DH Department of Health

A Resource Pack for Community Engagement
November 2010

Introduction

This resource pack is designed to provide information and resources for Health Trainer services on how to engage effectively with communities. The resource pack: sets out a definition of terms; explores the policy, guidance and research base; describes the broad stages of a process that HT Services use to engage communities; looks at the different ways in which HT services build community capacity through workforce development; and draws together the different ways in which the effectiveness of community engagement can be demonstrated. It is supported by a number of appendices.

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HEALTH TRAINER PROGRAMME: A RESOURCE PACK FOR COMMUNITY ENGAGEMENT
November 2010

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1. WHAT IS COMMUNITY ENGAGEMENT IN HEALTH TRAINER SERVICES?

1.1 Introduction

This pack is designed to provide information and resources for Health Trainer services on how to engage effectively with communities. It is designed specifically for:

- policy developers and commissioners
- directors/consultants in public health
- managers of health trainer services
- training and workforce development leads
- anyone interested in developing the community engagement aspects of public health services.

The resource pack is divided into five sections supported by a series of appendices, which address the following questions:

1. What is community engagement in health trainer services?

2. Why should health trainer services engage with communities?

3. How do health trainer services engage with communities?

4. How do health trainer services build community capacity through workforce development?

5. How is the effectiveness of community engagement in health trainer services demonstrated?

This first section sets out the terms that are referred to in the pack. Some of the terms do not have concise meanings and might be used by different people in different ways. We have set out how the terms have been used in this pack and also some of the other common ways in which people might use the same terms.

1.2 What is a community?

The term 'community' can be used in a number of ways. The common meanings are:

1. *communities of place* – that is, all of the people who live in a particular area or place and who have the same local facilities, services and environments in common. The extent / range of a community of place might be as wide as a region, county or town, or smaller such as a parish, neighbourhood or street[1].

[1] J Rowson, S Broome and A Jones, September 2010, Connected Communities: How social networks power and sustain the Big Society, RSA, London stress the limitations in solely in geographic terms. See http://www.thersa.org/projects/connected-communities

2. *communities of interest* – that is, a group of people or part of a society who are all alike in some way or who share a common experience, identity or need. For example, people of African-Caribbean origin, lesbian and gay people, people of a common faith, homeless people, or those who campaign on a specific issue such as the environment.

Individuals may belong to different communities at the same time which means that communities overlap.

> *'We are all members of several communities and our ties with them can increase or decrease. It is both illogical and dangerous to corral people as if they could only belong to one community.'*[2]

Communities can also be in conflict with one another.

The term 'community' is also used on occasion to denote a common feeling between people such as 'having a sense of community' although we have not used it in this way in this resource pack.

1.3 What is community engagement?

The terms community engagement, community development, community empowerment, community consultation and community involvement are often used interchangeably and can be confusing. Local Government Improvement and Development[3], defined these terms from a local government perspective. Their definitions[4] form a useful starting point for Health Trainer Services.

Community engagement by agencies or services is defined as:

> *'The action that agencies take to enable them to consult, involve, listen and respond to communities through ongoing relationships.'*

Community development is defined as:

> *'The process of building peoples' skills and ability to act together on their common priorities, usually by developing independent community organisations and networks, and with the support of community development workers within statutory or third sector agencies.'*

Community empowerment is defined as:

> *'The outcome of engagement and other activities. Power, influence and responsibility is shifted away from existing centres of power and into the hands of communities and individual citizens.'*

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[2] A Sen, 2006, Identity and Violence: The illusion of destiny, Allen Lane: London.
[3] Local Government Improvement and Development is one of the six bodies that form the Local Government Group overseen by the Local Government Association. It was formerly known as IDeA.
[4] See Source: Local Government Improvement and Development: http://www.idea.gov.uk/idk/core/page.do?pageId=16639526

Community consultation is defined as:

> *'The process by which agencies seek advice, information and opinions about strategies, policies and services. The existing decision makers take this into account when they make decisions. This includes many familiar activities such as surveys, research projects, public meetings, user and resident forums.'*

Community Involvement is defined as:

> *'... an over-arching term that covers providing information to citizens, consulting with them and involving them in active ways. This can include providing people with opportunities to:*
> - *influence or directly participate in decision making*
> - *provide feedback on decisions, services, policies and outcomes*
> - *co-design/work with authorities in designing policies and services*
> - *co-produce/carry out some aspects of services themselves and*
> - *work with the local authority in assessing services.*

In section 3 of this resource pack, we have set out a model of the different ways in which health trainer services engage with communities to address health inequalities and improve health and wellbeing[5].

