An Evaluation of Cornwall's Health Trainers 2007-08: Recruitment, Training and Practice

Final Report

September 2008

Alex Watt BSc MSc; Simon Bennett BSc MRes; Jenny Morris RGN BSc PhD.

Cornwall Health Research Unit

Opie Building

Trevenson Lane

Pool

Cornwall

TR15 3RG

Email: simon.bennett@ccb.cornwall.ac.uk

Website: http://www.chru.org.uk

// Acknowledgements

We would like to thank the Cornwall Health Promotion Service for funding the evaluation; all the staff involved with the Health Trainer service for taking the time to participate in the study; and Dr. Julia Frost, Lecturer at the University of Plymouth for her assistance with the analysis of the interview data.

Contents

	Page
Executive Summary	5
1. Introduction	8
1.1 National Structure	8
1.2 Health Trainer Service in Cornwall	11
1.2.1 Location and Personnel	11
1.2.2 Funding	13
2. Aim and Objectives of Evaluation	14
2.1 Aim	14
2.2 Objectives	14
3. Evaluation Design	14
3.1 Sample	15
3.1.1 Health Trainer Personnel	15
3.1.2 Health Trainer Clients	15
3.2 Data Collection	15
3.2.1 Personnel	15
3.2.2 Clients	16
3.3 Data Analysis	16
3.4 Focus of the Evaluation	16
3.4.1 Process	17
3.4.2 Outcome of the Service	17
3.5 Ethics	17
4. Results	17
4.1 Client Data Obtained as Part of the National Minimum Dataset	17
4.2 Client Participation in the Evaluation	22
4.3 Health Trainer Personnel	22
4.3.1 Recruitment of Health Trainers	22
4.3.1.1 Advertisement	22
4.3.1.2 Interview	23
4.3.1.3 General	23
4.3.2 Training	23
4.3.2.1 Contact	24
4.3.2.2 Mentors	24
4.3.2.3 Missing Aspects	24
4.3.3 Management and Support	25
4.3.4 New Skills	25
4.3.4.1 Personal Skills	25
4.3.4.2 Organisational Skills	26
4.3.4.3 General	26
4.3.5 Community Engagement	26
4.3.6 Liaison with Other Agencies	27
4.3.7 Client Interface	28
4.3.8 Barriers	29

4.3.8.1 Management **29**
4.3.8.2 General **30**
4.3.9 Positive Outcomes **30**
4.3.9.1 Health Trainers' Role **30**
4.3.9.2 Overcoming Barriers **31**

5. Discussion and Recommendations **31**

6. References **35**

Tables

Page

Table 1: Source of Recruitment to the Service (n=119) **18**

Table 2: Characteristics and Health Behaviour of Clients at First Contact **19**

Table 3: The Nature and Outcome of Goal Setting by Clients **21**

Appendices

Page

Appendix 1: Job Descriptions for Health Trainers and Community Health Development Workers **37**

Appendix 2: Healthy Neighbourhoods Partnership Structure **45**

Appendix 3: Health Behaviour Check **46**

Appendix 4: Example of Framework Analysis **54**

"But you're thinking well if she hadn't had a Health Trainer to take her by the hand and say come on let's go and have some fun she would never have done it and that would never have encouraged her to go and buy bikes for her kids so her kids would never have had the opportunity to ride bikes. It has a knock on effect whatever you do. As long as it's positive and not damaging in any way, it's exciting!"

Cornwall & Isles of Scilly PCT Health Trainer October 2007

Executive Summary

- Seven Health Trainers and three Community Health Development Workers were appointed to initiate the Health Trainer service in Cornwall. All the Health Trainers completed the three month training course. Due to health and other reasons three Health Trainers subsequently resigned. This evaluation focused on the four remaining Health Trainers and the three Community Health Development Workers.

- Health Trainers were identified as a tool for tackling inequalities in identified deprived areas whose residents were not utilising available health services. Their aim was to change their clients' behaviour in order to improve health and wellbeing.

- The organisational structure for the Health Trainers and Community Health Development Workers consisted of a partnership between the National Health Service (NHS), Cornwall Works, Cornwall Neighbourhoods for Change (CN4C) and British Trust for Conservation Volunteers (BTCV).

- From April 2007 until June 2008 the Health Trainers recruited 149 clients. More females than males used the service and the majority of clients were under the age of 40. As identified by postcode, 14% were from deprived areas. The 149 clients set 151 health behaviour goals, of which 21 were achieved. The most common goal was weight loss.

- Six clients were recruited into the evaluation but none completed the follow up questionnaires. From the interviews it emerged that initially many clients were not in a position to change their lifestyle and it was therefore inappropriate for the Health Trainers to attempt to recruit the clients into the study; this could be a factor that contributed to the poor response rate. As the Health Trainers have grown into their roles their understanding has improved and it is likely that if the client evaluation was undertaken at the current time there would be an improvement in client recruitment.

- The Health Trainers have seen a large number of clients and some of these have made changes to their behaviour that has improved their health. However, results are self-reported and any improvements have only taken place in the short term. As there were no data available from the client evaluation it is not possible to report any changes in quality of life or perceived self-efficacy.

- The training process was viewed very positively and the Health Trainers believed that completing the course not only improved their self-confidence but also equipped them in their role as a Health Trainer. However, a key aspect that all the Health Trainers would have welcomed was some training in how to engage successfully with the local community.

- Fourteen per cent of the clients recruited were from designated deprived areas. However, as such clients were identified only by their postcode it is recognised that this can be misleading. It is also recognised that as this was the first year of the new service it is understandable that the first cohort of clients could have been those amongst the easiest to reach. As the Health Trainers become more confident in their role and more established in the community it is anticipated that they will have more success in recruiting clients from areas of high deprivation.

- From the national minimum dataset and from interviews with the Health Trainers there is some indication that some clients have benefited from working with a Health Trainer in terms of being motivated to bring about behaviour change.

- A recurring theme that emerged was the initial lack of co-ordination between the partnerships and the lack of effective communication to others about the role of Health Trainers. They attributed this to a combination of political conflict and different agendas between the partnerships.

- Despite the initial problems the Health Trainers that are in post are growing in confidence and are beginning to develop their skills in recruiting and

dealing with clients. They are also raising the profile of the service and establishing a distinct and unique offering that dovetails with other health and social services.

- The Health Trainer service in Cornwall is emerging as a well defined service that provides a much needed resource to those individuals who do not readily access healthcare services.

1. Introduction

1.1 National Structure

The Health Trainer scheme was first introduced in the Government White Paper *'Choosing Health'* (Department of Health (DoH), 2004). A consultation had highlighted a proportion of the population who were looking for support to achieve changes in health behaviour but for various reasons were reluctant to consult a general practitioner (GP) or other health care professional. Therefore a new form of community-based support was required:

> *'… health trainers will be drawn from local communities, understanding the day to day concerns and experiences of the people they are supporting on health. They will be accredited by the NHS to have skills appropriate for helping members of their community to achieve the changes that they want to make. 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 that they live in, health trainers will be friendly, approachable, understanding and supportive. Offering practical advice and good connections into the services and support available locally, they will become an essential commonsense resource in the community to help out on health choices. A guide for those who want help, not an instructor for those who do not, they will provide valuable support for people to make informed lifestyle choices. Different neighbourhoods will need different types of health trainers and in developing good practice we will learn from seeing which models work best for different communities and individuals'.* (DoH, 2004:103)

There was a strong focus on Health Trainers being a tool for tackling inequalities in identified deprived areas whose residents were not utilising available health services. Far from being *"personal trainers on the NHS"* (Hall, 2004), the idea was that Health Trainers would offer support to the most disadvantaged and those who had difficulty accessing services, based on a health behaviour improvement model (Flint, 2006). Later the White Paper *'Our Health, Our Care, Our Say'* (DoH, 2006) proposed that Health Trainers would be linked to National Health Service (NHS) life checks for individuals at key stages of their lives.

Nationally it was envisaged that Health Trainers would become a key part of the public health workforce and eventually become a *'fundamental building block for*

health improvement' (DoH, 2004:109). The initiative was seen to offer opportunities for unqualified people to gain skills in public health work which may lead to career progression (referred to as a 'skills escalator'). A national draft competency framework was developed by the Sector Skills Council for the UK health sector, Skills for Health (2008), but health authorities were free to develop programmes to best meet local needs. The DoH encouraged the formation of partnerships for the delivery of the programme, with third party organisations from the voluntary and community sectors working in conjunction with the NHS. According to a recent release by the DoH, since 2005 1200 Health Trainers have been trained and are in post across England (DoH, 2008b).

The national Health Trainer Programme was launched in 2005 and 12 early adopter sites were chosen to develop schemes. These sites were located in so-called 'Spearhead' Primary Care Trusts (PCTs) – Trusts chosen by the Department of Health based on high deprivation status according to the English Indices of Multiple Deprivation (Office of the Deputy Prime Minister, 2004). From 2007-08 Health Trainer programmes were extended across England, and all PCTs are now funded through their 'Choosing Health' budget. The Health Trainer pilot in Cornwall was funded from a combination of sources, as explained in Section 1.2.2.

Evaluations have been published for four of the 12 pilot sites: Bradford (South *et al.,* 2006); and three sites in the North East - Gateshead, Northumberland and County Durham (Visram *et al.,* 2006). The key findings from these evaluations are summarised below.

