Service evaluation of health trainers in NHS Nottinghamshire and NHS Bassetlaw

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Abstract

This article relates the findings of an evaluation of the health trainer service provided by NHS Nottinghamshire and NHS Bassetlaw, which was delivered by the Centre for Health and Social Care Improvement in 2010. The aims of the evaluation were to scope, compare and contrast the service across the component geographical districts and against different service models, and evaluate the impact on stakeholders. Mixed methods, running parallel across the life of the evaluation generated an enormous quantity of data which showed that the health trainer service delivered on the aims and objectives of the initiative. The targeted clients were accessed according to socioeconomic status, and the service supported appropriate lifestyle risk assessment. Behaviour change for positive impact on health was enabled, evidenced by the number of Personal Health Plans developed, and the service demonstrated increased self-efficacy, choice, and control for clients. Recommendations are provided for the service going forward.

Key words: Public Health; Choosing Health; Health Trainers; Evaluation

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Introduction and background

As a result of the ‘Choosing Health’ public health white paper (DH 2004), the health trainer initiative was introduced and rolled out by the Department of Health in 2006, aiming to reach disadvantaged communities by employing local people (health trainers) to act as intermediaries between clients and healthcare services. Health trainers have an understanding of the
communities they work in, and provide one-to-one support and guidance to those wishing to change their behaviour for a healthier lifestyle. A key tool in addressing health inequalities, health trainers are either paid or unpaid within the NHS or work within a partner organisation. They are trained in a variety of settings, determined according to local requirements. Health trainers either identify, or have referred to them, appropriate clients drawn from hard to reach, disadvantaged groups, and work with them on a one-to-one basis to assess their lifestyle and identify areas they wish to change; they help the client to set their own goals, agree action plans and provide individual support where necessary. Monitoring and review of clients’ progress is undertaken to ensure clients meet their goals (DH, 2009). Their exact role depends on the needs of the local community, but typically involve encouraging people to stop smoking, increase their physical activity, eat more healthily, drink less alcohol, and practice safe sex. One key element is that of referring clients on to other health services for weight loss management, smoking cessation and exercise programmes.

Since 2005, at a national level, a competency framework has been established and accredited job roles have been modelled (DH, 2009). In addition, there have been many further developments in this area. For example, there are now two national awards based on health trainer competences: City & Guilds Level 3 (City & Guilds 2010) and the Royal Society for Public Health Level 2 (RSPH 2010); a National Implementation Team (the Hubs) provides full regional coverage for PCTs and other providers of health trainer services; and the Data Collection and Reporting System (DCRS) is collating an evidence base of local practices (DH, 2009a; 2009b). In turn, a handbook providing guidance and support to health trainers in their work to facilitate behaviour change has also been produced (DH 2008).

Critics of the health trainer initiative have argued that exercise referral schemes which offer only short-term benefits may not be effective in sustaining increased physical activity levels in the longer term (Harland et al, 1999; Foster et al 2005; NICE 2006). Moreover, from a broader perspective, many determinants of ill health are more wide reaching than individual agency, and health trainers are not equipped to confront broader health inequalities within society (Netherwood, 2007). Notwithstanding, many evaluations of local health trainer services have shown positive outcomes.

Local evaluations

Throughout the country, there is significant variation in delivery models, assessment practices, and evaluation strategies of health trainer services. Reviews of the early adopter phase of health trainer services conducted in the North East (Visram et al 2006) and in
Bradford (South et al. 2007) were largely inconclusive in terms of impact and effectiveness but showed, nevertheless, promising results.

An evaluation of the health trainer service in Cheshire and Merseyside found that positive benefits included having time to spend with clients one-to-one, presenting a non-judgmental attitude coupled with a non-clinical/non-medical, personalised service; health trainers can accompany clients to activities and have a practical focus whilst understanding the challenges faced by local communities. The health trainers are seen to empower people, and promote health education and understanding of messages about healthy living. Finally, they are viewed as providing an important bridge between communities and PCTs (Kitchen, 2009).

Key messages drawn from an evaluation of West Sussex health trainer service highlighted the limitations of the health trainer role regarding giving advice, and the appropriateness of the service for some older people and other client groups with special needs. Although the majority of clients were positive about the support they received, there was a need for more adequate follow-up support for some clients.

The report also found sparse and inconsistent data monitoring of client outcomes that needs to be addressed in order to enable more accurate assessment of the impact of the service in relation to behaviour change (Ward and Banks 2010).

This article now turns to relate the findings of an evaluation of Phase one of the health trainer service provided by NHS Nottinghamshire and NHS Bassetlaw. The evaluation was delivered by the Centre for Health and Social Care Improvement, School of Health and Wellbeing, University of Wolverhampton between March 2010 and September 2010. Insufficient space disallows a fuller coverage and discussion of health trainer service reviews and evaluations throughout the UK. However, these have been examined in depth elsewhere (Morgan, 2011).