1.4 Is community engagement the same as community development?

No although the two aspects are related to each other. Community development refers to 'building active and sustainable communities based on social justice, mutual respect, participation, equality, learning and cooperation'[6]. Engaging with communities is only one aspect of this and hence only one part of community development.

There is a group of workers who specialise in community development and a set of national occupational standards (competences) has been produced to describe the range of the work they undertake[7]. The first health trainer competence - HT1 Make relationships with communities - was drawn from a previous version of the national occupational standards for community learning and development. Some health trainers might develop an interest in community development and progress from a health trainer role into other work in this area.

1.5 What is health inequality?

Health inequality can be seen simply as "the big differences in life expectancy

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[5] Further descriptions and definitions can also be found in: A Coulter, 2009, Engaging communities in health improvement: A scoping study for the Health Foundation, Health Foundation, London.
[6] NICE, 2008, p38
[7] Lifelong Learning UK, 2007, National Occupational Standards for Community Learning and Development, London, Lifelong Learning UK – see http://www.lluk.org/4558.htm

between different levels in the social hierarchy in modern societies"[8]; or, more specifically, the gap in health status, and in access to health services, between different social classes and ethnic groups and between populations in different geographical areas. Health inequalities are a reflection of wider inequalities such as inequalities in aspirations and opportunities.

Health inequality relates to the principle of social justice, which is about enabling people to claim their human rights, meet their needs, and have greater control over the decision-making processes which affect their lives.

1.6 What is capacity?

Capacity is 'the knowledge, skills, competencies and motivation required by communities, organisations and individual professionals/service providers to engage effectively in joint discussions, decision-making, governance and service delivery'[9].

This is closely linked to the concept of *social capital*, which involves building 'bonds' and 'bridges' between people as a foundation for social support and community relationships[10]. Social capital has been adopted by the World Bank as a useful organising idea.

> *'Social Capital refers to the norms and networks that enable collective action. It encompasses institutions, relationships, and customs that shape the quality and quantity of a society's social interactions. Increasing evidence shows that social capital is critical for societies to prosper economically and for development to be sustainable. Social capital, when enhanced in a positive manner, can improve project effectiveness and sustainability by building the community's capacity to work together to address their common needs, fostering greater inclusion and cohesion, and increasing transparency and accountability.'*[11]

1.7 What are Health Trainer Services?

Health Trainer Services have developed since the publication of the White Paper *Choosing Health*[12]. This set out a new personalised level of support to reduce health inequalities by working with people from deprived and 'hard-to-reach' groups to increase healthy behaviours, offer opportunities to learn new skills to improve health and wellbeing, and provide potential links into employment.

Different models of Health Trainer services have developed across the country, with some hosted by healthcare organisations, some by local

[8] R Wilkinson and K Pickett, 2009, *The Spirit Level: Why more equal societies almost always do better,* London, Allen Lane
[9] Popay J (2006) Community engagement and community development and health improvement: a background paper for NICE See http://www.nice.org.uk
[10] Putnam, Robert (2000) *Bowling Alone: The collapse and revival of American community* (New York: Simon and Schuster)
[11] World Bank – see http://go.worldbank.org/C0QTRW4QF0
[12] Department of Health, (2004) Choosing Health: Making Healthy Choices Easier

authorities and some by third sector organisations.

1.8 What are health trainers?

Health Trainers reach out to people who are in circumstances that put them at a greater risk of poor health and wellbeing. Health Trainers often come from, or are knowledgeable about, the communities they work with. In most cases, Health Trainers are based in local services and offer outreach support to a wide range of local community venues. Health Trainers support people to adopt healthier lifestyles through empowering them and helping them to set a personal health plan (PHP). This outlines the individual's goals for a healthier lifestyle and a plan to achieve these goals.

The work of Health Trainers is underpinned by a Health Trainer Handbook[13], which provides the evidence base and theoretical framework for the behaviour change approaches that they use.

Qualified Health Trainers (HTs) have completed training and been assessed as competent against four National Occupational Standards (competences):

HT1 Make relationships with communities

HT2 Communicate with individuals about promoting their health

HT3 Enable individuals to change their behaviour to improve their own health & wellbeing

HT4 Manage and organise your own time & activities[14].

The national qualification and the nationally recognised training for Health Trainers is the Certificate for Health Trainers awarded by City & Guilds. The Certificate is at level 3 in the national Qualifications and Credit Framework.