In Bradford, the programme was led by a partnership of local government, PCTs and voluntary organisations. Seventeen Health Trainers were placed with a variety of organisations including GP surgeries, extended schools (schools offering a range of support services to the wider community), healthy living initiatives and support services. Data was gathered on 97 clients who met with a Health Trainer, of whom 58% made some progress on action plans – the main issues tackled were weight management (66%) and healthy eating (45%). Forty-five per cent were signposted to other services. The evaluators attributed the success of the pilot to the strength of the partnership board, which drew on a wealth of previous experience in community work. Issues for further consideration included promotion and publicity concerning the Health Trainer role, and improved communication regarding the position of Health Trainers within existing NHS provision.

The Health Trainer schemes in the North East of England were structurally larger than either Bradford or Cornwall. In Gateshead the programme was administered within a single PCT, but in Northumberland and Durham a number of PCTs formed a network to run a variety of Health Trainer schemes, with each PCT focusing on different target populations and developing different models based on existing community partnerships. The evaluation focused on models of delivery rather than analysing client data, and made the following key recommendations:

- *Take the opportunity to be innovative, building on existing good work without repeating the 'mistakes' of the past.*
- *Be clear about how the chosen model for Health Trainers will best meet local health needs.*
- *Plan carefully, paying particular consideration to practical issues such as recruitment and supervision of the Health Trainers.*
- *Develop an appropriate monitoring and evaluation framework as part of the initial planning process.*
- *Provide locally delivered training that is relevant, timely and appropriate to the needs of local Health Trainers, who will also require ongoing support and personal development once in post.*
- *Ensure that a two-way dialogue with the centre is maintained and that, when appropriate, project leads or managers seek clarification around any perceived mixed messages.*
- *Share good practice amongst sites to avoid 'reinventing the wheel' and to forge partnerships, learning from one another and providing peer support.*

(Visram *et.al.,* 2006)

In a further study the personal experiences of a sample of the first Health Trainers in the County Durham and Tees Valley Public Health Network were examined. The results showed that those interviewed felt personal qualities and a shared cultural identity were more important than formal qualifications and relevant work experience, but that these same factors were seen as a barrier in gaining acceptance from other health professionals. Additionally the findings showed that the perceived advantages of the Health Trainer approach over conventional clinical and medical services were a non-judgemental approach, flexibility to meet a range of needs and sufficient time to devote to individuals.

Observed outcomes among clients included increased self-esteem, weight loss, increased activity levels and the formation of new social networks.

Although the Health Trainers felt that their role was having an impact on the wider determinants of health, it was acknowledged that this was difficult to measure. Generally they felt that the training for the role provided transferable skills for career development, although barriers included a feeling of being restricted by their models of local service provision and existing skills and experience not being acknowledged (Visram and Geddes, 2007).

The following section describes the structure of the Health Trainer programme in Cornwall.

1.2 Health Trainer Service in Cornwall

The Health Trainer service in Cornwall was structured through a partnership (the Healthy Neighbourhoods Project) formed to achieve Local Area Agreement (LAA) targets. LAAs are a Government initiative designed to give more freedom to local agencies in managing key issues in their area. The Health Trainers programme falls under the LAA priority area of Healthy Communities (Cornwall Strategic Partnership, 2006).

1.2.1 Location and Personnel

In Cornwall, Health Trainer positions were advertised in the local press in November and December 2006. In order to encourage applicants, particularly those without academic qualifications, all who expressed initial interest were offered a place at an open event, attendance at which guaranteed a job interview. Additionally, Cornwall Works, an agency responsible for addressing worklessness and an NHS funding partner, offered applicants the option of a free place on one of their Routeway workshops, which are designed to build confidence in interview technique to facilitate a return to work. At least two of the originally appointed Health Trainers undertook the Routeway workshop before their formal interview.

Health Trainers were recruited to support the following local communities:

- Parc an Tansys/Pengegon (Camborne);
- Treneere (Penzance);
- Gannel (Newquay);

- Clay Area (nr. St Austell);
- Kinsman and Berryfields (Bodmin)
- Saltash and East Cornwall; and
- Malpas and Trelander Estates (Truro)

The areas were selected by the Partnership according to high deprivation criteria as defined by the English Indices of Deprivation (Office of the Deputy Prime Minister, 2004) combined with needs assessments conducted by the partners. Overall management of the programme was the responsibility of the NHS through the Cornwall and Isles of Scilly Health Promotion Service in partnership with Cornwall Works, and two voluntary and community agencies, the British Trust for Conservation Volunteers (BTCV) and Cornwall Neighbourhoods for Change (CN4C). As well as the appointment of Health Trainers to cover the seven locations, Community Health Development Workers (CHDW) were recruited, each with different responsibilities according to local need. In general the CHDWs were recruited to deliver a community development approach, support the Health Trainers and also to provide a dialogue between the community and health services providers. Through this approach it would be possible to begin to make changes to the way health services are delivered on the ground to make sure they are more appropriate to local needs.

The role varied according to location. Under the umbrella of BTCV, a CHDW was recruited to manage and support the Health Trainers and to help in raising their profile in the targeted communities in Camborne and Penzance. Under the CN4C model, a CHDW was to perform a similar role in Bodmin and Truro but, following the withdrawal of a Health Trainer at the end of the training period, the appointed individual also covered the Health Trainer placement in Bodmin. A third CHDW had no responsibilities for line management of Health Trainers, but with Neighbourhood Renewal funding performed community development and Health Trainer functions within Redruth North and Penzance Central. Line management duties for the Health Trainers in the Clay Area, Newquay and Saltash were the responsibility of the Cornwall and Isles of Scilly Health Promotion Service, and these three Health Trainers also worked with Cornwall Works in respect of clients who sought to re-enter the employment market. A Health Trainer Project Co-ordinator was appointed to liaise between the various partnerships and oversee the project, and was also responsible for overseeing the line management of the three Health Trainers who did not report to

a CHDW. Due to staff illness and changes there have been three different Health Trainer Project Co-ordinators since the initial recruitment of the Health Trainers.

The original job descriptions for Health Trainers and CHDWs are provided in Appendix 1. Health Trainers were specifically required to:

- *Engage with individuals in local communities which have identified health inequalities;*
- *Communicate with individuals about health and health improvement;*
- *Enable individuals to change their behaviour to improve their health;*
- *Communicate with individuals about their pathway back to work at the appropriate time;*
- *Manage and organise their time and activities to support individuals in the community.*

Both the Health Trainers and the Community Health Development Workers came from different backgrounds with a variety of educational achievements, from no qualifications at all to degree level. All had experience in working in areas supporting people in need either as part of their employment or through voluntary work.

Of the seven Health Trainers recruited, six completed the training course and qualified in June 2007 which overlapped with the start of their placements in May 2007. Since June 2007 two of the Health Trainers have left, leaving four still in post (the replacement Health Trainers were not included in the evaluation). Efforts made to contact the Health Trainers who left the service were unsuccessful. The four remaining Health Trainers were placed in different organisations including a local hospital, residential housing and a Citizens Advice Bureau.

1.2.2 Funding

The funding model involved a number of sources, as follows:

- Section 64 grant – made by Government to voluntary organisations to support DoH priorities;
- Neighbourhood Renewal Fund – Government funding to deprived areas defined by the English Indices of Deprivation, administered by a Local

Strategic Partnership. The local authority districts of Kerrier and Penwith were eligible for this funding;

- Cornwall Works, which reports to the Cornwall Strategic Partnership and Local Strategic Partnerships and has specific responsibilities for addressing issues of worklessness;
- NHS funding, provided through the 'Choosing Health' budget, ring-fenced for local public health initiatives.

An organisational chart for the Healthy Neighbourhoods Project for the period of time covered by this evaluation is shown in Appendix 2.

2. Aim and Objectives of Evaluation

2.1 Aim

To evaluate whether the introduction of Health Trainers improves the health of clients and reduces health inequalities in specified geographical areas of Cornwall. This study focused on the recruitment, training and workload of the initial wave of Health Trainers in Cornwall during their first year of operation.

2.2 Objectives

1. To evaluate the process of establishing Health Trainers within local communities;
2. To evaluate the impact Health Trainers and Community Health Development Workers have on the reduction of health inequalities in targeted areas of deprivation in Cornwall.

3. Evaluation Design

The focus of the evaluation was on both the process and the outcomes of the project and consequently a descriptive design with a developmental perspective was taken (Ovretveit, 1998). The main features of this method of evaluation is that the focus is on one or a small number of services, an intervention is involved, collaboration and feedback are characteristics of the design of the evaluation; and no controls nor an experimental design are used (Judge, 2000). The study was longitudinal,

incorporating a follow-up assessment at three months following training, with a final assessment at twelve months.

3.1 Sample

3.1.1 Health Trainer Personnel

The initial service model in the Healthy Neighbourhood Project consisted of one Health Trainer Co-ordinator, two Community Health Development Workers, seven Health Trainers, and one person who acted as a joint Community Health Development Worker and Health Trainer. Three Health Trainers withdrew from the project, and one Health Trainer did not respond to repeated requests for interview. Interviews were undertaken with the Health Trainer Co-ordinator, two Community Health Development Workers, and three Health Trainers. In addition the individual undertaking the joint role was also interviewed.

3.1.2 Health Trainer Clients

All of the Health Trainers' clients who used the service in the first nine months of the evaluation study were asked to participate in the evaluation.

3.2 Data Collection

3.2.1 Personnel

Semi-structured interviews were undertaken with all participants and covered the key areas of recruitment, training, support, management, skills gained, community engagement, liaison with other agencies, client interface, perceived barriers and positive aspects of the role. Whilst the same themes were explored with all participants, the perspectives varied according to the different roles undertaken by the participants. The Health Trainers were interviewed at three months following completion of training and again after 12 months in post. In addition the Health Trainers were asked to complete a weekly reflective diary which focused on new knowledge and skills gained, activity undertaken, barriers to progress, and general comments for each of the areas of training, community engagement, liaison with other agencies and meetings with clients.

