I've tried to look into it and there's been a little bit of a barrier I've felt from the NHS because... well I've only just tried to speak to them once or twice but there doesn't seem to be an acknowledgement of the role and also how can you develop thereafter so I suppose we would have to develop ourselves in our specific fields of diet, exercise, smoking, alcohol. So I suppose for us that's why it's important and crucial for us to get as much training I suppose as we can in each of these areas because it isn't an ongoing job it's going to finish because obviously we're in the post for 3 years.

I don't think the qualification's going to help, because I don't think it's got any kudos anywhere, particularly in the sort of medical profession or medically based professions that you'd want to follow on from this to develop a career, it doesn't hold any weight there I don't think. I would very much like to do more and build a career in this direction, but I don't think that's the thing to do it. I need to find more qualifications elsewhere that hopefully we can get onto.

3.3 Putting it into practice – working in the community and client work

This section of the report looks at the work of the health trainers in practice. It covers promoting the service and making the role of the health trainers visible in the community; public responses to the service; the health trainers' perspectives on their role and using the behaviour change model and offers some initial reflections on working with clients.

3.3.1 Promoting the service

A major challenge of the Health Trainers programme has been making the public and wider community aware of the service and what it aims to do. In the period after completing the core training the health trainers have worked to promote the service in their local communities. This has included visiting local groups and organisations, giving presentations and talks and making links within their communities. How and where to promote the service has been decided by each VSO using their local knowledge of communities and areas to target. In some locations, such as Crawley, the health trainers have been based with host organisations working with particular client groups, for example, organisations, which work with substance misuse and, homeless people. In other locations the health trainers hold drop-ins in different community locations, such as Children's Centres and GPs surgeries, and have participated in local events. All of these activities have contributed to raising awareness of the service and the growing number of referrals.

There have however been a number of issues raised concerning the challenges of promoting a county-wide programme with a clear health trainer identity whilst incorporating the individual and local aspect of each VSO partner organisation.

Many health trainers felt that communicating the message of what they actually do and establishing a client base had not been straightforward:

I think the trouble is, you're going out, you're talking about a job no one's heard of, you're saying you work for an organisation that half the time no one's heard of, and then on the other hand you're trying to say 'oh but I am officially backed by the NHS'.

Most of the health trainers reported that their job title conjures up associations with personal trainers in the public mind:

It is with the image, your impression that the public has certainly when you say health trainer; a lot of them seem to think that you're a personal trainer kind of thing.

It makes it harder to explain what the job's about, because if they hear the name people already get thoughts in their head, so we're going to see a group and we're having to already change what they think about us. Whereas if the name was different they might have more of an idea before we went and spoke to them.

There was considerable concern expressed that the promotion of the service at a strategic level had not been well planned and many of the health trainers had felt frustrated and demoralised at not having promotional materials to use in their outreach and development work. At the time of report they are still waiting for a generic leaflet to advertise their services and many felt unhappy about this.

We haven't had leaflets, they are being done six months down the line, and absolutely, I think everybody said absolutely that should have been in place within a month of us being in position, or at the point when we were launching we should have had those.

In the view of many of the health trainers this had added to the already difficult task of promoting a new and unknown service to the public and developing their relationships with other professionals which may have impacted on their client referrals.

The impression I got in the interview was completely different to what I am actually working now, you know what I've got to do in my job ... I didn't realise we'd have to work so hard to get the clients and I just feel, you know when am I going to start getting a client list. I've never been in a job where I've had to work so hard and ended up with so little regards to client base.

3.3.2 Understanding the role of the health trainer

The interim report of the evaluation produced after the first cohort of core training noted at that point there was a degree of uncertainty amongst the health trainers about putting the behaviour change model into practice. Many had expected the role to be more advisory in character and some had felt they would be drawing more on the previous skills and knowledge on health matters. During the focus groups the health trainers reflected on how their understanding of their role had developed since the core training and they had started to see clients. Learning the behaviour change techniques and putting them into practice with clients has been challenging, particularly learning to listen without offering advice:

It is difficult to learn and need to... even if you know the answer; you need to hold back, it is not a part of our role. So we want to help them but within the role, it is different, we can't tell them what to do, we need to ask them what they really want to do and how they are going to do it and when they are going to do it and asking more like open questions to get the answer from the client. So it is really a skill which we learn in the training and we are still learning on that one because it is really difficult, it is so easy to get into the trap by listening and think okay, I know the answer we can tell them but we need to hold ourselves back, no it is not in our role.

On the other hand, they reflected that the skills required for health trainer interventions go beyond their lay experience of working with people. This was becoming more evident as they gained more experience of one to one behaviour change:

I suppose our thinking isn't quite there yet to be able to think on our feet like that. For me everything's hard work and I have to think about what I'm going to say and I have to think about how I'm going... just do everything, I can't naturally have a conversation now and talk and be in Health Trainer mode, I do have to think about it and I have to be in the right frame of mind and that doesn't come easy to me.

Clearly the process of learning to use the behaviour change model requires time and practice to build up the health trainers' confidence. It was acknowledged that it is through working with clients that health trainers will consolidate their learning of the one-to-one behaviour change model.

3.3.3 Early indications of client work

During the first year, it was too early to begin to assess client outcomes, since health trainers were only beginning to see clients. In regard to this early work with clients, however, the VSO supervisors, the health trainers and Health Trainer Co-ordinator

all reported that informal feedback from those using the service had been very positive. Many of the VSO supervisors felt that personal qualities, interpersonal skills and the understanding of local communities enable the health trainers to work in ways in which they are perceived by clients as someone who is on the same level as themselves. This was also reflected in feedback that the health trainers received from clients.

My clients see me as somebody who's approachable and friendly. A lot of my texts that I get back from them are a lot of things they say to me is like the newest client 'you haven't judged my home', 'I don't feel judged by you'.

The researcher was able to talk to one client who was having sessions with a health trainer in the first year and who was mid-way through her one-to-one sessions. In response to questions about the ways in which the health trainer worked and what things she found helpful about having a health trainer she made the following comments:

[HT] is so sincere, she you know, I know when she's with me when I'm talking to her and she's talking to me , it's not just a job do you know, everybody should do a job that they like doing and you can tell that [HT] is, likes doing and is very caring.

It's motivation, whenever you know, when I see [HT] I get really motivated to things because she's there do you know what I mean, she's behind me, it's not just you know, I'm doing this because I have to do it you know, she is there, she wants me to achieve and also she is better than a counsellor.

Because she's very understanding and I feel that she wants me to achieve these goals and we talk about things, she doesn't cut me short, a counsellor will cut you short you know, more or less when you're there they'll start looking at the clock and their questions, their answers are so standard you know, oh it's so condescending and [HT] isn't that, she's not judgemental, she's not condescending, she's with me, she feels what, I feel that she feels what I feel.

This client clearly appreciated the support she was getting from her health trainer and her comments illustrate the importance of the relationship between the client and health trainer in the interaction. However she had not yet completed her programme of sessions so it was too early to assess how the intervention would enable her to make longer term changes and maintain them once the health trainer intervention had finished. Although it was not possible to assess whether this case is typical of the health trainers' client base, the researcher was struck by the very difficult and challenging life circumstances of the client and the complexity of external factors outside of her control which may affect the capacity to make changes. Some

of the issues highlighted in this interview were explored in the interviews conducted with clients during May-September 2009 and discussed in the next chapter.

3.4 Older people's Health Trainers

This section focuses specifically on the work of the older people's health trainers. The interim report identified a number of issues emerging in relation to the health trainers who are working with older people. These relate to the kinds of issues and problems that older people face and the ways to approach older people in delivering the health trainer service. The VSOs employing older people's health trainers work exclusively with older people, and through their knowledge and experience of delivering health and well-being services, have been able to identify the ways in which the Health Trainers programme needs to be considered in relation to the specific needs of older people.

3.4.1 Why older people's needs are different

During the facilitated workshop with older people's health trainers, the health trainers reflected on their experiences and why working with an older client group merits particular attention to issues related to ageing and later life. Growing older and later life are marked with major transitions which often entail loss. As well as the physical aspects of ageing which may impact on mobility and general health, as we age we experience more loss from bereavement, in particular, the loss of a lifetime partner is a major transition. Later life can also involve loss related to issues of identity, purpose and meaning to one's life and older peoples' worlds can become smaller and more insular. For these reasons, many older people experience social isolation, loneliness and loss of confidence. Older people may be reluctant or fearful of change and may become 'stuck in their ways'. These are the kinds of factors that impact on health and wellbeing which the health trainers suggested need to be considered when working with older people.

3.4.2 What does this imply for the ways in which Health Trainers work?

There was some concern expressed that four of the key priorities to address – obesity, smoking, alcohol, and sexual health are not the most appropriate for older people. The underlying issues of social isolation and loneliness do fit with the mental health priority and can be addressed by health trainers but the approach might need to be tailored and flexible. It may take longer to build up a relationship of trust with an older person before the behaviour change goals can be tackled, and the effectiveness of the intervention may depend much more on the quality of the relationship between Health Trainer and client (although, as we have seen, the nature of the relationship is likely to be important at all ages).

Older people may need particular support in identifying goals and how to manage change as one of the health trainers explained:

Sometimes I will give examples of other people and what they've done 'cos then you can kind of, you're not telling them what to do, you can say 'well this is what this person's done', but then I'll say 'but it is each to their own and do what feels you know, best for you'. But it's giving them some options because I mean a lot of older people that I work with don't have a clue about some stuff 'cos they've done what they've done for years, and to change it is, for them, a completely alien concept. So for them it's like 'well I don't even know where to begin, what should I do?'

Although older people may be resistant or reluctant to engage with ideas around behaviour change, the health trainers felt that there are positive benefits for older people in using the health trainer service, especially around aspects of emotional well-being and social engagement. There is potential for health trainers to contribute to reducing older people's isolation and putting clients in touch with services as well as supporting clients by building their confidence to make step by step change at their own pace. To develop the older people's Health Trainer service effectively, greater understanding of older people's complex health needs may be needed as well as the impact of bigger set backs from minor ailments that older people may experience. More specialist training on older people's health issues might assist in understanding conditions that are more common in later life and how these may impact on the health trainer's intervention work.

It may be more difficult to engage older people in the Health Trainer service and the health trainers identified the potential barriers as:

- Lack of knowledge of the service and what it does. The title 'Health Trainer' can be off-putting and wrongly associated with 'personal trainer' and therefore not something that would appeal;
- Asking for help can be difficult. Older people don't want to lose independence and pride may prevent them acknowledging their need for help;
- Older people often report not being taken seriously or listened to by health and social care professionals and a previous bad experience with (health) professionals may make them reluctant to engage;
- Paperwork – self efficacy forms and personal health plans can be off-putting and the language and concepts may be unfamiliar and misunderstood;
- If the interaction is impersonal and not person-centred it is unlikely to build the necessary trust for effective work.

The health trainers were asked to discuss possible ways of working with older people to that might overcome these barriers and encourage older people to use the Health Trainer service. The group felt that it would be important to develop innovative and creative ways of engaging older people. For example, running organised group activities which would help to establish relationships and trust that could be used to introduce the Health Trainer service. The group felt that organising social activities would be particularly useful for older people in view of the prevalence of social isolation as a presenting issue. These would act as a pre-cursor to engaging older people in one-to-one interventions. Other ideas included running coffee mornings and holding open days which included health checks. The need to engage with people who are not accessing services through developing group work has been recognised in the Competences for Health Trainers produced by Skills for Health¹ (2006).

The insights of those who have experience of working with older people delivering health and well-being services suggest that the Health Trainer service could make a positive contribution to addressing older people's needs. However, the implementation and delivery of the service may need to be more creative in approach to make it effective, as one of the VSO supervisors commented:

There needs to be a little more room ... to work more organically... for the work to be done to fit with the older person, for example by combining the Health Trainer role with the community link worker. There are differences but you could be doing a Health Trainer intervention then something small completely out of left field will happen which means the older person needs very practical immediate help and the Health Trainer framework trips them up.

3.5 Partnership working

The challenges of implementing the Health Trainers programme have been complex: building a relationship between partners who have not worked together before; creating a workforce with a new role that has not existed before; identifying clients for a new service and rolling out the programme across the county in diverse

¹ How will health trainers work with groups? Health trainers will have to find ways of developing relationships with communities and individuals and building their trust before they can effectively undertake work on individual behaviour change. How this is done will depend on the service design that is set up locally and within which the role of health trainers sits. Given that the focus of Health Trainer work is individuals who do not usually access health services / are often excluded from services, health trainers will need to access individuals through engaging and interacting with members of the community such as in community groups. For example, health trainers might have as a part of their role running a community group with the aspect of individual behaviour change being an extension of this role. (*Competences for Health Trainers*. Skills for Health 2006).

communities. This is the context in which the PCT and VSOs have developed their partnership. The interim report noted that both the PCT and the VSOs have a shared commitment to tackling health inequalities and providing local services to local people. However, it also noted that the different organisational cultures of partners may create difficulties in implementing the programme. This section of the report looks at some of the issues involved in partnership working. It covers the implementation of the programme; challenges and problem-solving; communication issues and reflects on the progress in establishing working relationships over the first year of the programme.