**NHS Nottinghamshire and NHS Bassetlaw context**

The first phase of NHS Nottinghamshire and NHS Bassetlaw health trainer service was commissioned on indices of multiple deprivation within the county. There are eight districts in Nottinghamshire: Ashfield; Broxtowe; Gedling; Mansfield; Newark; Sherwood; Bassetlaw; and Rushcliffe which, combined, have approximately 14 Whole Time Equivalent (WTE) health trainers.

The aims of the evaluation were to scope the health trainer service in detail, focusing on activities undertaken by health trainers, locations in which the activities took place, and the characteristics and qualifications of the
health trainers; compare and contrast the scope of the service across the component districts and sites, different service models (full-time, part-time and bolt-on roles); and evaluate the impact the service has had on health trainers, clients, service providers, service facilitators, and stakeholders.

**Methodological approach**

The methodological approach incorporated both qualitative and quantitative techniques, running parallel across the six-month life of the evaluation. This mixed methods approach provided comprehensive datasets which, upon triangulation, ultimately provided robust conclusions and recommendations.

To scope the service, a data audit of the Data Collection and Reporting System (DCRS) was conducted, using data within the timeframe of 1 June 2009 to 31 May 2010. The audit elicited data on levels of client engagement, locations of activities, services and service users, staff training, characteristics of health trainers and service users, and service effectiveness. To complement this audit, qualitative, semi-structured interviews (n=3) and a ‘two-week diary’ method (n=9) were employed with health trainers to obtain in-depth data on their perceived role and activities. To evaluate service impact, two bespoke online questionnaires were developed and distributed to a) 14 health trainers (designed to measure opinions and attitudes regarding the impact of the service on themselves), and b) 46 stakeholders, service providers and facilitators (designed to measure the perceived impact on the broader workforce).

In turn, a participatory appraisal workshop took place with a sample of eight clients, designed to evaluate whether the service is meeting their needs, and finally 12 semi-structured interviews took place with clients to augment findings from the workshop.

**Findings**

Overall, it was found that the health trainer service delivered on the aims and objectives of the initiative. The targeted clients were accessed according to socioeconomic status, and the service supported appropriate lifestyle risk assessment. Behaviour change for positive impact on health was enabled, evidenced by the number of Personal Health Plans (PHPs) developed, and the service demonstrated increased self-efficacy, choice and control for clients. Appropriate signposting by health trainers assured more effective contact with mainstream health services.

**DCRS data audit**

DCRS data showed a total of 977 clients (mostly White British and female) within the timeframe, the majority of whom were drawn from the most deprived areas of the county according to residential postcode. New clients
were recruited through promotional events and word of mouth, with November 2009 recording the highest number of new clients. Diet and exercise were the most frequently cited priorities for clients. 906 (24%) clients had received initial assessments within this time, and 220 clients went on to complete Personal Health Plans (PHPs). Completing a PHP was shown to have a positive impact on clients’ self-efficacy, general health, and wellbeing. Signposting was offered mainly to voluntary and community groups, with only 9% being referred to other NHS services.

**Health trainers’ interview responses**

It was the general perception of health trainers that the service was effective in targeting deprived areas and potential clients. There was a positive personal impact on health trainers themselves which helped to improve working relationships with their clients. Health trainers also enjoyed their role that provided them with regular client contact. However, there was some uncertainty over service objectives and a desire for a clear, structured management system in order to increase and improve guidance and support received. Additional support from the relevant PCT was also cited by health trainers as needed to improve their practice, and increased understanding of the service by other health professionals. There was also a perception that the DCRS could be simplified, and the training programme expanded to include mental health training.

**Health trainers’ diary entries**

Completion of two-week diaries on a daily basis by eight health trainers showed that they were involved in a considerable variety of activities (not least of which was meeting clients, DCRS data input, and service promotion). There was an even split between direct work with clients and routine paperwork. The DCRS was utilised a total of 85 occasions throughout this time. 165 existing clients and 95 new clients were reported in the diary entries, and 19 clients successfully reached their goal within the two-week period. More positive feelings than negative were reported about their role (‘enjoyment’, ‘pride’, excitement’, ‘hope’ and ‘satisfaction’ all being cited). A number of training opportunities were accessed (local service provision, administration, personal skills). The diary data showed that health trainers often felt unable to deal with clients who have mental health needs, vision impairment, and dental needs. This would appear to be in support of the findings of Ward and Banks (2010). Facilitators to an effective service were the high visibility of the service within the local community and good partnership working.

**Health trainers’ questionnaire responses**

Motivation to become a health trainer stemmed from acknowledging the importance of healthy lifestyles, and most intended to remain in role.
Career aspirations had changed for positive reasons (new interests and knowledge of more opportunities available). Most perceived that their job description failed to capture the entire scope of their role. Those who had a line manager were satisfied with the level of understanding and support they provided. Suggestions which might improve job satisfaction included: more support from senior management; better communication between districts; and more directed project management. There was skill development in knowledge of NHS and other services; understanding local health needs; and how to motivate people. The role influenced the behaviour and lifestyle of some health trainers themselves (increased exercise, healthier eating, and drinking less alcohol). Most felt they had received adequate training and support. Mental health was identified as a training aspect which could be enhanced. Some health trainers felt isolated and received little support from both their internal and external teams.