The Community Development Workers and the Health Trainer Project Co-ordinator were interviewed 12 months after the Health Trainers were in post. The

interview with the Health Trainer Project Co-ordinator also focused on management set up, partnership working and strategic planning.

3.2.2 Clients

After their initial contact with a Health Trainer, all clients were asked to complete a baseline questionnaire on their lifestyle and current health status, based on the national dataset (DoH 2008a). These questionnaires are included as Appendix 3. Additional questions related to perceived self efficacy (Jerusalem and Schwarzer, 1992) and four general questions were included to capture overall feelings about health, fitness, perceived quality of life and motivation to change lifestyle, using a visual analogue scale (Appendix 3, Question 6). A decision was made to include these latter two concepts in an attempt to measure interim outcomes related to behaviour change and intention to change health related behaviour.

Clients were then asked whether they wished to be followed up for the purpose of the evaluation study. Those who agreed were sent, together with a stamped addressed envelope, a follow-up health questionnaire to assess any changes in lifestyle and health status. A total of three attempts were made to follow up clients who did not respond.

3.3 Data Analysis

All interviews were taped, transcribed and the data analysed using the framework method to elicit key themes and categories (Ritchie *et al.*, 2007). All transcripts were read and analysed by two members of the research team and/or an outside researcher with experience in the framework method.

In addition the questionnaire data were analysed using Microsoft Excel to describe the health status of the clients, perceived self efficacy and any behaviour change of the clients over the evaluation period.

3.4 Focus of the Evaluation

For the clients the focus was on changes in health related behaviour, perceived self efficacy and an overall assessment of quality of life. For the Health Trainer personnel the focus of the evaluation was on the process of establishing the service within the community as well as the impact of the service on client behaviour.

3.4.1 Process

Consideration was given to the recruitment process for the Health Trainers, all aspects of the training programme, the management of the service, the on-going support provided to the Health Trainers and Community Development Workers, identification of the new skills obtained, and how well perceived barriers were overcome.

3.4.2 Outcome of the Service

Indicators of the success of the service included the number of clients recruited, the proportion recruited from deprived areas; and the number who set themselves goals for improvement in health behaviour and actually achieved these goals. In addition the extent to which the Health Trainers were successful in engaging with the community and liaising with other agencies was used as a measure of outcome.

3.5 Ethics

NHS ethical approval was granted by the Cornwall and Plymouth Research Ethics Committee in June 2007.

4. Results

4.1 Client Data Obtained as Part of the National Minimum Dataset

From April 2007 to June 2008, the Health Trainers recruited a total of 149 clients (based upon the numbers of completed questionnaires submitted to the Health Trainer Co-ordinator). Information from the interviews indicated that a number of Health Trainers were set explicit monthly targets for recruiting clients to the service. Target setting varied because of the differences in the priorities set by the participating partners. The total number of clients recruited by the five Health Trainers ranged from 13 to 53. Table 1 shows how the clients were recruited (missing data for 30 clients).

Table 1: Source of Recruitment to the Service (n=119)

Local Community	37 (31%)
Employment Centre	17 (14%)
GP	13 (11%)
Health Visitor	11 (9%)
Health Trainer	10 (8%)
Housing Group	7 (6%)
Friend	7 (6%)
Nurse	5 (4%)
Charity Organisation	4 (3%)
Council	4 (3%)
Self Referral	2 (2%)
Walking Group	2 (2%)

The main source of initial contact was from the local community, involving a number of initiatives such as leaflet drops, attending resident meetings, attending fun days and events at community centres.

Table 2 shows the characteristics and the self-reported health behaviour of the clients at first contact with the Health Trainer. It should be noted that the number varies for each question due to missing data.

Table 2: Characteristics and Health Behaviour of Clients at First Contact

Sex	n = 141
Male	63 (45%)
Female	78 (55%)
Age	n = 135
Under 40	71 (53%)
40-50	35 (26%)
51-60	18 (13%)
Over 60	11 (8%)
Self reported health status	n = 87
Excellent	7 (8%)
Very Good	7 (8%)
Good	30 (34%)
Fair	29 (33%)
Poor	14 (16%)
Perceived ability to improve health and well being without the help of trained professionals	n = 87
Definitely Yes	7 (8%)
Probably Yes	12 (14%)
Not Sure	23 (26%)
Probably No	30 (34%)
Definitely No	15 (17%)
Do you drink alcohol?	n = 81
Yes	50 (62%)
No	31 (38%)
Do you smoke?	n = 96
Yes	34 (35%)
No	62 (65%)
Do you exercise weekly?	n = 83
Yes	64 (77%)
No	19 (23%)
Resident in postcode identified deprived area	n = 97
Yes	14 (14%)
No	83 (86%)

From Table 2 it can be seen that more females than males have used the service. The average age of clients was 40 and the range was between 17and 86. The majority of clients were under 40 years old (53%). The majority of clients rated their health as good or fair (67%) whereas 51% of clients thought they needed help to

improve their health. Over 60% of clients stated they drank alcohol, and 35% indicated that they were smokers. Of the clients who stated they drank alcohol, 79% self-reported that they drank within the recommended limits (males 21 units per week, females 14 units per week) whilst 21% stated that they exceeded this. Seventy-seven per cent of clients undertook some form of exercise each week.

Using data provided by the Cornwall & Isles of Scilly Health Promotion Service an assessment was made as to whether the clients were resident in areas of deprivation as defined by the Health Promotion Service. From Table 2 it can be seem that analysis of the postcode data indicated that 14% of the clients were resident in deprived areas. This figure appears low but care should be taken in interpretation because the use of postcode data alone can be misleading (e.g. some clients were resident in sheltered housing that was not classified as deprived).

Table 3 shows the classification of the goals set by the clients. It should be noted that the decision to set goals was determined by the judgement of the Health Trainer. At the first meeting the Health Trainer made an assessment of whether it was appropriate for a client to set themselves a goal; in some cases this was not considered to be appropriate (for example if the client needed help with domestic violence) and in others it was only appropriate after a number of sessions. It should also be noted that the clients could set themselves more than one goal.

Table 3: The Nature and Outcome of Goal Setting by Clients

Goal	n = 151
Weight loss	32 (21%)
General advice	29 (19%)
Employment	25 (17%)
Exercise	20 (13%)
Diet	16 (11%)
Confidence building	14 (9%)
Stop smoking	12 (8%)
Reduce stress	1 (1%)
Other	2 (1%)
Achieved Health Goal (self report)	n = 49
Yes	12 (29%)
No	37 (71%)
Achieved Non Health Goal (self report)	n = 34
Yes	9 (26%)
No	25 (74%)

From Table 3 it can be seen that the most common goal set was weight loss (21%). Examples of issues that fell within general advice were advice on debt, support for single parents, housing problems and "improve social life". Employment was high on the list of goals set as one Health Trainer was specifically employed to provide employment advice to the long term unemployed. Of the 12 who achieved their health goals (diet, exercise, weight loss, stop smoking), five related to diet and three each for stopping smoking and exercise. Of the nine non health related goals achieved, five related to finding employment and training , the others being 'reduce stress', 'undergo training', 'improve confidence' and 'socialisation'.

One issue explored was whether the Health Trainers referred clients on to other services. From the data available it is estimated that approximately 40% of clients who are helped by a Health Trainer are also referred on to other services. These services ranged from lifestyle services e.g.: Shape Up, Eatsome, LeapActive, Stop Smoking Services, and walking groups to other services such as the Drug Action Team, Adult Social Care, CN4C general advice and to Cornwall Centre for Volunteers. It is understood that the Health Trainers often signpost their clients to a more than one appropriate service.

4.2 Client Participation in the Evaluation

Since June 2007 only six clients agreed to take part in the formal evaluation which involved completion of a follow-up questionnaire to measure changes in current lifestyle and self efficacy. Of the six who agreed to participate none responded to the three attempts to complete the follow-up questionnaire. At an initial series of meetings with the Health Trainers and during the interviews, the Health Trainers indicated that the main reason for non-recruitment to the evaluation was a result of an insufficient understanding of the evaluation requirements at a time when their priority was to become fully cognisant of the requirements of the Health Trainer role. It was clear that if they were to recruit clients to the evaluation at the current time, they would feel more confident in doing so. Importantly, the administration required for the evaluation was identified by the Health Trainers as a potential barrier to establishing a constructive relationship with clients during their first meeting.

4.3 Health Trainer Personnel

Three of the four Health Trainers and one Community Health Development Worker who was also working as a Health Trainer were interviewed at three and 12 months after the start of the pilot. In addition the two other Community Health Development Workers and the Health Trainer Co-ordinator were interviewed. The initial findings are outlined below grouped into nine key themes of recruitment, training, support/management, new skills, community engagement, liaison with other agencies, client interface, barriers and positive outcomes. The framework method was used for the analysis of this data and an example is shown in Appendix 4. Where appropriate, categories that have emerged from the key themes have been identified.

4.3.1 Recruitment of Health Trainers

Overall the recruitment process was seen as straightforward by the Health Trainers.

4.3.1.1 Advertisement

One of the main attractions of the advertisement was the fact that no qualifications were required; however this resulted in a large number of applicants and was very time consuming to process. One key message that recurred was that it needed to be recognised that the role of the Health Trainer is a skilled one and that potential applicants should be made aware of what the job involves. *"It is a very skilled role and that needs to be acknowledged more than it is" (CHDW 01).* A Community Health

Development Worker identified that it would be useful if potential candidates had experience of working in the voluntary sector and that should be used in the advertisement. *"The first Health Trainers recruited had a very steep learning curve. Now they come with more experience of working with homeless and voluntary work" (CHDW 03).*

4.3.1.2 Interview

The pre-interview course which, if attended, guaranteed an interview was viewed as a positive step and was welcomed by the applicants.