3.5.1 Decision-making and project management

All partners acknowledge that as a new project a certain amount of initial teething problems are to be expected. Implementation difficulties have been openly discussed at steering group meetings which have taken place quarterly. In addition, regular meetings have been held between the Health Trainer Co-ordinator and the VSO supervisors. Steering group meetings are chaired and serviced by the PCT and decisions are reached through a collective process of discussion and input from the VSO partners. This has, at times, contributed to a sense of frustration when aspects of implementation have taken a long time to progress which highlights the tension between aiming to be inclusive and reaching a consensus across six different partner organisations in practice.

As the programme has been put into action, issues that have arisen have been reviewed by the steering group. For example, the amount of management time needed to supervise health trainers was underestimated by the VSOs in their original tender. The PCT responded positively in problem solving the issue and asked VSO partners to review costs and re-submit budgets, acknowledging that as a new project this was to be expected and clarifying that the VSOs would not bear the cost of the shortfall. However, some of the VSOs felt that there had been miscommunication concerning decisions relating to expenditure on promotional materials. There was some concern expressed that decisions agreed at steering group meetings are not always followed through, particularly if minutes are not circulated with sufficient time to ensure that agreed action points are carried out. This has sometimes contributed to a sense of confusion over responsibilities and some of the VSO partners feeling that they have not been listened to.

3.5.2 Communication and division of responsibility

There were other areas where the division of responsibilities between the PCT and the VSOs appear to need some clarification. Whilst the health trainers are employed and managed by the VSOs, they receive training and ongoing clinical supervision from the Health Trainer Co-ordinator. From the health trainers' perspectives this had sometimes been confusing, particularly when they felt they were receiving conflicting information from two different 'managers'. In one instance, this had occurred in

relation to promoting the service and one health trainer explained how it felt like being pulled in different directions:

But maybe that's something the PCT should make...clear...clear to our employers. And it's just impossible. I think you've got like two employers pulling your strings.....and that's great if they're working in harmony and maybe they're sharing a similar view and things work, but if it doesn't work like that then it causes a lot of difficulties.

There were also concerns that as client work developed, any problems that arise specifically related to clients might be difficult to resolve, given that they are line managed by supervisors who have not received training on the Health Trainer model:

I can see issues in the future which haven't arisen yet around if you have problems dealing with clients and that... we haven't really hit many issues yet, but in the future, I mean if you've got problems with those and you're going to your line manager and the line manager hasn't done the same training that we have even, you know, so they're not really going to be able to advise you, or shouldn't be able to advise you on client issues. In which case you need to go to someone at the PCT, but I can see that being fraught with frustrations. It's a very slow process to even get an email reply.

Delays and slow progress in implementing the service had impacted negatively on the health trainers and had also contributed to a sense of confusion about who was ultimately responsible for making decisions and following them through. As two of the health trainers explained, it had been frustrating and demoralising:

It feels like it's not been planned at all. Feels like they're ... making it up as they go along, and because of that they keep changing things as it goes along, so we're at the bottom of the line as we are, we're the ones that get messed about when someone changes their mind higher up, you know. But the frustration has been such that at times you just think well no, this is just not worth it.

And it's like well who do you have to speak to, to get something done, it's really frustrating. And it's been demoralising hasn't it a bit, speaking from a team leader perspective, keeping people motivated and positive. It's very difficult when there's very little to be motivated about because we haven't got clear targets set, there's not this is when it will be ready or this is when it will be ready, and then that date's been pushed back and back and back. When were we supposed to get flyers, beginning of December? Originally it was the date wasn't it, then it was end of December, then it was the beginning of January.

The PCT and VSOs were aware that it had taken longer than originally anticipated to get the Health Trainer service up and running. Some of the delays can be attributed to factors outside of local control, such as the arrangements for the national dataset collection and the City and Guilds assignments. However other delays, for example, in getting personal health plans, leaflets and tokens for the data inputting have required local agreement and action. These seemingly minor things have had an impact on the health trainers' morale and confidence and contributed to a feeling that they are not being given the tools to do the job.

I don't feel confident as I think I could do to see a client yet because we haven't got the proper forms and we haven't got the personal health plans, so I would have to see the client without that and I'd feel more confident if I had the personal health plan to go through with them. And I'm sure if I'd been seeing clients for ages I'd be fine without it but when you're, it's quite scary for you seeing your first client without having all the equipment yet kind of thing.

3.5.3 VSO reflections on Health Trainers' programme

In spite of frustration at the delays in implementation overall the VSOs felt that being part of the Health Trainers programme had been beneficial for both the people in their local areas and for their organisations. The Health Trainers service has raised the profile of their organisations and helped to build links within the community. Many of the VSOs found the initial stages of the programme were very resource intensive and now that the programme has moved to the next stage and the health trainers are working with clients the results are beginning to be seen. Some of the VSO supervisors commented that it was very rewarding to see the progress that the health trainers have made from recruitment towards accreditation. In addition to the personal and professional development of the health trainers, the programme has brought other unexpected benefits for the VSOs. These include greater recognition of their organisations' existing activities and services that fit within health promotion in a broad sense. For some of the VSOs this has stimulated interest in developing other health related activities that can link with the health trainer service and in looking for opportunities to develop their volunteer programmes in ways which complement the Health Trainers programme. Overall, the VSOs acknowledged that at times overcoming different institutional ways of working has been challenging. Some had experienced difficulties of working within a framework that was perceived to be 'too statutory' and counter to their VSO identity and the value base which informs their practice. Not all of the VSOs shared this view and others commended the PCT for having the imagination to commission the voluntary sector to deliver the Health Trainer programme, using VSOs to reach out into the community and find out about the local needs. This in their view has strengthened links between the PCT, VSOs and the local communities.

Chapter 4: Findings from Part 2: The client perspective

4.1 Introduction

This chapter presents key themes that were identified in the extension study, through the interviews with clients who had recently completed or were near to completing all their sessions with a health trainer. In order to retain the anonymity of clients in the findings chapter, the only details given alongside quotations are the relevant gender and age range. Data relating to the sample and data collected for the purposes of the national evaluation is also presented at the end of this chapter.

4.2 Setting and achieving goals

During the interviews, clients were asked what changes they had wanted to make and about the process of goal setting, i.e. how for example their health trainer had helped them to set goals. A large majority of clients (14, 70%) spoke about improving their diet. In most cases this was with the aim of losing weight, although in two cases this was in fact in relation to improving emotional wellbeing and general health. Eight (40%) of these clients also talked about setting subsidiary goals or objectives around improving their fitness or incorporating more exercise into their daily routine, in order to help with weight loss and/or improve their sense of wellbeing. Three clients (15%) had set goals around smoking, two of which were to reduce smoking and one (alongside working on her diet) to stay off cigarettes (after already quitting). For two older clients, the goal was unclear, although these could perhaps be classed as 'social isolation'. Both of these clients spoke of their needs being around support to 'get out'. However, the goal was defined as 'fitness' by the health trainer in one case.

It was particularly difficult to assess the effectiveness of the health trainer's support in achieving goals in such cases where no explicit goals had in fact been set, and the goal-setting element of the health trainer role had not been communicated to the client. One older client did not even know she had a health trainer as the support received had not been described to the client in these terms. Several older people, two of whom had serious physical health problems (and spoke of how they considered they did not have many more years to live) considered the idea of 'goal-setting' as irrelevant to them:

I haven't got any goals, I'm too old to have any goals! (Female, 75+)

We didn't talk about anything to do with goals - it was just chit-chat. (Female, 75+)

I live from one day to the next. I don't think setting goals is helpful. (Male, 75+)

Even where clients were working towards an aim, there were a few cases where the client had not been overtly approached with the language of goal setting, perhaps because this was not something they judged to be helpful to the client:

We didn't talk about goals with the health trainer. I don't remember her mentioning anything about goals. (Female, 65-74)

An issue was highlighted around how goals were set and if these were always in line with the perceived needs of the clients or whether these were moulded to fit in with the agenda of the Health Trainer programme. As noted above, some older clients, for example, expressed needs around having some company to get out, rather than setting goals for behaviour change, as one expressed:

I was desperate for somebody to come at the weekends when my paid carer's not here to take me out for walks and just friendship as well. (Female, 75+)

Another older person found the goals set by her health trainer around walking to get ore exercise unworkable in practice because she had no-one to walk with and didn't like to walk alone. However, this wasn't something that was addressed in the sessions:

[...] everyone I know walks with a stick and when I'm with them I'm having to slow right up. They're not in a position to walk with me. (Female 65-74)

Another client, who was working towards reducing his smoking, spoke of other concerns which were more important to him around housing, mental health needs, social isolation and diet. He expressed a lack of understanding as to why the health trainer was focusing on the smoking issue, since he felt diet issues were more important to him in relation to the physical health problems he was experiencing:

I wanted to lose weight but then [HT name] only deals with the smoking side, I don't know why. She said she only wanted to focus on one thing at once. (Male 55-64)

Some of the older clients and all the younger clients, however, found the concept of goal setting helpful, particularly the way in which the health trainer helped to break-down the action plan into small, realistic steps that could be easily incorporated into the lifestyle of the client. In particular this seemed to work where it did not require him or her to make dramatic changes that may be difficult to sustain and were therefore viewed as achievable:

We talked about being realistic, you know, setting small targets. Then the changes that would be permanent changes [...]. And the other thing that I really liked was that it could fit in with my lifestyle, 'cause I could make the appointments that suited around work and family life. So I didn't have to think 'Oh God I've got to go tonight at half past eight' I could look at my diary and think 'well I can fit her in at that slot'. So that was really important to me, because again it didn't give me an excuse to wimp out. (Female, 45-54)

Each week we'd set a different goal like doing something different that I could do to change the way I was eating and stuff. And different things that we could do each week: like one of mine was to stop eating chocolate. With her encouragement I went from eating three or four bars a day, to a couple of bars a week. (Female, 21-34)

A large majority of the participants interviewed felt that the scheme had been beneficial to them in helping them achieve their goals. A few clients reported dramatic changes in their eating habits and were very pleased with the progress they had achieved through the support of the Health Trainer intervention:

I've like lost loads and loads of weight. I'm more healthy than I was, and I don't eat junk food continuously now! So it's really good, I'm really pleased with myself. (Female, 21-34)

Although the programme statistics suggest the majority of clients fully achieve their goals, the interviews showed a tendency for change not to happen as quickly or to the extent to which clients may have hoped. Setbacks to achieving goals were often felt to have been owing to, as one client described: 'life getting in the way'. Indeed, progress was sometimes hindered by unforeseen events such as illness of the client or other family members, or stress resulting from other family or work issues, moving house and so on. Nevertheless, many of the interviewees felt encouraged and considered the support received from the health trainer had helped to put them 'on the right track' and helped to kick-start the changes that they felt they could continue to work towards without the ongoing support of a health trainer:

I haven't really achieved where we wanted me to get to, but with all the other stuff that's been going on I'm still pleased with where I've got to, but it will be an ongoing thing anyway. So I feel a lot better in myself, I look a lot better than I used to. (Female, 35-44)

4.3 Wider impact

Although most clients were focusing on goals around diet/weight loss, some indirect benefits had also been achieved in other areas. These were either in relation to a secondary goal or unintended outcomes of the emotional support received through

the intervention, which extended beyond the specific aims they had set themselves in the sessions.