**Wider workforce questionnaire responses**

Stakeholders reported increased service uptake due to clients being referred by health trainers. There was no apparent difference between perceived and actual duties undertaken by health trainers, although it was acknowledged that health trainers often went over and above their role. There was agreement that training was appropriate, but that there was room for improvement in the four core areas. There was perceived value for money and agreement that the financial and human costs of setting up the service were justified. There was consensus that the service was innovative and did not duplicate work of mainstream provision or impact on their resources. There was agreement that health trainers worked efficiently within their own districts but could do more to improve collaborative working across localities; teamwork was favoured over individual working. It was perceived that more health trainers were needed to maximise client engagement. Overall, client success was scored quite highly by stakeholders, but it was acknowledged that some clients required further follow-up care once their time with the health trainer was complete.

**Participatory appraisal workshop outcome**

Clients agreed strongly that the health trainers provided an excellent service. There was an emphasis on diet and exercise as lifestyle changes clients preferred, with significant achievements being reported. Common frustrations prior to using the service had been the time taken to access support for lifestyle changes, and lack of accessibility of relevant information.

Subsequently, clients felt well-supported and motivated by their health trainer. Clients also reported a lack of understanding by GPs regarding their health concerns, and reluctance from other health professionals to signpost to
the health trainer service. For those who had completed PHPs, follow-on care was not entirely satisfactory, and those on exercise referral schemes were not satisfied with having no longer-term follow-up. This may support findings by Harland et al (1999), Foster et al (2005) and NICE (2006).

Clients’ interview responses

The primary health issues apparent in the areas in which clients lived were obesity and alcohol consumption. Awareness of the health trainer service was gained through leaflets, word of mouth, and events. Clients’ expressed high levels of satisfaction with the knowledge and understanding of their health trainer, and some clients also received additional support (emotional support and confidence-building). Most clients reported that their health trainer provided information on the availability and accessibility of a range of other services to help them (for example, local gyms, and leisure centres). All clients enjoyed an effective working relationship with their health trainer, reporting their excellent communication and availability using a variety of contact method (visits, phone calls, text messaging), alongside sensitive handling of clients’ personal circumstances. Key lessons learnt included knowledge regarding health, increased confidence to seek help, and how to be more active in changing their own health-related behaviour. No barriers or problems were experienced in accessing the service, but suggestions were mooted to improve advertising. Overall, all clients who were interviewed were highly satisfied with the service they had received.

Recommendations for the service going forward

In light of the evaluation findings, a number of recommendations were posited which served to support the health trainer service going forward. It was suggested that enhanced publicity throughout the PCTs and other NHS services was needed in order to raise awareness of the service and thereby maximise client engagement. Quarterly meetings between districts were suggested with ‘best practice’ seminars being held to showcase key successes and encourage better working across the county as a whole. The development of action plans was suggested for a) client follow-up to ensure the maintenance of healthier behaviours, elicit reasons for drop-out, and to discuss any barriers which may have arisen, and b) referral partner follow-up to improve working relationships between health trainers and providers. The DCRS, if used to its maximum, would facilitate deployment of action plans.

It was recommended that health trainer training should incorporate additional specialist information regarding mental health awareness and services. Although mental health is not one
of the core elements of training, health trainers come into contact with many in the community who have mental health issues, and clearly identified within the evaluation that this should be a priority for future training.

Since the DCRS showed evidence of less than optimal completion within the audit (again in accord with other local evaluations, for example, Ward and Banks 2010), it was recommended that a master class or booster training course is held every six months to encourage improvements in data monitoring, which will, as well as contributing to future service evaluations, contribute to the national picture of health trainer services. Provider organisations can also promote this by auditing their own data.

**Conclusion**

The health trainer service provided by NHS Nottinghamshire and NHS Bassetlaw has been scoped in depth, with a focus on activities undertaken by service staff, locations in which the activities took place, and the characteristics and qualifications of the health trainers. The scope of the service across the component districts and sites has been assessed, as has the impact on health trainers, clients, service providers, facilitators, and stakeholders. The evaluation has provided evidence of very good development, structure, and process of the health trainer service, with excellent impact overall for all stakeholders. Evidence suggests that a workforce has been developed with the capabilities, capacity, and appropriate skills to deliver the health trainer service to a high standard.

Although a full cost-effectiveness evaluation was outside the scope of this study, the broader workforce provided their views on perceived value for money, and perceived cost-effectiveness in terms of both financial and human resources. The service had no unintended outcomes (either positive or negative) that were evidenced within the data. Lack of training and expertise to deal with clients with mental health issues was the major equality and diversity issue to arise. However, service objectives were met and clients have achieved their self-set goals, with increased accessibility of mainstream services.

**References**