The level of training required was not made clear and some of the Health Trainers would not have applied had they known that the training involved a University course. *"The job advert did not mention University module, had it said that I probably wouldn't have applied" (HT 02).* One Health Trainer suggested that the nature and underpinning level of the course should be made clearer at interview. It was made clear at the interview that knowledge of the local area was important but one Health Trainer on appointment was located away from their local area.

4.3.1.3 General

The Health Trainers thought that for future recruitment, an existing Health Trainer should be involved in the interviews as part of the selection process; and also to be available to enable applicants to ask about the key elements of the role. All the Health Trainers are now involved in attending open days for future Health Trainers which, although time consuming, are seen as important in raising awareness and understanding of the Health Trainer role. The Health Trainer Co-ordinator stressed that it was important to attract the "right" people, not necessary those with qualifications.

4.3.2. Training

The training was set up as two 20 credit modules to be taken at various academic levels (certificate, diploma, undergraduate and masters), delivered by staff from the Faculty of Health & Social Care at the University of the West of England (UWE). The training took place over three months and consisted of training in communication skills, assessment of health needs behaviour change and maintenance of change, and inter-agency working. Both the Community Health Development Workers and the Health Trainers undertook the same training course.

4.3.2.1 Content

The Health Trainers agreed that the content of the modules was appropriate and that the teaching had been very good. However, a few were surprised that it was a University course even though they could choose the level they thought was appropriate for them. Two said they would not have applied if they had been aware of this. All agreed that the training equipped them for working as a Health Trainer although the usefulness of some of the skills learnt only became apparent once they were in post. All reported greater confidence in themselves following completion of the course. Whilst the Health Trainers thought the actual training was good, there were disruptions during the course due to an apparent confusion between what they were told about the length of their contract, the location of their placement, and general management and administration issues. There was some concern that the course length was too long and could have been completed earlier. However it was noted that there was a wide variation in the prior academic achievements of the Health Trainers and the course was designed to account for this.

4.3.2.2 Mentors

During the training each Health Trainer had a mentor appointed. All the Health Trainers commented on the importance of a good mentor, not just during the course but as an ongoing part of the process. It was also identified as important that the mentor was local to the area. With regard to the mentors appointed, the quality was perceived to be variable. Due to managerial staff problems whilst the Health Trainers were completing their course many thought that there was little or no support and felt that they were forced to take on a more proactive role (e.g. obtaining equipment) than they had expected.

4.3.2.3 Missing Aspects

Aspects that were identified as missing from the training course included:

- How to undertake effective community engagement (design of leaflets and handouts);
- Mapping health needs of the local community;
- Dealing with violence in the home, homelessness and family violence; and
- Training for data collection and recording.

Overall the training was appropriate and gave the Health Trainers the confidence and the majority of skills needed to undertake their roles.
(Note: Health Trainers are no longer required to undertake the University course, which has been replaced by a City and Guilds qualification).

4.3.3 Management and Support

From the initial interviews at three months it was clear that issues between the partnerships were impacting on the Health Trainers. There was a perception amongst the Health Trainers that the overall strategic plan of the Health Trainers was not fully understood by some managers. *"It is more important at a strategic level for managers to be aware of the role of Health Trainers and the outcome of the project rather than employ Health Trainers first then fumble around in the dark afterwards" (CHDW 01).* This was reflected by a lack of understanding of the role of the Health Trainers and the outcome of the project. As a result some of the Health Trainers reported that there was no initial guidance once they were in post as to what they were meant to be doing. *"I thought somebody somewhere would tell me exactly what I am supposed to be do and it never happened. The job role evolved around the people who were employed" (HT 02).* In addition there was an expectation that some groundwork would have been undertaken to ease the new Health Trainers into their roles but it became apparent that this was not the case. "*I would have expected some people to have known about us and who we were, some did but some didn't. There was no guidance in what we were meant to be doing" (HT02).* This resulted in some confusion and in some cases hostility from existing services. This led the Health Trainers to evolve the job role as they thought appropriate.

4.3.4 New Skills

The Health Trainers commented that once in post the usefulness of the skills acquired during the training were apparent.

4.3.4.1 Personal Skills

As well as the new skills obtained from the training programme, all of the Health Trainers reported an improvement in self-confidence. In addition, once in post they had learnt how to give presentations, promote themselves and their role and liaise with various organisations. As one Health Trainer explained: *"I feel I can hold my own*

at a doctor's meeting now" (HT 02). A further skill identified was how to deal with difficult clients.

4.3.4.2 Organisational Skills

The Health Trainers also stressed that there were new skills that they had to learn once in post which included networking and identifying political conflict in meetings.

4.3.4.3 General

Since being in post all the Health Trainers are given options to undertake ongoing training courses which are provided by the NHS. The Health Trainers decide themselves whether or not the courses provided are suitable for them and whether or not to undertake the course. These are generally seen as useful but can be time consuming. *"There is a lot of time taken up by training and it comes into conflict with delivering the service" (HT03).*

4.3.5 Community Engagement

In order to make themselves known to their local communities, the Health Trainers each adopted various strategies which included:

- Attending relevant meetings such as resident association meetings
- Visiting GP surgeries
- Meetings with health visitors.
- Leaflet drops
- Attending local events such as Fun Days
- Initiated projects which involved the local community (e.g. These are our Streets and Hearts and Home)
- Setting up walking groups
- Holding local cooking events

A perceived barrier to successful engagement with the local community was the lack of any groundwork undertaken prior to the placement of the Health Trainers and Community Health Development Workers. In particular a Community Health Development Worker identified a complete lack of prior consultation with the local

communities. *"What was lacking was there was no kind of consultation with the communities in the first instance" (CHDW 01).*

A key theme that emerged from all the interviews was the need for the Health Trainers and Community Development Workers to get out into the local community and get their faces known by knocking on doors and walking the streets. Otherwise their role would become one of a *"… glorified Health Visitor." (HT 03)*

Despite the lack of groundwork in place, once the Health Trainers and Community Health Development Workers were in post they used their own initiative in engaging with their local communities which has been very successful. This was reflected in the number of clients that have been recruited from local communities as opposed to being referred from other agencies. In particular projects such as 'These are our Streets' and 'Hearts and Homes', in which local residents from Parc-an-Tansys, Gwelmor and Pengegon in Camborne and from Treneere in Penzance were given cameras with which to record daily life in their communities, have been very effective in engaging local residents.

4.3.6 Liaison with Other Agencies

Initially the Health Trainers found it difficult to gain acceptance, partly due to a perceived lack of understanding by health care agencies and professionals about the Health Trainer role, and partly due to a lack of groundwork.

Again a key theme that emerged was the lack of groundwork in raising the awareness of the role the Health Trainers and the scheme in general from health care agencies and professionals. The Health Trainers had expected information about the Health Trainer service to have been communicated to key agencies and health care professionals in advance of them commencing their roles. This had not occurred and in some cases this lack of understanding caused tension between the Health Trainers and other health care workers. *"I had to write a letter to the Practice Manager. And that's the NHS all over isn't it. A project can develop in the NHS, this person doesn't know about it and doesn't see that they have to work together" (CHDW 01)*

The majority of Health Trainers believed that their management needed to explain the role of the Health Trainers to other organisations. Communications between the different managements were identified as being "poor" and a potential barrier. One reason why this lack of communication was a potential barrier was that the Health Trainers were not initially confident enough in themselves to approach other organisations and explain their role. However, it should be noted that since the

Health Trainers have been in post their self-confidence has grown to the extent that this is no longer an issue. It also became clear that once the role of the Health Trainers had been explained and understood, relationships between the organisations improved. *"Once it was clear that I was not there to take work away from them and was there to support them their guard comes down"(HT 02).* A related issue identified in the interviews with the Community Health Development Workers was that both the Health Trainers and Community Health Development Workers were appointed at the same time, which did not allow time for the latter to liaise with the various organisations on behalf on the Health Trainers.

4.3.7 Client Interface

As a consequence of the lack of communication about their role there were limited referrals from other organisations and health care professionals. This resulted in the Health Trainers having to be more proactive than they had expected. Innovative ways of recruiting clients were shown by the Health Trainers and included:

- Weight management groups
- Yoga groups
- Play and fun health days
- Walking groups

Once they began to work with their clients, however, the Health Trainers reported that the relationships they were establishing were rewarding.

A main issue that arose from the interviews concerned the fact that many of the clients had major issues to resolve before they could even consider lifestyle changes that would improve their health. As one Health Trainer pointed out: *"When I first see a client health is not a priority but later on they start to think about health issues"* (HT 04). It was also noted that once the Health Trainers start to see clients *"… word gets around and people start to come to see you for advice"* (HT 01). This advice is mainly to offer support but as the relationship with the client grows the Health Trainer is able to tackle health issues. An important issue raised by a number of Health Trainers concerned policy regarding lone working. It was identified that in a lot of cases the Health Trainers were seeing clients in their homes and although they took appropriate precautions in informing colleagues where they were going it was felt that they should

be made aware of any violence issues relating to the client or their spouses or partners.

4.3.8 Barriers

The Health Trainer personnel identified a number of perceived and actual barriers that they considered could impact on the effectiveness of their role.