One client who was seeing a health trainer in relation to diet, found that the support received had also helped him in his recovery from alcohol addiction and improved his sense of emotional wellbeing, allowing him to come off medication for depression which he had been taking for 6-7 years:

I was expecting them to just sort out my diet, I didn't actually realise that it would aid my recovery as well because basically the food that I eat now compared to before, I was eating a lot of fried food, now I eat all my fruit and my veg, but I know that, like I always eat bananas now, and that helps with my moods, because I used to suffer from depression but I don't even take medication from the doctors no more for depression. I just sort it out with my diet. (Male, 21-34)

Similarly, another client who was principally working on improving her diet through the sessions with the Health Trainer spoke of how the support she had received through the scheme had been helpful in recognising the link between smoking and food (i.e. substitution) and instrumental in sustaining her efforts to quit smoking:

I'd been smoking for about 28 years and this is the first time I'd ever really seriously stopped it. (Female, 35-44)

Some clients spoke of the way in which their Health Trainer had taken an holistic approach in focusing on helping them to examine and better understand and address the underlying practical and emotional reasons for their behaviour and the importance of the wider influence of other aspects of life:

I was really stressed out and she sort of helped me. We looked at the whole big picture instead of just looking at the weight problem. She said 'We won't concentrate on your weight, just to start off with we'll concentrate on making the time for yourself'. That was the biggest thing – she helped me sort of evaluate my life so that I had time to concentrate on myself, so that I wasn't just eating. I think that's what's worked with me, because she looked at the whole big picture rather than, just 'yeah, you've got to lose three stone' or whatever! (Female, 45-54)

He's very easy to talk to about these things, and he wasn't just interested in your health he was interested in, you know, going 'do you go out?' sort of thing 'what about joining this club? I know it's a very good one' and things like that, and 'I'll go with you for the first time' which we haven't done yet. Currently if the weather holds we'll do it this week. So he's very interested in the all-round of your health, not just one aspect of it. It sort of makes you...gives you a bit more confidence, in doing the things that you had lost, you know. (Female, 75+)

One client also found that the support she received through the health trainer intervention had resulted in a physical health benefit in relieving symptoms associated with arthritis:

...because, as I was watching my diet, I did get a bit less pain: so I was taking a few less pills. (Female, 75+)

In addition to benefits experienced by the clients themselves, a few clients spoke of how the scheme had also impacted those around them, e.g. in changing the eating habits of other family members:

I mean it's changed me, I mean my wife as well, the two of us since the end of December we've lost just coming up to 10 stone. So it has actually changed both of us, to be kind of more positive. (Male, 45-54)

The way I'm being with food is going onto my daughter. Because I walk around drinking water all the time my daughter's drinking water all the time. It's educated us all I think. It's definitely better. (Female, 21-34)

4.4 Friendship, understanding and motivational support

Most clients felt that the health trainer had demonstrated an authentic understanding and sensitivity towards their circumstances, and several spoke of how they felt encouraged and inspired through the friendly and understanding approach of their health trainer:

Her approach was so easy going and so understanding and I found this really helpful because she shared with me her life as well. You know, I know she doesn't have to do that, but I think the help with some of the circumstances – because I'm on my own and she raised her children on her own from quite a young age – when she talks to you about some things that happened with her children when they were younger it made me realise, well yeah, yet she's still so positive and bubbly, and I just thought 'yeah, anyone can achieve anything.' (Female, 35-44)

I'd like to think in a way that she's become more of a friend. To think that I'm not going to see her after this week feels a bit sad really, because you know, she's been there to talk about anything I feel. She said we can use the sessions for whatever, so if I needed just to talk to somebody about something if that then helped me to not reach for the chocolate or whatever then that was a bonus. (Female, 21-34).

She was very sympathetic and understanding about when you're elderly and don't get any exercise and all that, and want to enjoy life as well as lose weight. She's very good, she is very good. And very helpful, because she was so sympathetic and all that sort of thing, it made me think twice about eating too many cakes and that sort of thing. (Female, 75+)

Alongside the friendly and approachable manner of the health trainer, many of the clients spoke of how the motivational support of a health trainer was particularly important to them. Although for some, there were benefits in learning new information or raising awareness of health issues, the main value of the intervention expressed was around the motivational input which supported clients to put into practice what they 'already knew'. In particular, clients were motivated by having someone to 'report' back to:

I've had someone to answer to. So when we've set the goals, she's going to be here in two or three weeks saying 'so what have you done?' you know. She doesn't tell me off but I don't want to let her down, I don't want to let myself down. (Female, 21-34)

I just feel that, I think anybody, if they've got somebody watching them or coming to see them, you do more – you're inclined to take more notice of them than you are of yourself. I mean he said 'think that I'm on your shoulder all the time when you're gonna go and nibble.' [...] So I think it's just because you've got somebody behind you. (Female, 65-74)

Clients were also often motivated to keep working towards their goals through the positive encouragement expressed by their health trainer:

She just walked hand-in-hand with me, you know what I mean? Just, you know, even just simple praising, you know, for someone else to say to me, you know, you're really doing brilliantly. (Female, 35-44)

A particular motivational technique that some clients adopted on the suggestion of their health trainer was 'reward giving', i.e. the client giving themselves healthy rewards for achieving their objectives. This was particularly beneficial in helping client develop self-motivational skills. These didn't have to involve any financial cost, but tended to focus on simple ways to relax and find enjoyment in activities that didn't involve eating:

I always used to reward myself with food, with chocolate or biscuits in peace and quiet when the kids aren't around. But no, when the kids aren't around and you've got peace and quiet and if you feel you've done something good, find something else to reward yourself like sitting down with a book or a nice long soak in the bath. It's finding things like that. That was another thing helping me. (Female, 21-34)

4.5 Providing information, suggesting and advising

Some clients spoke of how they welcomed the health trainer's gentle approach to suggesting and prompting new ideas. Several clients spoke of how health trainers were particularly helpful in providing information and signposting to local services

that may be of benefit such as gyms or other relevant resources and activities the client may benefit from:

We started talking naturally because we're both local, we would talk about local things. Then as I say she had things that she brought in obviously specifically from my form I'd filled out, and said 'well this is available, that's available.' (Male, 55-64)

She gave me the confidence to go back to the gym. She said she could either come up there as well for the first or second sessions or just, I could go up there and kind of carry on with the exercises and that. But she actually got me the paperwork and the information and told me what forms I needed to take with me so, yeah she basically got the ball rolling for me... so I was well pleased about that. (Male, 45-54)

She helped me phone up like certain sports centres and ask about childcare and she gave me group listings of like when mums tend to meet with their kids and go on walks and stuff. (Female, 21-34)

It's nice to have someone who knows the locality. When I wanted to find out about an allotment – because she got me into things like that - of course because she's local she knows the local area. She's brilliant. (Female, 45-54)

Some also spoke of the benefits of the way in which health trainers would work with the client to help reach their goals rather than giving instructions. For some the way in which clients were enabled to think about ways in which they could make changes to their lifestyle was found to be empowering and helped clients to grow in confidence in their own ability to meet their goals:

She didn't tell me what to do or what not to do, so...we have our meetings, and I suppose the ideas come from me and actually that makes you feel quite confident afterwards and 'well actually I can do this'. It's just the fact that she's there to prompt me and point me in the right direction. (Female, 21-34)

...she's explained it and worked with me so easily that it doesn't make me feel 'oh I'm so thick I've never thought of that'. You know, she's always been so positive and like 'oh have you tried that?' you know? So she's never been patronising or I've never felt that she's gone over the top, and I've never thought 'Oh I'm such a wally', yeah I think she's done it in such a good way. (Female, 35-44)

He wasn't overpowering or anything like that, he's got a soft voice anyway so he just quietly talked about things, suggested things and asked me things that were, you know, relevant to the circumstances at the time. He was very good in fact. He's very helpful to me really. (Female, 75+)

I thought that I might have a more rigid programme to follow. I thought she would give me 'you've got to do this and you've got to do that'. But we worked it out ourselves, it was more of a team effort than just being told what to do and I think that's why I liked it. I wasn't given precise things to do. (Female, 45-54)

Some clients also particularly valued the information they had received from the health trainer through leaflets etc. or information as to where to find useful information on the internet. This prompted, in some cases, clients to engage in pro-actively researching issues around healthy eating for themselves:

She's given me lots of leaflets to read and some website addresses to go and look at nutritional values of food and the way that we burn them so that I can get all of the different things out of it. (Female, 21-34)

Although most clients valued the information received from the health trainer, some expressed disappointment around limitations of the support the health trainer could give, for example in not being able to provide them with some of the information they wanted, or tell them anything they 'didn't already know'. A few clients also indicated a lack of understanding of the 'hands-off' approach of the health trainer and indicated they would have preferred a more directive form of support:

Most of the time it's just ticks, because I was doing it right. I said 'I'm probably not the right person to, you know, because I probably know what's what'. (Female, 65-74)

The only thing he couldn't answer me was are eggs good for you or are they high cholesterol? I think they're high cholesterol. He couldn't answer it because it wasn't on his list. (Female, 65-74)

I probably need more of a kick up the bum to get me to do more. I found because she left it to me I just slide back. (Female, 65-74)

As indicated in findings from stage 1 of the evaluation, questions were also raised through the client interviews, as to the extent to which health trainers understand the boundaries of the role. Although the health trainer training was felt to clarify the health trainer role as non-advisory, in practice it seems that health trainers often did advise clients and it was not possible to establish the basis of this advice. The interviews raise questions as to how realistic it is for health trainers to avoid giving any advice (clients often expect and welcome this). Although most of the advice suggested by health trainers was welcomed and useful, there were also instances reported, in which advice had been questioned or considered unhelpful, and even in which the advice could have had a serious detrimental effect, due to the health trainer's lack of knowledge of the client's medical circumstances. Most notably one client spoke of how she was advised to take an exercise class that was inappropriate (and possibly even dangerous) because of a particular physical condition:

[...] there's no way I could do that, it would really hurt me. So I only went to one lesson and I'm afraid I backed out of that one. She thought I would have been alright with it, but uh-uh. (Female, 65-74)

In another case, a health trainer was giving quite extensive support to a physically disabled client who was suffering from diabetes. The health trainer advised on exercises to carry out in the wheelchair and in terms of labelling foods etc:

He delved into different things and he looks through all of the food in the cupboard and in the fridge and read all the instructions that I can't do and tell me 'that's a no-no' and 'that's ok', sort of thing, and he gave me a card with all the different things so that if you were shopping you'd be able to know from the colour on the tin or whatever it was, whether it was bad, a high risk, medium or low (Female, 75+)

The client in this case was positive about the support received. However, this is an example which highlights a concern regarding circumstances in which health trainers may be offering specialist advice which assumes particular knowledge, whilst the source and reliability of this knowledge is unknown.

4.6 Paperwork

The extent to which paperwork had been used with clients varied. One client thought there was too much paperwork, since this may be off-putting to some:

I did find the A4 sheet with all the little columns in it was difficult to complete, and as I said, at the same time I do wonder people with poor literacy skills might be a bit over-awed by the paper, the implications of a lot of paperwork. (Female, 55-64)

Some clients reported their health trainer had used little or no paperwork with them. This was particularly the case with some of the older clients. In one case, an older participant noted that making a written record had been suggested, but she did not feel this would have been useful:

I haven't written anything down. It was...he did suggest that, but I never seem to get round to that. But I know what my goals are without writing them down. I know what I want to do, so there's no point in writing down: 'I want to lose weight' or 'I've got to do something else'. I know that in my head. I didn't see any need to write it down really. (Female, 75+)

In other cases, where paperwork had been used to a small or no extent it was not clear whether this was owing to judgements made on the part of the health trainer as to the inappropriateness, or the inability of the client to use and understand the paperwork. One older client who did not think she had even been seeing a health trainer (as the service had not been communicated to her in these terms) and had health problems which affected her memory, could remember being given some

leaflets but couldn't remember what they were about or where she had put them. In such circumstances, where there was a lack of understanding as to the purpose of the health trainer intervention it seems that paperwork around goal-setting would not have been understood and would have seemed irrelevant. A few older people, however, found the paperwork more helpful:

She gave me a booklet about how to eat more healthily and also I started off making a record of everything I ate, she gave me forms for making a record of everything I ate, which I found very helpful. Obviously if you think about what you're eating you're sure to not overdo things. I found the paperwork useful. (Female, 75+)

Younger clients also tended to find the paperwork used in the health trainer sessions to be useful and to have been worked with in a sensitive and helpful manner. In most cases paperwork was not considered off-putting and did not seem to create any barriers in terms of building rapport:

The form part I don't mind at all and I find it really helpful. I can see they're so well put together that if somebody wasn't finding that easy to do, she's really helpful – you know, she doesn't give you the answers or do it for you – but she'll say, you know, for example 'in this bit it's looking at this part of it' so it's not daunting at all (Female, 35-44)

Some clients found making a written record of goals and other visual aids such as 'wheel of life' charts and the 'confidence ruler' to be helpful in order to clarify goals and chart progress.

It was written down and I had to sign it as if it was like a little contract between me and her, which made me want to do it more rather than breaking a contract! (Female, 21-34)

The discipline of keeping a food and/or exercise diary was often found to be particularly useful in increasing awareness and helping to identify areas to focus on:

It was useful to keep a diary because it shows us what you are doing, and then somebody else can look at it and say 'well, you're drinking about 10 cups of coffee a day, is that really healthy? Why don't you change one of those to water?' Which is something that I have done, I found that very useful. It's something I didn't realise. (Male, 55-64)

I did do a food diary and it was really a case of keeping the food diary which I did find helpful actually, because once I was a bit dismissive but it does work, it makes you focus on what you're doing, and aware of what you're doing, which one doesn't always have. Definitely the exercise one made me more aware. (Female, 55-64)

When I'd had a good week I could refer back to when I'd had a bad week and could think 'I didn't lose any weight that week' and I could go back to the week that I had lost the weight and look at those ones and the trigger points. She'd say 'what made you pig out that day?' and I'd think about it and I'd remember writing it down. Because if you write it down you remember it more, don't you? So I thought 'oh I'm not going to do that again'. So yeah – it's nice. I've got a folder with it all in. (Female, 45-54)

If I hadn't have done it [food diary], I wouldn't have realised how much I was eating in the course of a day, and then spread it out over the course of a week and I think it was more a case of am I really eating that? And is that what...? And when I look at it myself sort of thing, you break it down and you think, wow I'm eating more than what I thought. (Male, 45-54)

It was quite nice because I had a little sheet that I used to write down everything I'd done and she could say 'Ok you've done this, that's better, and what do you need to improve on next?' (Male, 21-34)

In one case, where a client a client commented that she felt it would have been helpful to have continued for longer with the food diary but stopped after the first week on the advice of the health trainer:

I didn't do the food diary after the first week because she said I didn't need to, so I didn't bother again. I think if I'd done that the whole way through then it might have been a better idea because then you can see where you're going wrong. Can't see you're going wrong if you only do it once. (Female, 65-74)

4.7 Comparing and understanding the Health Trainer role

4.7.1 Comparing with health professionals

Most clients were in regular contact with other health services and there was little evidence that the scheme had been successful in meeting its aim of recruiting those who are not already in touch with services or who may be reluctant to seek help. However, the majority felt that the health trainer scheme addressed a gap in services. Even though in some cases other forms of support were available and had in some cases been utilised, advantages over support available through a health clinic, dietician or support group were noted. In particular, some clients spoke of the value of the greater time and attention, convenience, approachability and flexibility of the health trainer service in comparison with the more formal and time-restricted service provided by health care 'professionals':

Doctors don't have the time do they to keep following up? So it's quite nice to know there might be somebody to back you up. You know, I think it's a very good thing. [...] for me it's been easy because [HT name] comes here. Once I've gone down to her office but every other time she's come here so I don't have to worry about childcare...it's in your own home, so you're relaxed and you're at ease. You're not sitting in the doctor's surgery where everyone tends to clam up a bit. (Female, 21-34)

I'd say it's a lot more informal, which to me is nice. Sometimes if you've got a GP going up to you and saying 'Don't eat this!' sort of thing then you just might not pay attention to them. (Male, 21-34)

In our area it's virtually impossible to see nurses and doctors. You have to plan to be ill six months in advance! No... so the health trainer is more approachable. I mean if I want to see her again she says I can. We know where she is - we go down there quite often, whereas with the doctor, for one reason or another you can't really talk to them. She said if you need to get in touch, I've got her mobile number and she said to just get in touch. (Male, 55-64)

I would never ever think of going to the doctors for the weight problem, although I know you can. I would only go to the doctors if I was ill! So it wouldn't have entered my head. Although I have been to the doctors as I've been signed off work with stress and everything, but I just got tablets and got signed off, I wasn't offered anything else. (Female, 45-54)

Well a health trainer comes to the house like that and he gets involved in things that are in the house on the spot, you know, whereas if you go to a dietician in the hospital you just go there for a few minutes and talk and then you leave, sort of thing. I asked if I could see her again to keep it sort of, what's name, but she didn't offer to see me again, so I found that his help was more than what I really got from the dietician. (Female, 75+)

Clients tended to see the health trainer role as distinct from that of a health 'professional'. Most felt the support received from a health trainer was more 'on-the-level', with some talking of the value of sharing a similar background in terms of life experiences. Many felt the health trainer demonstrated a greater sense of genuine non-judgemental interest and concern than other health professionals and therefore found them easier to relate to and build a trusting relationship with:

She was there to not judge or criticise but to help and bring out any positives and get rid of negatives. I mean it has helped a hell of a lot. I mean to compare the two I would say a health trainer is more of like a positive builder whereas a nurse would be more kind of do it because it's just a job, so yeah. I felt like I wasn't patronised or judged or anything, no. (Male, 45-54)

He's very quiet, he's not ...he doesn't make you feel as though he's pushing past the mark or anything, he just listens you know and replies, which is good. Because sometimes you get people who are so busy telling you what's good for you that they don't listen. You get brow beaten a bit sometimes! You get a little bit of it from health professionals but not from him. (Female, 75+)

I confided in him and I told him things that, you know, the doctor wouldn't know. (Male 65-74)

Some clients, however, felt that their success in achieving their goals was owing to the combination of the support they had received through the health trainer intervention and other services. For example, one client, who had given up smoking, appreciated the helpful combination of medical support she had received through a nurse alongside the motivational and emotional support available through the health trainer:

'Cause with [name of HT] I can sit down and like chat chat, you know, and talk about what I'm doing and what I need to do and things, but with my nurse, [name] she gave the patches, and just it was general, just about smoking, do you know what I mean? It wasn't anything kind of other - do you know what I mean? So, it was a really good balance for me to have. (Female, 35-44)

Another client, who was recovering from alcohol addiction, noted a wide range of support he had been able to receive through a range of services available to him, and felt the Health Trainer service had strengthened the effectiveness of these other forms of practical and psychological support received:

I class it as a jigsaw puzzle, the more bits that I've got, the easier it is. (Male, 21-34)

4.7.2 Comparing with support groups

Most clients also felt there were advantages of receiving support from a health trainer, than participating in a support group. In particular, the more relaxed nature of the personal one-to-one support received through the health trainer service was valued by a number of clients. The alternative of talking about weight loss or smoking cessation in a group context was something a number of clients did not feel comfortable with:

It was lower key than being dragged off to a weight loss club and that sort of thing. (Female, 55-64)

I think I prefer seeing a health trainer. I know I've been in groups before but some of these are a bit of a 'very good idea!' clap and cheer and you know sort of thing. I'd prefer not to do that sort of thing. (Male, 65-74)

It takes confidence with meeting new people. I'm shy. [HT name] suggested going in the big groups [smoking cessation] so I said 'no'. (Male, 55-64)

Some clients who had previously tried weight loss groups such as Weight Watchers and Slimming World also felt that dieting regimes imposed by such groups had not been helpful to them, and some also noted that the expense of membership was off-putting:

I think totally I'd never go back to that [diet group]. It's just yo-yo dieting, because as soon as you come off of them, unless you're really strict, you end up having to keep going back onto them. Whereas I would hope what I've done with [HT name], I've changed the way I eat, hopefully I've changed what the children are eating. (Female, 21-34)

I have tried the others. One, the cost put me against them. And then two, I didn't like the group...I didn't get on with them at all. I much prefer the one to one. And the fact that she didn't just concentrate on the weight: it was why I'd put on weight and how I could...With the others they give you a diet, we just talked about healthy eating and changing my habits and everything, more than you know you've got to stick to so many calories or points or whatever...those are too regimental for me. So it was much better. (Female, 45-54)

I could still go to a slimming club but for one thing when you're elderly going to a slimming club you feel so stupid and of course there's not much of a result when you're elderly – well I find so anyway. I want to lose it because it would be better for my arthritis but then I don't want to sort of go on a rigid diet at my age because I like my food and my drink!" [...] they don't care at slimming club as long as you're paying. They just say 'oh try harder to lose next week'. It's nice to think there's a personal interest you know, with somebody coming. It's more caring. Of course you need when you're elderly to think that somebody's interested to help you on. (Female, 75+)

One client, however, felt that the support received through a slimming club was in some respects more helpful as she learnt new information about fattening foods through the slimming club and had a greater understanding of the methods used. In comparison she was disappointed at not having learnt anything new through the health trainer:

Can I be honest with you? In the end I didn't really know why I was going in the end. I'm still not sure what they're meant to do for you in the way of health training (Female, 65-74)

A few interviewees felt that health trainer role ought to include the option of being

weighed as this would be beneficial to them:

I think if you could have been weighed at the time so that you've got to show somebody what's what that would've been quite helpful... so he can see for himself whether you have or whether you haven't, and if he... but of course although he is classed as a Health Trainer he can't do anything like that or, you know take your blood pressure or anything like that, so... that's, in my case where it was the weight that I went for in the beginning, it would be helpful to me. (Female, 65-74)

If you're looking after people and helping them with diet, in my opinion they should provide the things ...I mean, to find a decent set of scales [...]. The bathroom ones you can buy are useless. If I stand on them the thing spins round about 10 times, you know! I know they cost a bit of money but I'll push for that. (Male, 65-74)

One client noted that she was given the option of being weighed in the sessions and she had found this helpful:

It was my choice to get weighed every week and I had a chart that she kept so I could see my progress and the wheel of my emotions and how I felt. I found that useful. She always started the session with did I want to be weighed? But I always did even when I knew I'd put it on, so that was my choice. (Female, 45-54)

4.7.3 Counselling / life-coaching

Some interviewees likened the health trainer service to that of counsellor or life coach, but for some the low-key approach of the health trainer was preferable to seeing a counsellor:

I suppose it's the approach because it's so personal. I talked about lots of things with her in confidence, and I felt very reassured that it was confident, and I could say lots of things to her. I found myself saying things out loud that I hadn't even admitted to myself. So I suppose it was counselling in a way, but because it didn't say it was a counsellor it was much easier. (Female, 45-54)

It's been nice to have someone other than my family to talk through things. In a way it's a bit like a mini counselling session to a certain degree, there's got to be that sort of element in the type of person in role because you are opening up your life, you know, I've just been so up and down with everything, I've had a few problems and she's been great. (Female, 21-34)

For some clients who had been experiencing mental health needs, however, the support of a counsellor may have been more appropriate. Two clients expressed that although they were hoping to address issues around emotional wellbeing, they had come to realise this was beyond the remit of the Health Trainer project. One of these had been seeing a counsellor beforehand and expressed disappointment with the

fact that the health trainer had been unable to address the issues that he felt were important to him. Unfortunately, since he suffered from a physical disability, he was unable to afford the cost of transportation to be able to visit the counsellor:

I wanted more of the counselling side really not what [HT name] does. It's a pity. That costs me about £20 a time in the taxi. [...]. The lady counsellor has been a lot more helpful than [HT name]. (Male, 55-64)

Another client felt that she had not been able to benefit as much from the Health Trainer scheme as she would have liked because she had been suffering from depression during the time of the intervention:

I think she had me at the wrong time. Because I think I was too depressed when I first started it. So it was only several weeks on and the tablets take about three months to get into your system. (Female, 65-74)

4.7.4 The term 'Health Trainer'

Several interviewees commented on how they found the health trainer role to be something other to what they first expected. This may in part be owing to the title of 'Health Trainer' which has been found to be misleading:

I think the term 'trainer' is a bit of a misnomer because you're more of an advisor-cum.... it's gone out my head now, begins with an 'm'.. erm mentor, that's it, you're more of a mentor in that way than... because a trainer is, I did think 'oh my god we're going to be running round the block and things like that.' (Female, 55-64)

I think because of the term 'health trainer' I think when I've told people that I'm seeing one in [town] they thought it was a fitness trainer you know, and I said 'no it's not, it's actually looking at your life and areas you want to maybe make improvements on. (Female, 21-34)

4.8 Sustaining change

Whether or not clients had been as successful as they had hoped in meeting their goals, most felt that they had or would be able to maintain the changes they had made and to push these further:

I haven't had a huge weight loss but I have lost weight and I've kept it off, which gives me the confidence to just carry on and progress and see what happens, you know, because I don't usually keep the weight off, it all springs back. (Female, 55-64)

Some, however, were concerned about their ability to maintain changes after the health trainer backing had gone.

I won't make a change unless I have someone standing behind me. As soon as [HT name] stops, I'll stop. And she's stopped now and I haven't been to the gym since. That's me.... As soon as the backing's gone, I don't maintain it. I just go back to my old ways. (Female, 65-74)

In some cases the momentum of change had also been interrupted due to gaps between sessions being prolonged:

During that time [HT name] went away on holiday for a couple of weeks and unfortunately I had a couple of problems health-wise myself so I had to go to the doctors for that. So I sort of interrupted it until sorted those things out. But you know I really want to go back and start again, more start from scratch because I was doing very well, I lost about a stone and a half in weight in about a month but I've put it all back on again. (Male, 65-74)

Some clients talked about techniques they had learnt, such as keeping a food diary, which had or they hoped would help them to carrying on making changes after the course of the sessions had ended:

Hopefully I can carry it on when I finish, yes. My husband's been putting them [food diaries] up on the computer for me and giving me more than I need. So when [HT name] stops giving them to me I will make my own, and I think for a little while I need to keep going on this chart really. 'Cause once the chart isn't there I will probably stop. (Female, 65-74)

So it's just got to that stage when she has gone, and I'm not seeing her, am I still going to be able to maintain it? And keep myself on the right track and set little goals. But she said this week as the last week she'll give me a plan and some stuff that helps me get through and helps you to set your own self goals and everything. So apparently I'll be fine! (Female, 21-34)

Although most clients felt they did not need many more full sessions with the health trainer, several noted the importance of bringing the sessions to a gradual end, and in keeping some channels of contact open with the health trainer, once the sessions have ended:

I think that after you've finished with them you probably need one perhaps that month, then one the next month - just to see if you...to catch up with you and see if you're actually doing whatever they said to do. Because I don't think...you lose the support of them once you've finished with them. That's it – they're gone. She didn't say I could phone her or anything. She said 'this is your last one' and you're on your own mate! She didn't say that but you know what I mean! (Female, 65-74)

I'd like to, if she's willing to let me, you know, just keep her updated because I think that will be good if I can just drop her an email once a month saying 'Hi, this is where I'm at and this is what I've achieved' you know... because that was really good and to suddenly lose that would be quite hard [...]. I think the support is really important because it's like the aftercare really. You've had a treatment in effect. (Female, 35-44)