4.3.8.1 Management

The management barriers that were identified can be separated into two sub categories; misunderstandings and internal politics:

- *Misunderstandings*

  A recurring category was that of management misunderstanding of the role of the Health Trainers. As was put succinctly by a Community Health Development Worker: *"At the Partnership level as well as at the strategic level people were not really informed about the role of the Health Trainers and that cascaded down" (CHDW 01).* This lack of awareness of their role was seen as a contributing factor to the lack of groundwork that caused many of the initial problems: *"I don't think senior management have a deep understanding of the project"* and *"… the barriers were at senior level in that there was not enough preparation" (CHDW 02).*

  Although this message about management misunderstanding came out strongly in the first set of interviews the situation changed significantly by the time the second interviews were undertaken. During these interviews the majority opinion was that there was a much better understanding of the project and roles; and also an improvement in the manner of communications between the partnership organisations.

- *Internal Politics*

  Initially, internal politics between the partnership organisations was identified as a barrier. This manifested itself in a number of ways including a lack of trust between the partners and concern about losing control over the Health Trainers, thus resulting in a power struggle. In addition there was a perceived lack of communication between the partners which led to tension between the project funders and role of the Health Trainers. All this was summed up as the:

"… partnership not being a partnership and there was a reluctance to work together" (HTC).

4.3.8.2 General

Other barriers identified included:

- Deprivation had to be addressed first before tackling health issues;
- The amount of administrative paperwork could deter potential clients;
- Short time frame to achieve benefits;
- Very high initial expectations;
- Lack of resources resulting in appearance of being unprofessional;
- Having set targets to recruit clients.

It is fair to state that the barriers identified above were to be expected in the context of a new service being established by a partnership structure in which organisations with differing priorities were involved; but it is important to note that the majority of these barriers have been overcome as the service has evolved.

4.3.9 Positive Outcomes

Positive factors that were identified during the two rounds of interviews can be separated into: (i) aspects of the Health Trainers' role; and (ii) overcoming the barriers identified above.

4.3.9.1 Health Trainers' Role

The following quotes from the Health Trainers illustrate some of the positive attributes of how they perceived their roles:

"It's a brilliant idea and positive that people in the community are employed to support their own communities " (HT 03)
"It is great to see clients changing their behaviour " (HT 02)
"I love going to see people that are making changes, it excites me" (HT 02)
"I feel that I am beginning to make changes to people's lives" (HT 01)

Other positive factors that emerged were that the Health Trainers were more confident and had a better understanding of their roles. They also commented on the fact that one of the positive aspects of the lack of management was that they were able to develop their role and be innovating without too many restrictions. Some of the Health Trainers also saw the removal of client targets as a positive move.

4.3.9.2 Overcoming Barriers

The main issues that emerged concerned the improved relationships and communication between the partnerships and senior management.

5. Discussion and Recommendations

The initial recruitment procedure was a very open, non-exclusive process which attracted a large number of potential candidates. As this was a new service it was unclear as to what key attributes were needed to be a successful Health Trainer and as such a large number of candidates were interviewed. This was very time consuming and resource intensive. Now that there is a pool of successful Health Trainers available it is recommended that these are used in the recruitment process, both in explaining the role to potential candidates and also identifying candidates with the key attributes. This should reduce the number of potential candidates that need to be interviewed.

In terms of training overall the process was viewed very positively and the Health Trainers believed that completing the course not only improved their self-confidence but also equipped them in their role as a Health Trainer. However, a key aspect that all the Health Trainers would have welcomed was some training in how to engage successfully with the local community. It is recommended that if possible this should be included in future training. Again, using the experience of the existing Health Trainers could be a potential solution. A key issue that needs to be addressed is the safety aspect of Health Trainers working with clients. There needs to be a structure in place whereby potentially dangerous clients or their partners/spouses or family are identified and this information is made available to the Health Trainers. Training should cover what the appropriate procedure should be in dealing with these situations. A further issue that arose was that both the Community Health Development Workers and the Health Trainers undertook the training at the same time. This meant that they both started in their posts at similar times which limited the

amount of preparation work the Community Health Development Workers could do in their area prior to the Health Trainers starting.

The main objective of the Health Trainer service was to change the behaviour of people who do not generally use existing health services, in such a way that their overall health and wellbeing improves. In total 149 clients have used the service and over 20 have reported a positive change in behaviour. One of the main problems in assessing the success of the Health Trainer service is that it is very difficult to assess changes in behaviour, especially over the short term. Although it clear that the Health Trainers have seen a large number of clients and some of these have made changes to their behaviour it must be taken in the context that any results are self-reported and have only taken place in the short term. As there were no data available from the client evaluation it is not possible to report any changes in quality of life or perceived self-efficacy.

In terms of routine data collection there was wide variation in the completeness of forms returned by the Health Trainers. This has led to inconsistency and a large amount of missing data during the first year of the service. From the data returns there appears to be a wide variation in the numbers of clients seen by the Health Trainers. This ranged from 15 to 53 but it is unclear whether this was due to target setting, missing data or other issues. It is recommended that the importance of timely, accurate and complete data is made clear to all those involved in completing the national minimum dataset returns.

A further issue that needs to be addressed is the setting of targets and priorities for the Health Trainers. It became clear that due to the different organisational objectives of those involved in the partnership, there were variations in priorities and targets between the Health Trainers. For example, for one Health Trainer the first priority was to assist clients in returning to work whilst changing their health related behaviour was considered a secondary objective. In addition, this Health Trainer was set a target number of clients to recruit, whilst other Health Trainers had no such targets. This had an impact on the overall results as it skewed the number of clients who achieved a non-health related goal.

From the interviews all the Health Trainers commented on the detrimental effect of having a target of a set number of clients per week or month would have on the client recruitment process. Those Health Trainers who did initially have targets reported that they would complete the minimum dataset forms for inappropriate clients

(e.g. a person who wanted advice on how to become a volunteer) just to meet their targets.

In terms of the evaluation of the clients it was disappointing that the recruitment to the study was so poor. In hindsight this was due to a number of factors. One of the major issues that arose in relation to the design of the evaluation was the initial lack of understanding by the Health Trainers about the aims and process of the evaluation project, despite that fact that considerable time and effort was spent by the evaluation team to explain the nature and requirements of the evaluation. Unfortunately, this coincided with the Health Trainers' frustration with their management and related issues. Because of this lack of understanding, it is possible that the Health Trainers were initially unwilling to approach clients to participate in the evaluation. Another issue that emerged from the interviews was the fact that many clients were not in a position to change their lifestyle and it was therefore inappropriate for the Health Trainers to attempt to recruit the clients into the study; this could be a factor that contributed to the poor response rate. As the Health Trainers have grown into their roles their understanding has improved and it is likely that if the client evaluation was undertaken at the current time there would be an improvement in client recruitment.

There was also confusion between the academic staff at UWE, the Health Trainers and the steering group about the nature and purpose of the evaluation both in terms of the routine data monitoring and the data required for the evaluation. This led to some frustration and confusion at a time when there were many other concerns about the development of the role.

One of the major purposes of the Health Trainer service was to access the 'hard to reach' clients who were not already in touch with other services, with the long term objective of reducing health inequalities. From the data available it appears that 14% of the clients recruited were from designated deprived areas. However, as the clients from "deprived" areas were identified only by their postcode it is recognised that this can be misleading. It is also recognised that as this was the first year of the new service it is understandable that the first cohort of clients recruited could be those that are amongst the easiest to reach. As the Health Trainers become more confident in their role and more established in the community it is anticipated that they will have more success in recruiting clients from areas of high deprivation. To assist this further, work needs to focus on how the Health Trainers' role can be publicised so that they can more readily access individuals who are not currently in contact with health or social services but who would benefit from the Health Trainer service.

As this is a new service the Health Trainers have had to adapt as they developed their role. Their expectations were different as to the actual role and they have had to be flexible as to how they recruited and dealt with clients. This has implications for target setting and the appropriateness of target setting with such a new role. Some of the Health Trainers initially found it difficult to work towards targets rather than outcomes. This was mainly due to the fact that some Health Trainers were being funded by organisations that required different outcomes to those perceived by the Health Trainers.

A recurring theme that emerged from the Health Trainers was the initial lack of co-ordination between the partnerships and the lack of effective communication to others about the role. This was attributed to a combination of political conflict and different agendas between the partnerships. As a result there appeared to be little or no groundwork laid to enable a smooth transition from training to placement for the Health Trainers.

Feedback to the partnership organisations on the progress and success of the Health Trainers was seen as important in leading to greater understanding of their roles and objectives.

One measure of the success of the Health Trainer scheme is whether the targets set by the clients have been achieved. The national minimum dataset and interviews with the Health Trainers indicated that some clients benefited from working with a Health Trainer in terms of being motivated to bring about behaviour change.

Despite the initial problems the Health Trainers that are in post are growing in confidence and are beginning to develop their skills in recruiting and dealing with clients. They are also raising the profile of the service and establishing a distinct and unique offering that fits in with other health and social services.

In conclusion, the information obtained from those involved indicates that the Health Trainer service in Cornwall is emerging as a well defined and much needed resource to those individuals who do not readily access health care services. However, due to the poor response rate it was not possible to fully assess the impact on clients, therefore it is important to continue to audit the service to ensure that the key objective of reducing health inequalities is achieved in the long term.