For some, a connection with the host organisation was reassuring, as it gave the sense of continuity, inasmuch as the client would still have the opportunity to see the health trainer from time to time and perhaps stop and have a brief chat:

I know that although I won't be seeing them anymore I can always phone them or pop in. I know they're not permanently funded but I'd hate to think that they weren't there. It's important to have that kind of ongoing contact. (Female, 45-54)

I don't feel as if I've been signed off. I would love to pass her next week and say 'oh yes I've lost another pound this week' which I possibly will. [...] knowing she's there is the main thing. (Female, 75+)

4.9 Background data

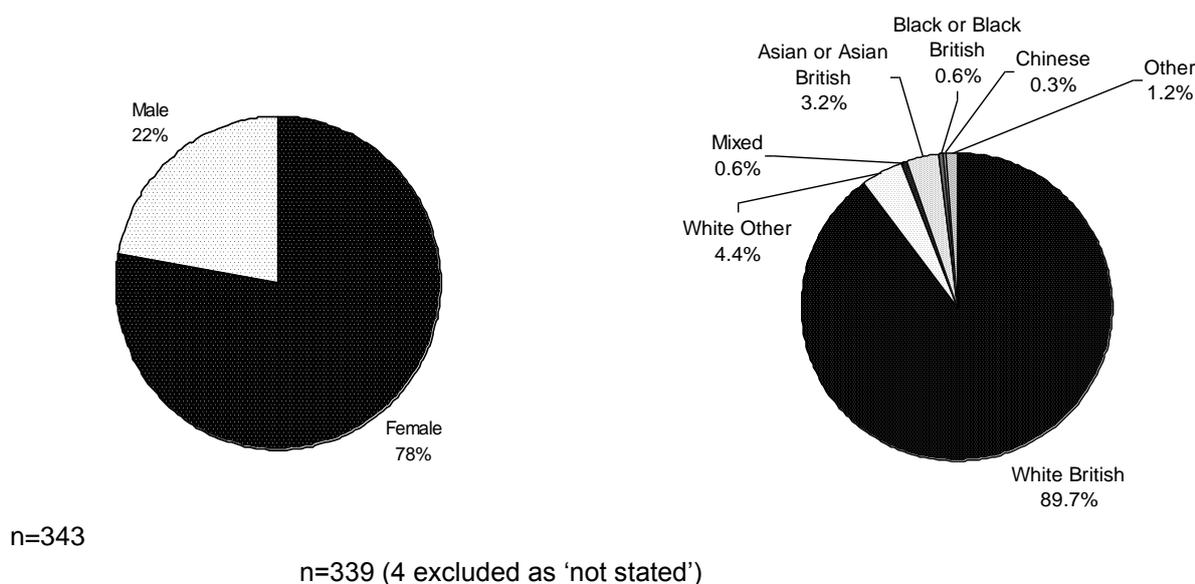
4.9.1 National dataset

At the time of the evaluation client data were being collected by health trainers and collated in a central dataset, for the purposes of the national 'evidencing delivery'. West Sussex PCT (Primary Care Trust) provided the researchers with some of these data. These showed that health trainers had seen a total of 343 clients (as of 04/09/09) and as shown in Figure 2, over three quarters (267, 78%) of these were female. A large majority, (304, 90%) were reported as 'White British' which

compares with 94% of the overall West Sussex population² and over a quarter were aged 65 or over, which compares with 20% of the West Sussex population.³

Therefore older persons were slightly over-represented among users of the service. The age breakdown of total clients and how this compares to the sample is presented in Table 6 below.

Figure 2: Pie charts showing the distribution of clients by gender and ethnicity

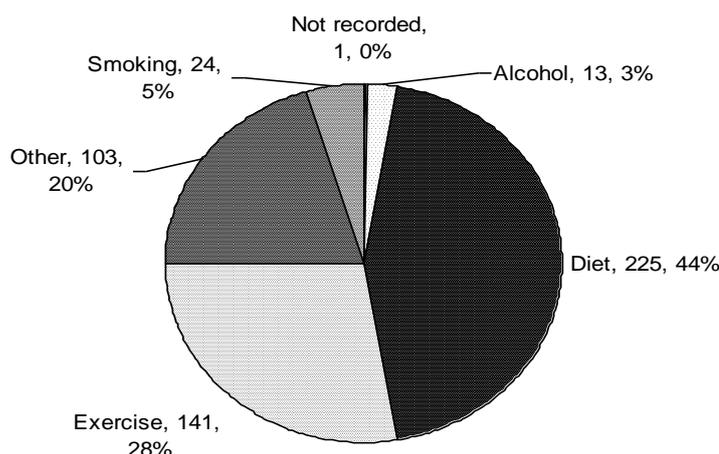


It was possible for clients to be working towards one or more goals. Therefore, as shown in Figure 3 below, more goal areas (507) have been recorded than clients in the database. Often, for example, diet and exercise goals may be combined. However, it is clear that the majority of clients were seeing a health trainer in relation to issues around diet or exercise (72% of goals). A much smaller proportion of goals were focused on smoking cessation (5%) or cutting down on alcohol consumption (3%). No breakdown was available regarding the other key areas of sexual health and mental health / social isolation as these were included in the 'other' category (20%).

² (2001 National Key Statistics Table KS06: <http://www.statistics.gov.uk/StatBase/ssdataset.asp?vlnk=8919&Pos=&ColRank=1&Rank=240>).

³ (2001 National Key Statistics Table KS02: <http://www.statistics.gov.uk/StatBase/ssdataset.asp?vlnk=8915&Pos=&ColRank=1&Rank=240>)

Figure 3: Pie chart showing distribution of goal areas



Out of the 507 goals recorded in the database, information on whether these had been achieved was collected for 292 (58%) of these (some had not yet completed their sessions so this information was not applicable). The decision as to whether the goal had or hadn't (or had been part-achieved) was made by the health trainer in the last session after discussion with the client. At this stage, 222 (76%) goals were recorded as fully achieved, 37 (13%) as part-achieved and the remaining 32 (11%) as not achieved. As shown in the Table 6 below, the greatest success was recorded in the area of diet (82% of goals had fully been achieved in this area), whilst less than half (47%) of goals relating to smoking cessation were reported as being fully achieved. Some follow-up data were also collected 3-6 months after client sign-off. However, the data made available to the researcher were very limited and did not allow any meaningful findings (in relation to the extent to which changes had been maintained) to be deduced.

Table 6: Goal area by goals achieved / part achieved / not achieved

| Goal Area | Achieved | Part Achieved | Not Achieved | Valid Total | Valid % fully achieved | Not recorded/ required | Total goals |
|-----------|----------|---------------|--------------|-------------|------------------------|------------------------|-------------|
| Diet | 115 | 16 | 10 | 141 | 81.6 | 84 | 225 |
| Exercise | 58 | 13 | 10 | 81 | 71.6 | 60 | 141 |
| Alcohol | 2 | 0 | 1 | 3 | 66.7 | 10 | 13 |
| Smoking | 7 | 3 | 5 | 15 | 46.7 | 9 | 24 |
| Other | 40 | 5 | 6 | 51 | 76.4 | 52 | 103 |
| NR | 1 | 0 | 0 | 1 | 100 | 0 | 1 |
| Total | 223 | 37 | 32 | 292 | 76.4 | 215 | 507 |

NR=not recorded

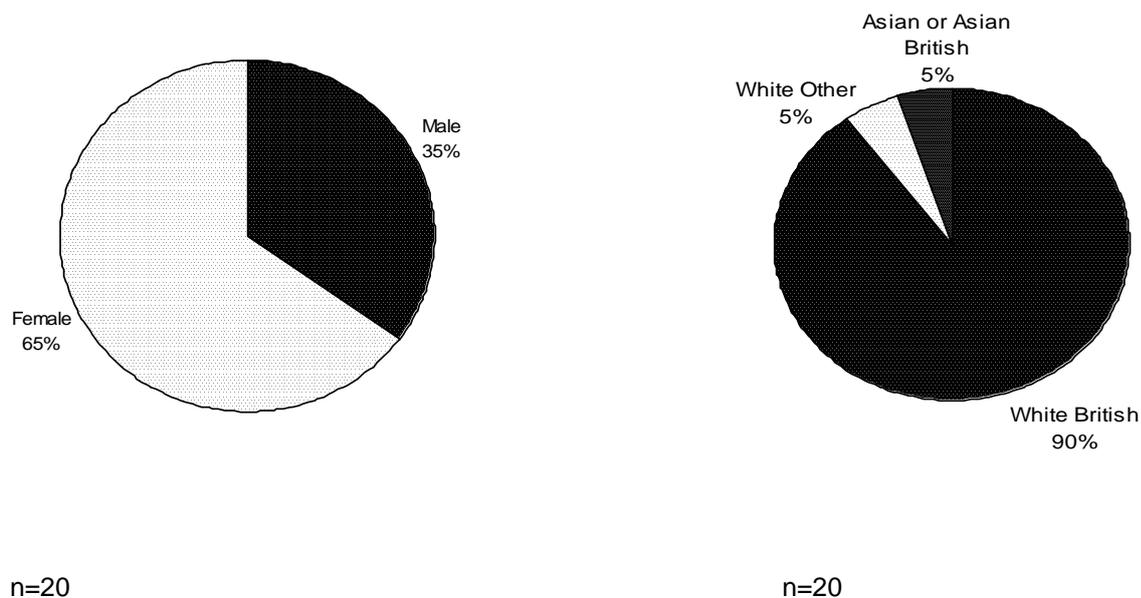
4.9.2 Sample data

The following information was collated through the use of a short questionnaire (Appendix 7) which participants were asked to complete at the end of the interview:

Gender, ethnicity and religion

13 (65%) of interviewees were female and 7 (35%) male. Therefore male respondents were over-represented in relation to total clients recorded in the dataset. 18 clients reported their ethnicity as 'White British' which equates to the same proportion (90%) of 'white British' clients in the dataset. Other ethnicities of interviewees included 'Other Asian background' and 'White European'. Most participants (12, 60%) reported their religion as Christian, 1 (5%) as Muslim, 1 (5%) as 'Other' and 6 (30%) as having no religion.

Figure 4: Pie charts showing the distribution of interviewees by gender and ethnicity



Age

The sample included clients with a variety of ages ranging from 21-86, and five interviewees were over 75. As shown in Table 7, older respondents were slightly over-represented when compared with total clients. However, this gave an opportunity to explore issues around the appropriateness of the model for older people.

Table 6: The age distribution of the interview sample, compared with the age distribution of the client dataset.

| | Sample (n) | Sample (%) | Dataset (n) | Dataset (%) |
|-------------|------------|------------|-------------|-------------|
| 18 – 25 | 1 | 5 | 24 | 7.8 |
| 26 – 35 | 2 | 10 | 40 | 12.9 |
| 36 – 45 | 2 | 10 | 50 | 16.2 |
| 46 – 55 | 2 | 10 | 44 | 14.2 |
| 56 – 65 | 6 | 30 | 71 | 23.0 |
| Over 65 | 7 | 35 | 80 | 25.9 |
| Valid Total | 20 | 100 | 309* | 100 |

* 34 respondents in the dataset declined to answer the ethnicity question

Marital status

Just under a third (30%, 6) of interviewees were married and 3 (15%) lived with a partner. Four (20%) were widowed, three (15%) divorced and four (20%) described themselves as single.

Employment status

More than twenty responses were recorded for this question because for some interviewees more than one category was relevant (e.g. retired and voluntary work). Only two participants reported being in full-time employment (10%), whilst nearly half (45%, 9) were retired. Three respondents (15%) reported doing voluntary work, three (15%) as long-term sick or disabled, a quarter (25%, 5) in part-time work, one (5%) a student and one (5%) 'other'.

Accommodation and living arrangements

Over half the participants (55%) were living in rented accommodation. Four of these (20%) were renting privately, four (20%) were in Housing Association property, and three (15%) in council-rented accommodation. Nine (45%) interviewees were living in their own home.

Nearly half the participants (45%, 9) lived alone.

Income and benefits

Three quarters (15) of participants were in receipt of at least one form of state benefit included on the form.

Two people declined answering the question about income. Of those who answered, a large majority (83%) reported their weekly income to be in the lowest band (i.e. £0-£249 per week excluding housing benefit and council tax benefit). Two participants (11%) selected the £250-£449 income band, and one (6%) the £450-£749 income band.

This data suggests the sample of clients largely fit with the target group of the Health Trainer programme, i.e. those from deprived backgrounds. However, as this is only a small sample which was not randomly chosen, it is not possible to generalise this finding to the whole client population. In addition, it should be noted that the data also shows that some clients included in the programme could not be regarded as financially 'deprived'.

Chapter 5: Conclusion

5.1 Discussion

This section summarises and discusses the findings presented in both parts of the evaluation.

5.1.1 Developing the health trainer workforce

The recruitment during the first year was time and resource intensive, both for the VSO supervisors and the Health Trainer Co-ordinator. It involved the establishment of a new workforce to undertake a new role which many do not fully understand. The aim of recruiting to coincide with the ethos of *Choosing Health* and targeting those already active in communities who may not have formal qualifications or who have been out of the labour market created unexpected demands in terms of the support such applicants would need. The potential support needed should be considered in future recruitment and the support needs of existing health trainers is an ongoing issue that needs monitoring. In order to recruit people from the community who may have little experience of the job application process, future recruitments might need to consider the kinds of support that might be helpful in completing the application form.

Some of the health trainers have specific learning support needs which were not anticipated. Although support is offered by the Health Trainer Co-ordinator, specialist learning support should be considered to meet individual needs. The issue of how well the training caters for different learning styles and needs might need to be reviewed as the needs of those who may have been out of the workforce or who have little formal education or qualifications may include literacy and basic skills, IT, as well as confidence building.

Few of the health trainers had yet to consider how they might use their experiences as a Health Trainer to develop their future career. Many expressed some concern that as a new role it is not widely recognised and does not appear to fit within the NHS career structure. Some questioned the value of the City and Guilds qualification in terms of their future employment and envisaged the need to take more specialist training in a specific area. The longer term development of the Health Trainer role and how it fits within the broader health workforce will need to be considered as part of the three year programme and the health trainers felt they would benefit from a clearer understanding of the potential for their own professional development.

5.1.2 Promoting the service

As a completely new programme a key challenge in implementing the Health Trainers service has been getting the service and the role of the health trainers

known and understood in the wider community. This task of getting the right message across has been more difficult because of public perceptions of what the name 'Health Trainer' implies. The publicity and promotion is likely to form an important aspect of the success of the programme. The frustration at not having adequate resources and materials to promote the service was widespread amongst the health trainers who felt this should have been more of a priority for the PCT.

Although much has already been done to promote the service at community events and the health trainers are building links and establishing themselves in their communities, work in this area, strategically and locally, needs to be ongoing. Future evaluation of the service could usefully include an assessment of the referral pathways to gather evidence and learning on the kinds of events and activities which attract clients to the service.

5.1.3 Partnership working

Clearly the process of building an effective partnership has had some difficulties. These appear to focus around different organisational practices and communication issues between partners. There appears to be a need for greater clarity in the division of responsibilities particularly in relation to the health trainers' perceptions about decision-making, accountability and support. The speed at which the programme has developed and delays around some aspects have impacted negatively on the morale and confidence of the health trainers. This suggests the need for a better understanding of the constraints and ways of working in each organisation.

There is a tension for the VSO partners needing and receiving support from the PCT whilst maintaining own identity and independence. This has surfaced particularly in relation to the older people's health trainers but also in the area of promotion materials, personal health plans and leaflets. The challenge here is to build a shared identity for the Health Trainers' service but which can incorporate the individual needs of the partner organisations.

There are clear benefits emerging for the VSOs from the Health Trainers programme and the future evaluation might consider including a focus on the outputs from the VSO perspective. These could relate to the ways in which the Health Trainers service is contributing to capacity building in health promotion in a broad sense within the sector and in development of volunteering activities to link to the health trainer service.

5.1.4 Benefits and tensions of the 'health trainer' role

Some of the health trainers felt that the actual role was quite different to what they had understood from the job packs and interview. This was in relation to their understanding of themselves as people with 'lay' knowledge who would be able to use their existing skills and experience to work on improving health. This might

reflect the early stage of a new programme or indicate that more clarity is needed in the information given about the health trainer role. However, it may reflect a more fundamental difficulty with the Health Trainer programme in its inherent ambiguities of utilising lay knowledge and experience within a prescribed model of behaviour change.

Some confusion and false expectations were also commented on by clients around the role of the health trainer, arising from misleading connotations associated with the title 'health trainer'. There were some issues raised about the limitations of the health trainer role, for example where the health trainer stated weighing the client was outside their remit (although others did do so). It was also clear that the health trainer role could often not replace other services, e.g. such as a nurse helping with smoking cessation, but could rather complement existing services.

Although health trainers had generally been helpful to clients in signposting other relevant services, there were also some issues raised around whether in some cases, clients required more specialist support e.g. in relation to those with serious mental health needs, provision of an alternative kind of service such as a trained counsellor may have been more beneficial. There appears to be a lack of consistency in the understanding and approach of health trainers in regard to the assessment of prospective clients. Improved communication in some cases is necessary. This was particularly highlighted in the case of one client who had complex needs and had been judged to 'not be ready' for the Health Trainer scheme by one health trainer, but then taken on by another (from a different VSO) who was unaware of this previous assessment.

Since all interviewees were in touch with other health services, and often in regular contact with GPs, it appears doubtful the scheme has been effective in reaching its aim of targeting clients who are not in contact with other services. However, clients did tend to regard the health trainer role as distinct from those of health 'professionals', in the sense that they were more approachable and easier to relate to and confide in. They valued the more informal, flexible, and person-centred approach and the greater sense of understanding and concern conveyed.

Another tension in the role, however, was that health trainers were trained to avoid using their previous skills and experience in regards to 'advising' clients in areas where they have specific health related knowledge. This was because in practice it was often felt to be impractical to avoid giving advice where this was expected by clients. Health trainers therefore did advise which led to problematic issues around the health trainers' lack of information concerning the client's medical background and how this advice or even 'suggestions' may therefore affect particular individuals.

There also seemed to be a lack of consistency in approach in regards to working 'holistically' with the clients. Some health trainers appeared to have considered their role to be to take a 'narrow' approach in terms of dealing with a singular goal area, without adequately taking into account the client's emotional or practical needs. These may have been seen as 'outside the health trainer remit' as was in some

cases reported as having been conveyed to the client. However, it seems clear that failure to address these issues could also hinder progress in the goal area – due to intrinsic links between these issues and the negative behaviour patterns health trainers were seeking to help the client address. Where the health trainer had helped the client to look at the ‘bigger picture’, for example through considering the relationship between diet choices and the needs or addictive behaviours / other emotional problems, this was found to be particularly helpful. This broader approach appeared to have had a wider impact in terms of assisting clients and even their other family members to maintain other changes. Such changes included: increasing a sense of well-being, improved physical and mental health and even a strengthened recovery from alcoholism and smoking (even where the main focus was on diet).

5.1.5 Achieving and maintaining behaviour change

Whilst some clients felt they had been very successful in achieving change, some had not achieved changes to the extent they would have liked during the programme. However, the intervention had been important in enabling them to make a start in making positive changes i.e. putting them ‘on the right track’, or laying a foundation for change. The intervention had given them the confidence, heightened awareness and techniques, which, if they were sustained, would develop changes over the longer term. Although it was not possible through this evaluation to effectively measure the extent to which changes had been maintained, most clients felt they had been left equipped to maintain and make further progress in relation to the changes they wanted to make. For some clients, however, disruption in frequency of sessions with the health trainer had hindered achieving and maintaining change. Although, this tended to be owing to events occurring in the client’s life (e.g. illness, holidays etc.) this highlights the need to avoid such interruptions to the intervention where possible. The importance was also highlighted of the need for the transition at the end of the health trainer sessions to be handled carefully and phased gradually. In addition, clients also felt it reassuring to have some ongoing channels of contact open to them (e.g. phone/email) following the conclusion of the health trainer sessions.

5.1.6 Older people’s health trainers

The specific needs of older people, particularly in relation to social isolation and exclusion, do fit within the priorities of the health trainer programme but as the above discussion highlights, the ways to approach working with older people need to be considered. The VSOs involved in delivering the older people’s health trainers have expertise in this area which can be drawn on to develop the Health Trainer service in ways which will be most effective with the older client base. This may involve adopting some flexibility to use the behaviour change tools in a subtle way and in combination with a community link role. The VSOs’ expertise could also usefully be

utilised in the design of promotional materials, leaflets and how they are used with older clients. There was particular concern that the personal health plans, self-efficacy forms and paperwork could be very off-putting for older clients and were likely to lead to disengagement. However, as a result of this, some judgements had been made by health trainers to restrict the use of paperwork on the part of the client and it was difficult to assess the extent to which this was necessary. When health trainers did attempt to use paperwork with older people this was in most cases found to be useful and beneficial. It should therefore not be assumed that this will be the case with all older clients, but that this should be assessed sensitively on an individual basis. It was suggested that a sub-group of the steering group be set up which could follow up on these issues and respond to the points made by the older people's health trainers in the workshop.

There was concern for the core training needs to better acknowledge and reflect older people's specific needs. The *Improving Health: Changing Behaviour NHS Health Trainer Handbook* and the *Health Trainers Training Pack: A toolkit for Developing Core Competences*, do not specifically refer to the issues raised by the older people's health trainers. The discussion here suggests that for the model to work effectively with older people a certain amount of subtlety and flexibility in approach may be necessary. On the other hand there was a concern that the flexibility of approach should not be stretched to the extent that the support received was not recognisable as the behaviour change model. This did seem to be apparent in some cases among older people for whom the very concept of goal-setting was not considered relevant or helpful and who may have benefited more from a different kind of service. It may be necessary for these issues to be reflected on locally and with colleagues in other areas, as the extent to which the behaviour change model could be utilised more flexibly has wider implications for the national programme.

5.1.7 Meeting the wider aims of the programme

In relation to the core aims of the health trainer programme to contribute to the agenda of the five priorities outlined in the 'Choosing Health' White Paper, it is difficult to assess the extent to which the scheme has been successful. Although, it is evident the scheme has had some effectiveness in relation to weight loss, it was not possible for the researcher to establish the extent to which this has tackled obesity, since not all health trainers were measuring the BMI of clients or tracking their weight loss. The 'before' / 'after' data that was made available to the researcher on BMI (and other indicators of behaviour change) was too limited and incomplete to be able to deduce any meaningful findings in relation to long-term change. It was also doubtful that some clients had a significant weight 'problem' to begin with and some were seeing a health trainer in relation to generally improving their diet and general health rather than with the aim of losing weight.

In relation to smoking cessation, a small number of clients have achieved their goals in this area. A significant number had a goal in the 'other' category (which may include the issues of alcohol consumption, sexual health, and social isolation/mental health) but no data was available on how this category was comprised. No interviewees had specific goals in the area of alcohol consumption or sexual health. However, there was evidence that the scheme can be very effective in assisting / stabilising the recovery of clients who had recently made a change in the area of smoking and alcohol consumption, and that the intervention could also have a positive impact on emotional well-being. Although the goals had not been specifically addressed as such in the sessions, the issue of alleviating social isolation had in effect been worked towards with some of the older people interviewed. However, the positive results which had been achieved resulted from methods which deviated from the standard health trainer role, and in one case appeared to have been largely owing to support received through other services provided by the VSO.

5.2 Recommendations

5.2.1 Training and support for health trainers

- If the aim of recruiting health trainers who may not have formal qualifications or who have been out of the labour market (as outlined in *Choosing Health*) is to be met, full consideration of their potential support needs must be made as well as ongoing monitoring of support needs of existing health trainers.
- Related to the above, a review of the training (in the widest sense) may be necessary to ensure that it caters for different learning styles and the needs of those who may have been out of the workforce or who have little formal education or qualifications. Training may need to include literacy and basic skills, IT, as well as confidence building.
- Future recruitments should consider the kinds of support that might be helpful in completing the application form to encourage recruitment of people from the community who may have little experience of the job application process to become health trainers.

5.2.2 Clarifying the 'health trainer' role

- There is a need for greater discussion and clarification of issues around the health trainer role. If health trainers find that they are required in practice to give advice, mechanisms for support and guidance are a necessary safeguard, for example, by linking health trainers in with health professionals for supervision (e.g. to refer to and check the appropriateness of potential suggestions in regard to a particular client and their medical history).

- If the support suggested above is not to be made available, there are serious issues to be resolved around whether selecting clients with certain health issues (such as diabetes for example), is appropriate since these clients require a more specific type of support. However, excluding clients with a health condition that may cause complications in terms of the intervention is likely to be impractical in practice, since there is no way for the health trainer to know whether such conditions might apply where there is no connection with health professionals who have this necessary information and knowledge.
- Greater clarity and information on the nature of the health trainer role is also required at recruitment stage in order to assist applicants in understanding how their existing skills and experience might be used in delivering the health trainer service and may help to avoid health trainers feeling frustrated by limitations around using their existing health related knowledge.
- The longer term development of the Health Trainer role needs to be considered and where it fits into the broader health workforce. The current health trainers were unclear about the potential for their own professional development and how the health trainer qualification would contribute to the future careers.
- Some clients found the role of 'Health Trainer' hard to understand and had to some extent been disappointed with their hands-off approach. This may be in part owing to a lack of clarity on the part of the health trainer in some cases, but also may be hindered by the misleading term of 'trainer'. It may thus be helpful for stakeholders to consider changing this term to one which more closely fits with the role carried out by health trainers (e.g. 'mentor').