6. References

Cornwall Strategic Partnership (2006) *Local Area Agreements.* [Accessed 5 June 2008 at http://www.cornwallstrategicpartnership.gov.uk/index.cfm?articleid=12893]

Department of Health (2004) *Choosing Health.* The Stationery Office: London

Department of Health (2006) *Our Health, Our Care, Our Say.* The Stationery Office: London

Department of Health (2008a) *Improving Health: Changing Behaviour. NHS Health Trainer Handbook.* The Stationery Office: London

Department of Health (2008b) *Health Trainers – Review to Date.* The Stationery Office: London

Flint C (2006) quoted in CAHHM (Centre for Arts and Humanities in Health and Medicine) and Chrysalis Consulting. *What might the Health Trainer role look like in practice?* CAHHM: Durham

Hall S (2004) *Plan for personal health trainers on NHS.* The Guardian, 13th November

Jerusalem M and Schwarzer R (1992) *Self-Efficacy as a Resource Factor in Stress Appraisal Processes.* in Self-Efficacy: Thought Control of Action. Schwarzer R. (ed.) Hemisphere: Washington

Judge K. (2000) *Testing evaluation to the limits: the case of English Health Action Zones.* Journal of Health Services Research and Policy **5:1** 3-5

Office of the Deputy Prime Minister (2004) *The English Indices of Deprivation.* The Stationery Office: London

Ovretveit, J (1998) *Evaluating Health Interventions.* Open University Press, Buckingham

Ritchie J, Spencer L and O'Connor W (2007) *Carrying out Qualitative Analysis.* in Qualitative Research Practice, Ritchie J and Lewis J. (eds.) Sage: London

Skills for Health (2008) Health Trainer Competences. [Accessed 18 July 2008 at http://tools.skillsforhealth.org.uk/competence/searchResults?keywords=Health+Trainers&level%5B%5D=1&level%5B%5D=2&level%5B%5D=3&level%5B%5D=4&adv_search.x=23&adv_search.y=10]

South J, Woodward J, Lowcock D and Woodall J (2006) *An Evaluation of the Bradford District Health Trainers programme – an early adopter site.* Leeds Metropolitan University: Leeds

Visram S, Geddes L, Carr S and Drinkwater C (2006) *An Evaluation of the Early Adopter Phase of the Health Trainers Project in the North East.* Northumbria University: Newcastle

Visram S and Geddes L (2007) *What does it mean to be a NHS Health Trainer?* Northumbria University: Newcastle

Appendix 1: Health Trainer Job Description

Job Title	**HEALTH TRAINER**
Department/Directorate	Public Health
Job Reference Number	
Payband	Agenda for Change Band 3 (tbc)
Hours	18 Hours minimum (flexible working possible)
Contract	Fixed Term 1 year (*probationary period included)*
Location	Various across county
Reports to	Health Trainer Coordinator/ Community Health Development Worker
Responsible to	Health Trainer Coordinator/ Community Health Development Worker

Job Summary
This post will contribute to tackling inequalities in health through promoting and supporting people to develop healthier behaviours and lifestyles in the context of their own local communities. It focuses on engaging with individuals in communities and offering them practical support to change their behaviour to achieve their own choices and goals. Health Trainers will be a practical resource to help connect people into services at local level. The work will focus on communities who are marginalised and who experience the greatest inequalities in Health. Health Trainers are not expected to have specialist knowledge in any one area of health/ illness. The Health Trainer will work with partners so as to engage individuals and link them to partners ensuring a coherent pathway back to work is explored and actioned where appropriate. This could include referrals for confidence building, training through to volunteering and employment.

Specifically the health trainer will:

- engage with individuals in local communities which have identified health inequalities
- communicate with individuals about health and health improvement
- enable individuals to change their behaviour to improve their health
- communicate with individuals about their pathway back to work at the appropriate time
- manage and organise their time and activities to support individuals in the community

Health trainers will be supported in their work by:

- supervision in the workplace
- direct contacts with the local health improvement team
- other health trainers
- Cornwall Works Facilitators and relevant organisations as identified by the Healthy Neighbourhoods Partnership
- Community Health Development Workers

Specific Activities

1. Engage with individuals in local communities which have identified health inequalities

a) Identify and make contact with people within the local community to work with
b) Work with existing groups and support the development of new groups in order to identify and engage with individuals
c) Develop and maintain relationships with individuals who are experiencing the greatest inequalities in health
d) Promote the equality and value the diversity of individuals
e) Build up and maintain knowledge of contacts within the community
f) When appropriate discuss employment issues and link to relevant partners

2. Communicate with individuals about health and health improvement

a) Provide information to individuals about health and wellbeing
b) Provide information to individuals about the relationship between behaviours and health
c) Enable individuals to develop their knowledge and skills about health and wellbeing
d) Signpost individuals to other agencies for information, support and resources
e) Provide information to individuals around the differing types of development in terms of confidence building, training, volunteering, part time work and full time work as appropriate

3. Enable individuals to change their behaviour to improve their health

a) Help individuals identify how their behaviour and context might affect their health and wellbeing
b) Help individuals to develop a personal health plan to enable them to make the make the changes that they want to
c) Support individuals in achieving their personal health plan
d) Support individuals in maintaining their behaviour change
e) Help individuals to access and use local services
f) Support individuals to move along the pathway back to work

4. Communicate with individuals about their pathway back to work at the appropriate time

a) When appropriate discuss employment issues and link to relevant partners
b) Provide information to individuals around the differing types of development in terms of confidence building, training, volunteering, part time work and full time work as appropriate
c) Support individuals to move along the pathway back to work
d) Capture using Cornwall Works processes the level of support given and the level of employment advise either delivered or referrals made
e) Support individuals where appropriate to identify the barriers to work.
f) Support their identified goals through the appropriate referrals to Cornwall Works Facilitators

5. Manage and organise own time and activities to support individuals in the community

a) Plan own time and activities around the needs of individuals in the community
b) Respond effectively to referrals – self-referrals from the individuals, and those from colleagues / other workers
c) Keep adequate records of the work undertaken as agreed with line manager
d) Capture using Cornwall Works processes the level of support given and the level of employment advise either delivered or referrals made
e) Alert line manager to any issues in work (including concerns about individuals or work in the community)
f) Inform line manger of ways in which local services can be improved to improve the health and wellbeing of the local community / barriers that individuals are experiencing in changing their behaviour
g) Take an active part in developing own knowledge and skills
h) Seek advice and support as and when appropriate
i) Monitor and maintain health, safety and security of self and others
j) Adhere to organisational policies and procedures

HEALTH TRAINER
PERSON SPECIFICATION

We will select people who have the following skills or experience and we may ask you to tell us about these at the interview. When you fill in your application form you can use examples to show us that you have these skills and experiences. Examples can be from past jobs or from activities in your life such as organising a wedding or a birthday party, because if you can do those things you will have used the same skills that it takes to organise a meeting.

REQUIREMENTS	ESSENTIAL	DESIRABLE
Educational/ qualifications / experience		
No formal qualifications are needed but you must be willing to be trainer as a Health Trainers	X	
Good knowledge of English	X	
Knowledge of one or more language that is used by local people		X
Experience of working with local community groups in some capacity		X
Knowledge		
Know about the things that make people healthy and unhealthy		X
Know about local communities and their needs	X	
Know about the broad health and health services needs of the local community		X
Know how to find out about local services and how to support individuals to use them		X
Know about behaviour change methods		X
Know your own limits of skills, competences and responsibilities and work within them	X	
Skills and abilities		
Able to talk to people face-to-face	X	
Ability to write down information in clear accurate English		X
IT Skills		X
Good at listening to people	X	
Able to get on with different kinds of people	X	
Supportive and encouraging to people in difficult situations without making judgement about them	X	
Able to respect confidentiality even in difficult situations	X	
Respectful and value people regardless of background	X	
Able to find information to help people	X	
Able to use what you have learnt from a situation to help others	X	
Interested in helping people to find ways to solve their problems	X	
Able to learn from your own experiences	X	
Able to identify, assess and manage risks	X	

JOB DESCRIPTION

Job Title: Community Health Development Worker

Grade: Band 5 £19,166 - £24,803

Location:

JOB PURPOSE

To deliver a community based health initiative in targeted areas. This will help groups to take responsibility for their own health whilst working within their own localities with hand-holding support. This will require working with established networks and partnerships as well as the creation and servicing of new partnerships (Local Operational Partnerships). In the first instance this will be within the social housing estates of Treneere (Penzance) and Parc An Tansys/Pengegon (Camborne) *or* Malpas & Trelander (Truro) and Kinsman and Berryfields (Bodmin). Specifically you will work with groups of residents to identify their own needs and support with the delivery of solutions. This will include negotiating with both residents and service providers alike. This role will provide a conduit for the residents to develop more accessible services within their localities. This project will look at improving well-being and health, leading to opportunities of employment and routeways to recovery; the ultimate aim to reduce health inequalities and worklessness within the geographical target areas. You will work within the framework of the current community workers. This role will also be the line manager for the Health Trainers Service within the specific geographical location.

DIMENSIONS

As Community Health Development Worker you will provide ongoing support to up to two different social housing estates to work with residents and service providers to ensure services are delivered in a responsive and accessible manner. You will provide line management for the Health Trainers whilst encouraging and strengthening the work of local resident volunteers through Health Champions. This project will work towards increasing the uptake of services, in particular health, resulting in overall well being and health improvement; thus reducing health inequalities and contributing to reducing worklessness. You will also support people to make positive life changes including going on to employment, further training, volunteering or achieving personal goals.