5.2.3 Supporting clients with specific needs

- The ways to approach working with older people and better acknowledging and reflecting age-related needs in the core training needs to be considered.
- The VSOs' expertise in working with older people could also usefully be utilised in the design of promotional materials, leaflets and how they are used with older clients.
- Greater focus on flexibility and subtlety when working with specific client groups may be necessary, particularly in regard to use of paperwork. Although most people found the paperwork helpful, some older people and people with learning support needs may find this off-putting. On the other-hand it should not be assumed that paperwork will not be found useful to the client.
- For some older and clients and younger clients with specific needs (particularly around mental health) the service is not appropriate. There is a need for a more rigorous assessment to be applied in the initial session with a

health trainer, in terms of identifying the type of help the client requires and whether this can be met in other ways more appropriate than the health trainer scheme. It may be that befriending or counselling support would be more beneficial.

5.2.4 Partnership working

- Different organisational practices and communication issues have been somewhat of an obstacle to effective partnership working. There is a need for a better understanding of the constraints and ways of working in each organisation.
- Greater clarity in the division of responsibilities between the VSO and the PCT is needed, particularly in relation to the health trainers' perceptions about decision-making, accountability and support.
- A tension emerged for the VSO partners of working with, and receiving support from the PCT whilst maintaining own identity and independence. The challenge is to build a shared identity for the Health Trainers' service but which can incorporate the individual needs of the partner organisations.

5.2.5 Client outcomes

- Although the health trainer programme can and has achieved positive outcomes in supporting clients through behaviour change (at least in the short term) this has mostly been in relation to goals around diet and exercise. If the aims of the programme is to meet the five key priority areas (as outlined in *Choosing Health*) for health improvement there therefore needs to be greater consideration of how to recruit and support clients around working towards goals in other areas.
- It was difficult to assess long-term outcomes, since some clients had not yet completed their sessions and the timescale of the evaluation did not allow these clients to be followed up at a later date. Those who had completed sessions reported some difficulty with maintaining change but most felt that they were equipped to continue putting into practice helpful tips and techniques acquired through the sessions, and thus put themselves 'back on track'. However, there is a need for more consistent follow-up support, in order to reassure clients through their transition to 'going alone'.
- The programme had limited success in targeting those who are out of touch with health services, and clients were not exclusively from disadvantaged communities. Greater consideration needs to be given in regards to clarifying these aims and over how to promote uptake of the programme among target groups.

5.2.6 Future monitoring / evaluation of the programme

- It would be useful for referral pathways and promotion activities to be monitored in order to gather evidence and learning on the kinds of events and activities which attract clients to the service.
- Since health trainers were in many cases not working with clients at the time of the initial stage of the evaluation, it may be useful to receive feedback on issues arising for health trainers in regard to working with clients. This would be in order to focus in more detail on the client / Health Trainer interaction, and consider the nature of the relationship and how it contributes to the behaviour change model.
- There is a need for greater precision, consistency and thoroughness in data collection on goal types, success in achieving and maintain goals and other measures of behaviour change (e.g. BMI) in order to be able to more effectively monitor ongoing client outputs. Training for health trainers on data collection and inputting may need to be improved.

References

Department of Health. 2004. *Choosing Health*

Department of Health. 2006. *Our Health, Our Care, Our Say*

Michie, S., Rumsey, N., Fussell, A., Hardeman, W., Johnston, M.M Newman, S. and Yardley, L. 2006. *Improving Health: Changing Behaviour NHS Health Trainer Handbook*. Department of Health.

Skills for Health. 2006. *Competences for Health Trainers*. Department of Health and the British Psychological Society

APPENDIXES

Appendix 1: Letter to Potential Applications for Health Trainer Posts

12th May 2008

Dear Applicant,

West Sussex Health Trainers Evaluation

I am writing to you because you recently expressed an interest in the Health Trainers post with [name of organisation] who have forwarded this letter to you on our behalf. We have been asked to carry out an evaluation of the Health Trainers programme by West Sussex Primary Care Trust who would like to understand what sort of people are interested in becoming Health Trainers.

We would greatly appreciate if you could help us by completing the enclosed questionnaire. You do not have to tell us your name and your identity will be kept anonymous. We are enclosing a stamped addressed envelope for you to send the completed questionnaire back to us here at Brighton University.

If you have any questions about the questionnaire please do feel free to give me a call on 01273 643903.

Kind regards,

Dr Lizzie Ward
Research Officer
Health and Social Policy Research Centre
University of Brighton

Appendix 2: Questionnaire for potential applicants

WEST SUSSEX HEALTH TRAINERS EVALUATION

Please answer the following questions as fully as you are able by ticking boxes or writing in the spaces provided. All the information you provide will remain confidential to the researcher and your identity will be kept anonymous.

1 Male Female

2 Postcode

3 Please state your age

4 How would you describe your ethnic origin:

Asian or Asian British

Indian

Pakistani

Bangladeshi

Other Asian background

Black or Black British

Caribbean

African

Other Black background

White

British

Irish

European

Mixed

White/Black Caribbean

White/Black African

White/Asian

Other mixed background

Other

Chinese

5 Do you consider yourself to have a disability? Yes / No

6 What is your current work status?

Full time work

Part time work

Carer

Other

Voluntary work

Unemployed

Retired

7 What is your highest educational or vocational qualification? (please state what level)

8 Do you have dependent children?

Yes / No

9 Can you tell us what interested you about this job?

10 If you decided not to apply for this job can you tell us why?

Thank you for completing this questionnaire. Please return in the SAE to Lizzie Ward, HSPRC, University of Brighton, Falmer, BN1 9PH

Appendix 3: Health Trainers Information Sheet

The University of Brighton has been asked to evaluate the Community Health Trainers Programme in West Sussex. The Primary Care Trust is interested in learning how the programme can enable the professional development of the Health Trainer workforce as well as how the Health Trainers programme contributes to helping people make changes related to their health.

As part of the evaluation we will be looking at the recruitment and training of Health Trainers. We would like to talk to you about your experience of the training you have undergone for the Health Trainers programme. We will want to talk to you for around half an hour but want to stress that you are free to finish the conversation at any point without giving a reason.

We will ensure that everything you tell us will be treated in the utmost confidence. Your name will not appear in the report, although with your permission we may ask to reproduce something you have said as an example, and this will be done in a way which does not directly identify you.

The main researcher on this project is Lizzie Ward. If you would like to talk to Lizzie you can call her on 01273 643903. If you would like to speak to someone who is independent of the study you can contact Dr Phil Haynes, Head of School. School of Applied Social Science, University of Brighton, on 01273 643465.

Appendix 4: Participant Consent Form

Health Trainers Programme in West Sussex

Participant Consent Form

- ◆ I agree to take part in this research which is to evaluate the work of the Health Trainers Programme in West Sussex.
- ◆ The researcher has explained to my satisfaction the purpose of the study and the possible risks involved.
- ◆ I have had the interview explained to me and I have read, or been read, the information sheet and I understand it.
- ◆ I am aware that the researcher will be asking me questions and I have seen the questions in advance.
- ◆ I agree to the interview being recorded.
- ◆ I understand that any confidential information will be seen only by the researchers and will not be revealed to anyone else and will be anonymous in the report.
- ◆ I understand that I am free to withdraw from the investigation at any time without giving a reason.

Name (please print):

Signed :

Date :

Researcher:

Appendix 5: Post Training Interview Schedule for Health Trainers

1. Can you tell me about your background, other jobs you have done and why you applied to be a Health Trainer?
2. What skills and experience did you already have that you thought would be useful for being a Health Trainer?
3. What did you expect from the training before you undertook it – did it match up to your expectations?
4. How did you feel after finishing the training?
5. What have been the key things you have learnt? (knowledge, skills, personal development)
6. Did the training help recognise or develop your existing skills?
7. What did you think about the way the training was organised and run (practical issues – venues, times etc)
8. What did you think about the content (detail, time on each topic, chance to practice, consolidation of learning)
9. How have you found the training in terms of:
 - a. Managing your own learning
 - b. Study skills – were there any additional learning needs that were not acknowledged or caused problems
10. What aspects of the training worked best for you in terms of learning?
11. Was there anything 'missing' that you would have liked included?
12. Have you had any difficulties with the training and how have these been dealt with – eg did any problems early on improve? Support?

13. What impact has the training had so far on:

- a. Yourself
- b. The organisation you work with
- c. The clients you work with (if not yet started this aspect suggest how you see the training helping in the future)?

14. How do you see your career as a Health Trainer developing?

15. Are there any other benefits of doing the training that you had not expected?
(peer support? networks? knowledge exchange?)

Appendix 6: Interview schedule for VSO supervisors and PCT Co-ordinator

Recruitment

What do you think were the issues from your organisation's perspective for the recruitment?

How did you go about the recruitment? What do you think worked well? What would you do differently? [application form? advertising? interviews?]

How did the deadlines and timescales impact on the recruitment process?

Training

Do you think the training meet the needs of the health trainers?

Were there any practical issues around the organisation of the training which impacted on who could be selected – the timing and deadlines?

Have you identified any further training needs and how are these being met?

Support and Supervision

What are the key issues for you around supervision?

How much of your time is spent on support and supervision of HTs, has this changed from what was originally expected? Will this change in the future?

Can you tell me about the training that the PCT has provided for supervisors and if you think it met the needs for supervision?

How much of the day to day supervision of HTs do you envisage will be clinical questions and how do you think these will be met?

How do you see the HTs developing their career / role – how have they benefited from their role?

Relationships with partners

What were your expectations at the start of the programme of the joint working between PCT and VSO partners? Have these changed?

How have decisions been reached about meeting the needs of the programme?

Have there been any challenges or barriers to working in partnership? And how have they been dealt with?

Organisational needs

Were there any issues of capacity and resources (from own organisation) that has impacted on meeting the timescales set by PCT?

Do the costs associated with delivering the programme match up to what was originally thought in the bid – if changed how?

Appendix 7: Interview Schedule for VSO Supervisors: Stage 2

1. Generally how are things going with the health trainers?
2. What do you think have been the main issues / challenges over the last year?
3. The recommended model – health trainers from own communities with no previous qualifications – how has this worked in your organisation? (any organisational issues about this model)
4. To what extent do you think your health trainers are similar to the client group – in terms of understanding their communities? Do you think they are regarded by their clients as being from the community?
5. What existing qualifications did your health trainers have – or what range – highest and lowest qualifications?
6. Are you happy that the training they have received has enabled them to carry out health trainer role?
7. Are there any issues around the learning that you think need addressing – support needs the City and Guilds qualification?
8. Are there any issues about other community / health services – any duplication? Or how the health trainers fit into other services offered?
9. Who are the clients? – do you have a sense of the client base:
 - Where referred from
 - What issues
 - Age
 - Gender
 - Where they live
10. How do you see the health trainer's service developing?
11. Has the health trainer programme been a benefit to your organisation? – if yes in what ways?

Appendix 8: Feedback from Workshop on Older People's Health Trainers

Workshop for Older People's Health Trainers – 11th February 2009 – 12-4pm

Feedback from Session 1: Working with older people

1) How and why are older people's needs different?

- Access – not able to access as much and are limited by mobility; illness – disease – ongoing – health needs; transport; finance
- Set in their ways: stubborn; fatalistic
- Person's history
- Less open to ideas
- Change can be frightening – new technology – feeling out of step/ cut off
- Physically harder to do things – ageing body
- Loss of confidence – e.g. after a fall
- Feeling fearful
- Loss and bereavement - *isolation* - *mental well-being*; big life changes e.g. widowhood

2) What things about growing older need to be taken into account?

- Practicalities – access to toilets (water tablets)
- Importance of home visiting
- Not stereotyping older people
- Help maintain independence
- Bigger set backs from minor ailments
- Mobility
- Vulnerability
- General health – eyesight, hearing etc.
- Different generation – rules/culture
- Family
- Finances

3) What things do you need to think about when working with older people?

- Paperwork: don't see need for it – red tape
- Being hands-on and practical – not just signposting but doing things
- Focusing on what they can do - abilities
- Personal touch

- Time to build trust
- Different needs
- Safety issues for client + yourself (stairs)

4) What is important for forming a good relationship when working with an older person?

- Time needed to build relationships
- Warm approach needed
- Trust
- Rapport
- Relaxed
- Comfortable
- Being seen as capable by client
- Sympathetic
- Humanistic – treating people as human
- Being able to relate/empathise
- Feelings – showing you're human – within boundaries
- Continuity
- Understanding the importance of 'the relationship'
- See you as a friend – responsibility – they have different expectations of the relationship

5) Why might it be difficult to get older people to engage with services?

- No knowledge of the service
- Pride
- Don't want to take medication
- Suspicion
- Lack of confidence
- Cost implications
- Suspicion of NHS
- Age of person providing service – 'you are too young'
- Wrong views about what we do – wrong name – health trainer is scary (they don't want to do running!)
- Don't want to lose independence
- Don't want to ask for help
- Previous bad experience with (health) professional

Feedback from Session 2: The role of older people's health trainers

1) How are older people's health trainers different to the generic health trainers?