KNOWLEDGE, SKILLS & EXPERIENCE

- Experience of working through a community health development approach specifically with an understanding of the wider determinants of health
- Experience of working with community groups and statutory agencies in a supportive role for the identification, development and delivery of solutions to jointly identified needs
- Understanding of funding opportunities

- Awareness of barriers to work and their impact on communities, particularly where there are high levels of worklessness
- Good written and oral communication skills
- Experience of working in the development of community projects and service provision
- IT experience, including working in the Windows environment
- Experience of working with clients within a group setting
- Ability to work on own initiative as well as part of a team
- Ability to foster partnership working
- Highly established negotiation skills
- Evidence of peer support
- Line management experience

KEY RESULT AREAS

- To provide a responsive community health development project to assist the needs of local residents of two estates
- To work with local residents to identify local health and employment needs and aspirations alongside the Health Trainers
- To identify all other agencies/workers in the areas and promote joint working and partnership
- To identify the needs of residents and put together a work plan including objectives, outputs and outcomes in partnership with Health Promotion Service and the Health Trainer Coordinator relevant to the timescales of the project
- To assist with the development and delivery of training in response to the above ensuring that delivery is completed in a timely and organised way including venue booking, catering and participant confirmation as required
- To act as a conduit between residents, other agencies, the Health Trainer Coordinator, service providers including statutory, community and voluntary and private sectors.
- To work through a partnership approach to identify the barriers preventing easy access to services local people within their locality reporting them to the Health Trainer Coordinator
- To work alongside the evaluation team to ensure that the project is comprehensively monitored and evaluated.
- To complete monthly reports updating and reviewing progress against set targets
- To service the Healthy Neighbourhoods Partnership including attending the regular meetings.
- To provide an accessible and flexible approach at all times including working unsocial hours including evening and weekend working when necessary
- Keep abreast of ongoing developments at local, regional and national level, identifying information/good practice sources and be responsible disseminating and providing information to local groups and projects through attendance of locality meetings.
- To meet regularly with locality groups and projects to conduct needs assessment in relation to training requirements.
- To provide day to day line management and support to the Health Trainers and when appropriate the Health Trainer Health Champions
- Identify skills/resources from within the community and provide support and encouragement for their appropriate use.
- Assist community project work by identifying and highlighting appropriate funding streams, encouraging their uptake, support the development of community projects where required.

- Collate information from Health Trainers for monitoring and evaluation purposes.
- Collaborative working with Neighbourhood managers where they are in post and other CHDWs where appropriate.
- Other duties as reasonably requested by the Health Trainer Coordinator and the Partnership.
- Identify people from the community that may benefit for referral to the Health Trainers, particularly in the early stages of the project

COMMUNICATIONS & WORKING RELATIONSHIPS

- Work closely with the Health Trainer Coordinator to ensure a cohesive approach effective lines of communications between all elements of the project.
- Working closely with the residents
- Working closely with the Health Promotion Service
- Working with Cornwall Works facilitators to assist people to the routeways of work.
- Work in partnership with other workers and agencies established within the target areas
- Promote partnership and joint working to effectively deliver the work programme of the project
- Linking closely with other community workers within your given area.
- Communications with community groups; Primary Health Care Organisations; members of the public and others
- Keep in contact with and meet regularly with line manager for support and supervision
- Attend the Healthy Neighbourhoods Partnership meetings
- Neighbourhood Managers where available

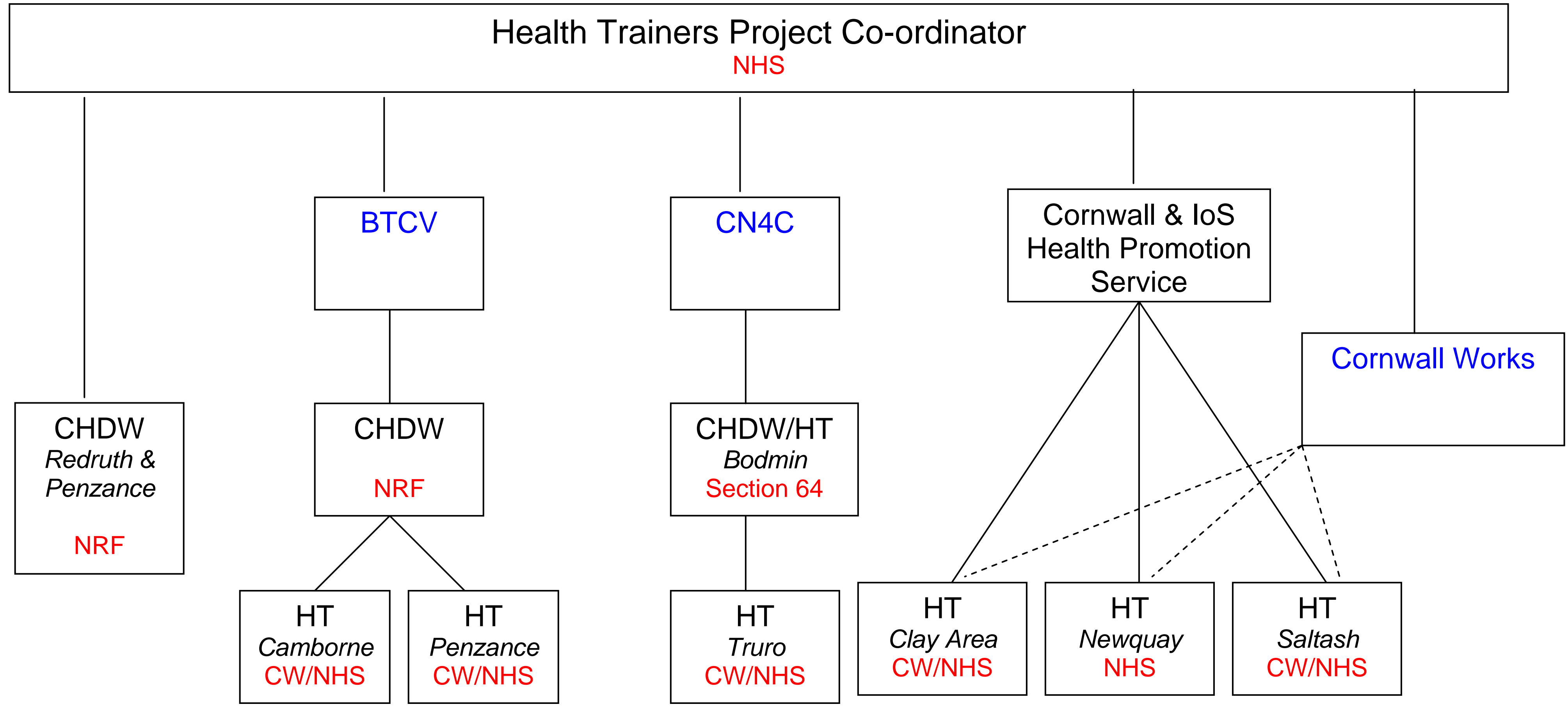
MOST CHALLENGING PART OF YOUR JOB

To facilitate real, life changing behaviour for members of the community through sustainable community health development supporting personal successes and identification of positive pathways for individuals.

Person Specification
Community Health Development Worker

REQUIREMENTS	ESSENTIAL	DESIRABLE
Education/ Qualifications /Experience		
Good education or ability to prove literacy and numeracy	x	
Willingness to learn quickly	x	
Community development, education, social work qualification , or similar		X
Community Health Development experience	x	
Experience of working with community and voluntary groups, statutory agencies, private and public sectors in a supportive role for the identification, development and delivery of projects	x	
Support for the and facilitation of project development within the local community	x	
Monitoring and evaluation	x	
Experience of delivering informal training sessions	x	
IT experience, including the use of Word and Excel	x	
IT experience using Access		X
Successful experience of writing funding applications		x
Skills and Abilities		
Ability to set up procedures in support of office and project work	X	
Group work skills	X	
Presentation skills	X	
Good written and oral communication skills	X	
Understanding of funding opportunities		X
Positive and supportive attitude	X	
Ability to work to deadlines	X	
Good organisational skills	X	
Commitment to team working	X	
Approachable	X	
Ability to get on with a wide range of people	X	
Ability to work under pressure and be flexible when required	X	
Desire to enable people to achieve through their own actions	X	
Ability to work on own and as part of a team	x	
A basic understanding of Health Promotion		X
A basic understanding of the ethos of healthy living		X
A basic understanding of the barriers to employment		X
A basic understanding of health inequalities		x
Additional Circumstances		
Flexible working in accordance with the requirements of the service	X	
Able to travel throughout Cornwall	X	
Able to work outside of normal office hours if required	x	

Appendix 2: Healthy Neighbourhood Partnership Structure (funding sources in red)



BTCV – British Trust for Conservation Volunteers
CHDW – Community Health Development Worker
CN4C – Cornwall Neighbourhoods for Change
CW – Cornwall Works
HT – Health Trainer
NHS – National Health Service
NRF – Neighbourhood Renewal Fund

Appendix 3: Health Behaviour Check

General Questions

Please fill in your contact details. This information will be kept confidential.

Name or identifier:

Address:

Postcode:

Contact Telephone Number:

Your GP:

Who suggested you might use the NHS Health Trainer service?
(Name of person/practice/organisation):

For the NHS Health Trainer:

Date:

Name and Identifier (of Health Trainer):

Location:

Time of start of interview:

Time of end of interview:

This section asks you about things you do that affect your health and how you feel about your health:

a) How would you describe your health generally over the last week? (please tick the circle next to your answer)

Excellent ◯ **Very good** ◯ **Good** ◯ **Fair** ◯ **Poor** ◯

b) Do you agree with the following statement;
"I can improve my health and wellbeing without the help of trained professionals"

Definitely yes ◯ **Probably yes** ◯ **Not sure** ◯ **Probably no** ◯ **Definitely no** ◯

1.What you do

These questions are about the time you spent being physically active in the last 7 days.

Vigorous activities – these are activities which take hard physical effort. They make you breathe much harder than normal and may include heavy lifting, digging, aerobics or fast bicycling. Only count activities that you did for at least 10 minutes at a time.

Moderate activities – these are activities which take moderate (a medium amount) physical effort. They make you breathe a bit harder than normal and may include carrying light loads, bicycling at a regular pace, or walking at a reasonable pace. Only count activities that you did for at least 10 minutes at a time.