- Specialise in a particular age group

- Age appropriate approach – treat as individual not how old – but age matters
- Different value base (own organisation)
- Home visits as part of person-centred approach (if needed) – geographical distances/public transport issues in rural areas
- Differences in experience and knowledge – age gap between client and health trainer, therefore, building trust and relationship needs more work (particularly for younger health trainer?)
- Health issues – different and more specialist training needed – complex health needs
- To be able to understand conditions without becoming health experts/professional – how condition impacts on the work health trainer will do
- Knowledge/skills/training on health trainer programme not enough to understand older people's health issues
- Focus on isolation, mental well-being and confidence
- Health trainer programme targets not appropriate for older people

2) How can older people benefit from having a health trainer?

- Reduce isolation
- Friendlier and easier access compared to statutory services
- Free
- Follow up and continuity – personal touch for client
- Building confidence
- Re-engaging with their community – putting in touch with services
- Helping to change step by step – at own pace – holistic care

3) What are the barriers to putting the behaviour change model into practice with older people?

- Paperwork
- Clinical approach – formal, robotic, impersonal
- Jargon – PCT/medical
- Restricted practice – too confined to the model – one size fits all model
- The targets not appropriate for older people – isolation, feelings and confidence rather than smoking, alcohol etc
- Fear of failure (older persons), not being able to reach goals
- Small things make a big difference to older people and these don't count on paper
- Self-efficacy forms not right for older people – wheel of health; personal health plan
- Set-backs e.g. falls, illness

4) How can we overcome these?

- Model works when goals are appropriate for older people – focus on confidence building and isolation, falls
- Using our own creativity
- Be flexible
- Be person-centred
- Not robotic approach
- Being creative, pragmatic and thinking outside the box
- Listen to what the older person wants
- Change 'health trainer' name

Feedback from Session 3: Reaching older people and developing the service

- Work harder with professionals – GPs, hospitals, social workers etc. – PCT led; falls prevention
- Make health trainers part of the NHS/structures/teams
- Door-knocking/leaflets
- *Name* – health trainer – difficult

An 'Activate' Day

- Health checks available
- Health talks – weight management groups – 8 weeks but one to one health trainers offered within sessions
- Advertise properly – special leaflet for older people: use of language very important and order of issues
- Needs to reach wider community – so they know service exists – word spreads

Health trainers day – launch?

- Local media
- Older people's groups – newsletter
- Use other events – festivals; community events
- Sheltered housing: coffee mornings; lunch clubs
- Carers Day
- Contact carers organisations
- Supermarkets and local shops
- Organise own coffee morning – not already established ones
- Get out into community
- Ways of doing health checks, e.g. weighing people, blood pressure, blood sugar, waist measurement
- Specialist training – to run groups: smoking cessation; health walks
- Timing – during the day

- Healthy eating – recipes and have fun with food sessions – and offer health trainer
- Cook and eat groups and offer health trainer service as part of it
- Reminiscence groups – as a way of linking

Appendix 9: Health Trainers Focus Group Information Sheet

The University of Brighton has been asked to evaluate the Health Trainers Programme in West Sussex. The Primary Care Trust is interested in learning how the programme can enable the professional development of the Health Trainer workforce as well as how the Health Trainers programme contributes to helping people make changes related to their health.

As part of the evaluation we will be running focus group discussions with all the Health Trainers to look at the experiences of being a Health Trainer. We would like you to reflect on your experiences of the training you received, how this relates to the practice and how you see your professional development as a Health Trainer.

The focus group discussions will be written up and form part of the final evaluation report for the PCT. This will form an important part of the process of learning about the implementation of the programme and the development of the Health Trainer workforce. Your name will not appear in the report, although with your permission we may ask to reproduce something you have said as an example, and this will be done in a way which does not directly identify you.

The main researcher on this project is Lizzie Ward. If you would like to talk to Lizzie you can call her on 01273 643903. If you would like to speak to someone who is independent of the study you can contact Dr Phil Haynes, Head of School. School of Applied Social Science, University of Brighton, on 01273 643465.

Appendix 10: Consent Card

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 understand that the Health Trainer role is a new role, and, as a result, it will be evaluated by the PCT and the Department of Health to see how worthwhile it has been.

I agree that my details can be monitored, but **my confidentiality will be maintained at all times** and forms stored in accordance with PCT policy and procedures, and my name will not be mentioned in any reports.

Health Trainers are not clinically trained. I understand that if I have any existing medical conditions or plan to make significant lifestyle changes, that I am advised to consult my doctor.

I understand that the Health trainer can support me and offer guidance to enable me to make healthy choices but will not be sufficiently qualified to offer health advice.

Name:

Date:

Health Trainer:

As part of the evaluation we have asked the University of Brighton to contact clients to ask about their experience of the service. If you are happy to be contacted by the researcher please tick the box and answer the questions below.

Please could you tell us what things are important in helping you have good health:

.....
.....

Please could you tell us what sorts of things might get in the way of being as healthy as you would like:

.....
.....

Appendix 11: Client Information Sheet

Health Trainers Programme in West Sussex

We would like to talk to you about your experiences of having a health trainer. This is because it's quite a new programme and the Primary Care Trust is interested in finding out how it is working.

We would like to talk to you about any changes you feel you have made as a result of having contact with the Health Trainer and the questions we want to ask are enclosed. We would like to talk to you for around an hour but want to stress that you are free to finish the conversation at any point without giving a reason.

We will ensure that everything you tell us will be treated in the utmost confidence and we will not pass information on to anyone else. With your permission we would like to record the conversation as this helps us to make sure we have correctly understood what you tell us. Your name or details that would identify you will not appear in the report, although with your permission we may ask to reproduce something you have said as an example.

We can visit you at home or arrange to talk to you at another location if you would prefer. We will cover your transport costs or any other costs you may incur, for example, if you look after someone and need to arrange care for them while you are talking to us.

What you tell us will contribute to a report for the Primary Care Trust. This will be useful for developing the Health Trainers Programme and understanding what helps people make changes to their health and lifestyle.

The main researcher on this project is Lizzie Ward. If you would like to talk to Lizzie you can call her on 01273 643903. If you would like to speak to someone who is independent of the study you can contact Dr Phil Haynes, Head of School, School of Applied Social Science, University of Brighton, on 01273 643465.

Appendix 12: Interview Schedule for Clients

- Can you tell me how you came to have a health trainer? How did you hear about the service?
- How many sessions have you had? Are you still having sessions with the health trainer?
- Over the last year, have you / how often have you seen any other healthcare services...? (e.g. GP, Health Visitor, Practice Nurse, CPN, Community Link Worker, Social Worker, Counsellor)
- What did you think in the beginning about having a health trainer? Was it what you expected?
- What changes did you want to make? What was the most important thing to you?
- Were there any things you felt would be difficult about achieving your goals?
- Have you been able to make the changes that you wanted to?
- What things do you think made a difference in making the changes you wanted to make?
- What happened in the sessions with your health trainer?
- What was helpful about having a health trainer?
- Do you think your health trainer understood you and your circumstances?
- Was there anything that wasn't helpful? (about programme)? What could have helped you more?
- Do you think you think you will be able to maintain the changes? Where do you see yourself / your health in 6 months - 1 year?
- Is there anything else that you feel is important about the health trainer service that we have already spoken about?

Appendix 13: Letter to Clients

Date

Address

Dear

Health Trainers Programme Evaluation

I am a researcher working at University of Brighton and carrying out an evaluation of the health trainer programme on behalf of West Sussex Primary Care Trust. I am writing to you as your health trainer, [INSERT health trainer's name], has let me know that you might be willing to take part in evaluating the health trainers programme. I have enclosed some information about the evaluation and what taking part would involve.

I can contact you by phone next week once you have had a chance to read through the information to see if you do want to take part and we can arrange a convenient time for me to visit you at home to talk to you. If you have any questions about the evaluation that you want to ask before that then please give me a call on 01273 644599.

Kind regards,

Laura Banks
Research Fellow

01273 644599

l.c.banks@brighton.ac.uk

Appendix 14: Client Information Sheet

Health Trainers Programme in West Sussex

We would like to talk to you about your experiences of having a health trainer. This is because it's quite a new programme and the Primary Care Trust is interested in finding out how it is working.

We would like to talk to you about any changes you feel you have made as a result of having contact with the Health Trainer and the questions we want to ask are enclosed. We would like to talk to you for around an hour but want to stress that you are free to finish the conversation at any point without giving a reason.

We will ensure that everything you tell us will be treated in the utmost confidence and we will not pass information on to anyone else. With your permission we would like to record the conversation as this helps us to make sure we have correctly understood what you tell us. Your name or details that would identify you will not appear in the report, although with your permission we may ask to reproduce something you have said as an example.

We can visit you at home or arrange to talk to you at another location if you would prefer. We will cover your transport costs or any other costs you may incur, for example, if you look after someone and need to arrange care for them while you are talking to us.

What you tell us will contribute to a report for the Primary Care Trust. This will be useful for developing the Health Trainers Programme and understanding what helps people make changes to their health and lifestyle.

The main researcher on this project is Laura Banks. If you would like to talk to Laura you can call her on 01273 644599. If you would like to speak to someone who is independent of the study you can contact Dr Phil Haynes, Head of School, School of Applied Social Science, University of Brighton, on 01273 643465.

Appendix 15: Client Questionnaire

About yourself

Thank you for agreeing to take part in the Health Trainers evaluation. It will help us to understand your answers better if we have a little bit of a background about you.

| | |
|--------|--------------------------|
| Male | <input type="checkbox"/> |
| Female | <input type="checkbox"/> |

Can you tell us your age in years?

| | | |
|-----------------|---------------------|--------------------------|
| Are you: | single | <input type="checkbox"/> |
| | married | <input type="checkbox"/> |
| | civil partnership | <input type="checkbox"/> |
| | Living with partner | <input type="checkbox"/> |
| | widowed | <input type="checkbox"/> |
| | divorced | <input type="checkbox"/> |
| | separated | <input type="checkbox"/> |

| | |
|---------------------------------|--------------------------|
| Are you currently: | <input type="checkbox"/> |
| Working full time | <input type="checkbox"/> |
| Working part time | <input type="checkbox"/> |
| Unemployed | <input type="checkbox"/> |
| Retired | <input type="checkbox"/> |
| Student | <input type="checkbox"/> |
| Caring for friend or relative | <input type="checkbox"/> |
| Temporarily sick or disabled | <input type="checkbox"/> |
| Long term sick or disabled | <input type="checkbox"/> |
| Voluntary work | <input type="checkbox"/> |
| Looking after family member (s) | <input type="checkbox"/> |
| Other | <input type="checkbox"/> |

Do you currently:

Live on your own

Live with your spouse/partner

Live with family member(s)

Live with others

Other

| |
|--|
| |
| |
| |
| |
| |

What kind of accommodation do you live in at the moment?

Council rented

Housing association rented

Private sector rented

Own home

Sheltered housing

Residential home

Other

| |
|--|
| |
| |
| |
| |
| |
| |
| |

Do you receive any state benefits?

Income support

Job seekers allowance

Family tax credit

Children's tax credit

Statutory sick pay

Incapacity benefit

Disability living allowance

Disability working allowance

Attendance allowance

Invalidity allowance

Housing benefit

Council tax benefit

Others (which?)

| |
|--|
| |
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| |
| |
| |

What is your total income per week from all sources (excluding housing benefit and council tax benefit?)

- £0 - £249 (£0 - £12,999 per year)
- £250 - £449 (£13,000 - £23,399 per year)
- £450 - £749 (£23,400 - £38,999 per year)
- £750 or more (£39,000 or more)

| |
|--|
| |
| |
| |
| |

How would you describe yourself?

Asian or Asian British

- Indian
- Pakistani
- Bangladeshi
- Other Asian background

Black or Black British

- Caribbean
- African
- Other Black background

White

- British
- Irish
- European
- Other** (please specify)

Mixed

- White/Black Caribbean
- White/Black African
- White/Asian
- Other mixed background
- Chinese**

Do you consider yourself to have a Yes / No disability?

What is your religion or belief?

- None
- Christian
- Muslim
- Hindu

- Sikh
- Jewish
- Buddhist
- Other

Appendix 16: Client Information Form (completed by VSO supervisors)

Name: _____

VSO: _____

Date: _____

Please complete the table showing the number of clients in each category for each Health Trainer in your area (NB: 'consent' refers to being contacted by a researcher about the evaluation).

| | Number of clients | | | | | |
|---------|-------------------|---------------------------|------------------------|---------------|------------------|--------------------------------------|
| HT name | Seen to date | With sessions in progress | Completed all sessions | Given consent | Declined consent | Consent not yet requested /undecided |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

If any clients have given consent please supply details below:

Name: _____

Address: _____

Tel no: _____

No. sessions to date: _____

Main goal area: _____

Name: _____

Address: _____

Tel no: _____

No. sessions to date: _____

Main goal area: _____

Name: _____

Address: _____

Tel no: _____

No. sessions to date: _____

Main goal area: _____

Name: _____

Address: _____

Tel no: _____

No. sessions to date: _____

Main goal area: _____