During the last 7 days, on how many days did you do…	Days per week	Hours/minutes on a typical day	Estimated total hours/minutes for the week
Vigorous physical activities?			
Moderate physical activities?			

2. What you eat

Think back over the last week - roughly how many portions of fruit, vegetables, fried food and high fat dairy food did you eat? Fill in the table below.

Type of food	**How many portions did you eat in the last week?**
Fruit (e.g. bananas, apples, oranges)	
Vegetables (e.g. carrots, broccoli, peas)	
Fried food (e.g. burgers, chips, fried chicken)	
High fat dairy food (e.g. cream, full fat milk, cheese, butter, ice cream)	

Here are some examples of what we mean by a portion of fruit and vegetables:

1 apple, banana, pear, orange or other similar sized fruit

2 plums or similar sized fruit

½ a grapefruit or avocado

1 slice of large fruit, such as melon or pineapple

3 heaped tablespoons of vegetables (raw, cooked, frozen or tinned)

3 heaped tablespoons of beans and pulses (however much you eat, beans and pulses count as a maximum of one portion a day)

3 heaped tablespoons of fruit salad (fresh or tinned in fruit juice) or stewed fruit

1 heaped tablespoon of dried fruit (such as raisins and apricots)

1 handful of grapes, cherries or berries

a dessert bowl of salad

a glass (150ml) of fruit juice (however much you drink, fruit juice counts as a maximum of one portion a day)

3. What You Drink

1) Do you drink alcohol (including drinks you brew at home)?

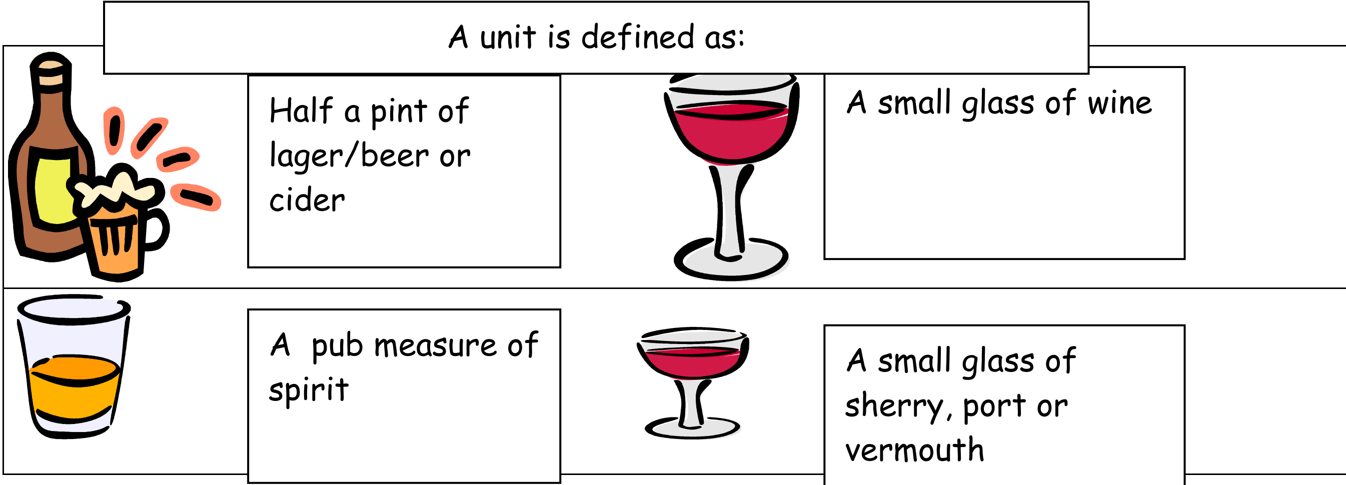
O Yes

O No (please go to Q4)

Looking at the table below, estimate the number of total units of alcohol you drank each day last week

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Units							

What is a unit?



4. Smoking (including hand rolled cigarettes)

a) Do you smoke?

- O Yes
- O No (please go to Q5)

b) How many cigarettes per day do you usually smoke? If you don't smoke daily please say so.

_______ Cigarettes per day

- O I don’t smoke daily

c) How many cigarettes per week do you usually smoke?

_______ Cigarettes per week

d) Have you tried to give up smoking before?

- O Yes
- O No (please go to question 5)

e) How many times have you tried to give up smoking?

_______ times

f) When was the last time you tried to give up?

____

5. SOME QUESTIONS ABOUT YOURSELF

Please fill in a couple of questions about yourself.
(This information will be kept confidential)

a) Tick all boxes which best describe your situation

- O In paid employment
- O A full time student
- O A full time homemaker/full time parent
- O Retired
- O Long term sick/disabled
- O Unemployed

- O Living alone
- O Voluntary work
- O Other, please specify

b) Which types of income do you receive? E.g. earnings from employment, job seekers allowance, child benefit

---

____

c) What describes your housing situation?

- ○ Own your own house
- ○ Renting
- ○ Other, please state ---

d) Have you got any qualifications such as GCSEs/O levels, NVQs, A levels?

- ○ Yes. Please specify______________________________________
- ○ No

e) What ethnic group are you from?

White

- ○ White British
- ○ White Irish
- ○ White Cornish
- ○ White Other

Mixed

- ○ White and Black Caribbean
- ○ White and Black African
- ○ White and Asian
- ○ Other Mixed

Asian or Asian British

- ○ Indian
- ○ Pakistani
- ○ Bangladeshi

Black or Black British

- ○ Black Caribbean
- ○ Black African
- ○ Other Black

- ○ Chinese

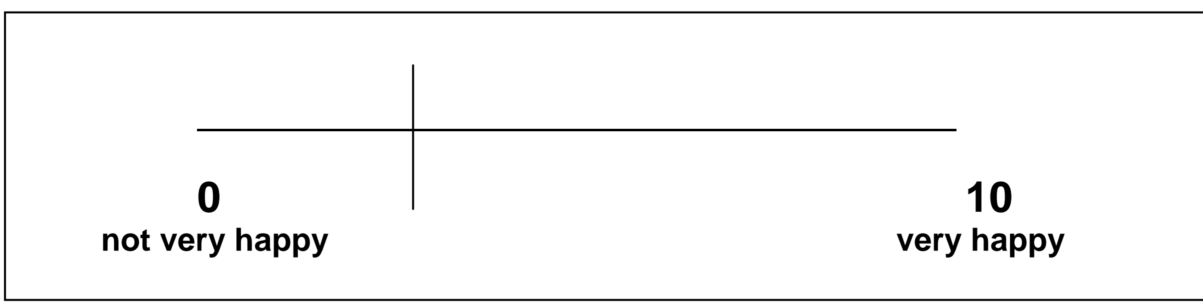
- ○ Traveller

- ○ Any other group: Please specify…………………………………..

6. SOME QUESTIONS ABOUT HOW YOU FEEL

a) On the lines given below place a vertical mark at the point that best suits the way you feel now

Example



0 — **not at all healthy** ______________________ **10** — **very healthy**

0 — **not very fit** ______________________ **10** — **very fit**

0 — **poor quality of life** ______________________ **10** — **very good quality of life**

0 — **not motivated to change** ______________________ **10** — **very motivated to change my lifestyle my lifestyle**

b) Please respond to the following statements using the numbers below.

1 = Not at all true 2 = Hardly true 3 = Moderately true 4 = Exactly true

Questions	Your Response
I can always manage to solve difficult problems if I try hard enough.	
If someone opposes me, I can find the means and ways to get what I want.	
It is easy for me to stick to my aims and accomplish my goals.	
I am confident that I could deal efficiently with unexpected events.	
Thanks to my resourcefulness, I know how to handle unforeseen situations.	
I can solve most problems if I invest the necessary effort.	
I can remain calm when facing difficulties because I can rely on my coping abilities.	
When I am confronted with a problem, I can usually find several solutions.	
If I am in trouble, I can usually think of a solution.	
I can usually handle whatever comes my way.	

Appendix 4: Example of Framework Analysis

	Researcher 1	Researcher 2	Researcher 3
Recruitment	Pre interview day course very good. Advert very open. Lots of people applied –too many. No qualification or experience needed. Not enough information given. Advertisement almost too accessible, too inviting. It is a very skilled role and that needs to be acknowledged more than it is. Important to let the applicants know what the training is. Be very very clear about what the job is about. The job advert did not mention University module, had it said that I probably wouldn't have applied. Good to have pre-interview day, guaranteed interview Having a HT involved in recruitment so that they can recognise certain traits that other health professional can not. Workshops good –guaranteed interviews Raising awareness Lots of people applied Not necessary looking for people with qualifications. Advert was different –intrigued. Did not specify qualifications. I had a fair idea of what was involved. The first HTs recruited had a very steep learning curve. Now they come with more experience of working with homeless, voluntary work. Recruitment of some HT by Cornwall Works were to reduce the numbers of people on long term unemployment and they wanted to reduce these numbers and therefore reach their targets. This led to some inappropriate appointments. Need people with experience of working in voluntary sector. At interview told needed local knowledge of area but was given different area to the one he knew.	Wanted job from advert Did pre-interview training which was very good. Training day gave you a chance to see opposition! Job appealed because wanted to help clients make positive changes to their lifestyles. Was anxious about work arrangements Should have Health Trainers on the job interview panel.	Important to explain role to potential recruits. Potential recruits attracted by lack of qualifications Did not want to exclude potential recruits by requiring qualifications and experience. Selection process from hundreds of applicants – very time consuming. Cornwall Works workshops – attendees guaranteed an interview. Some applicants had experience of community work. The process may not have been helpful in selecting the most appropriate people.