1.9 What are health trainer champions?

In some health trainer services, there are also Health Trainer Champions (HTCs) as well as health trainers. Health Trainer Champions facilitate the uptake of Health Trainer and other health interventions. This is often referred to as 'signposting and improving access to services'.

Health Trainer Champions have usually carried out health improvement

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[13] S Michie, N Rumsey et al, 2008, Improving Health: Changing Behaviour – NHS Health Trainer Handbook, Department of Health: London

[14] See https://tools.skillsforhealth.org.uk/competence_search and put "health trainer" in the search box.

training through a recognised programme at level 2 of the Qualifications and Credit Framework[15], such as the Royal Society of Public Health's Understanding Health Improvement Award.

[15] Previously the National Qualifications Framework

1.10 How does the Community Sector fit into this picture?

The *community sector* is generally made up of small organisations or groups related to a specific community of place. The community sector includes many self-help groups that share a community of interest or cause. Volunteers usually run community sector organisations in whole or in part. The activities of the community sector can range from nurseries and playgroups to community centres and village halls, tenants' associations, environmental groups, arts and sports groups, credit unions, and self-help groups.

Community sector groups may or may not be part of voluntary organisations.

1.11 What is the Voluntary Sector?

The *voluntary sector* is made up of groups/organisations, which are normally formally constituted, and who carry out activities other than for profit (but not public or local authorities). They may have significant turnover in fundraising, endowments or earned income. Voluntary organisations normally employ paid professional and administrative staff and may or may not use volunteer help.

Voluntary organisations and community organisations are sometimes referred to as the Third Sector as they provide additional services and support to individuals and communities.

1.12 Conclusion

This section has set out the main terms used in this resource pack to explain what communities and community engagement means in the context of health trainer services. The next section looks at why health trainer services should engage with communities and how this adds value to, improves the effectiveness of, services.

2. WHY SHOULD HEALTH TRAINER SERVICES ENGAGE WITH COMMUNITIES?

2.1 Introduction

Community engagement is an essential aspect of health trainer services. This is because a small but significant proportion of the population is not registered with a GP nor do they access other healthcare services. Reaching out to the individuals who are likely to have the greatest risks to their health and wellbeing and supporting them to change their behaviour is vital to improve their life chances and address health inequalities.

As well as developing the skills of engaging with different people, Health Trainers and Health Trainer Champions need to understand different communities, the resources that exist within those communities and some of the barriers to people using existing services and making changes to their lives. Recognising that there are many different communities of interest within a community of place assists in finding and contacting those people who tend to be forgotten or are less heard. This enables these individuals to get the support they need and to access healthcare and other services and support systems.

This section explores the purpose and relevance of community engagement for Health Trainer Services. Section 2.2 focuses on the policy and guidance which supports community engagement approaches. Section 2.3 explores the research base and emerging evidence for the effectiveness of community engagement.

2.2 What does national policy and guidance say about community engagement?

2.2.1 Choosing Health White Paper, 2004

When the Department of Health introduced the concept of Health Trainers in the 2004 White Paper *Choosing Health*[16] there was a commitment that, from 2006, NHS Health Trainers would be providing practical support to help individuals in their local communities improve their health through adopting healthier lifestyles. The implication was that this required the development of services that would:

- be focused on health inequalities
- not be through another ‘professional’ advice giver but through ‘help from next door’
- be visible and accessible
- engage with people where they are to be found

It also required a new workforce to be recruited from the local community, or from individuals with local knowledge, who would be trained so they were competent to practise. Individuals also needed to be capable of working in a multitude of settings, which included not only the NHS but also other local organisations such as local authorities, businesses, and the voluntary and community sector.

[16] Choosing Health: Making healthy choices easier, DH 2004 http://www.dh.gov.uk/en/Publicationsandstatistics/publications/PublicationsPolicyAndGuidance/DH_4094550

It is now possible to see that this policy context formed the springboard for a new workforce and a new service as well as a new approach to tackling inequalities. This involved an understanding of the connections between 'what you deliver' and 'how you deliver' which is at the heart of Health Trainer Services. Thus in designing and delivering Health Trainer Services the two complementary aspects of engaging with communities as well as offering personalised support to individuals in those communities have been vital in reaching marginalised groups and tackling inequalities.

2.2.2 Developments following Choosing Health – last Government

Since the 2004 White Paper, national policy, strategy and guidance have illustrated the relevance and potential impact that Health Trainer Services can have in both shaping cross-government policy and strategies and influencing delivery strategy across a wide range of issues[17].

Appendix A, which was developed in November 2009, draws together:

- key findings from a short mapping exercise to identify policies, theory and practice most relevant to the community engagement aspects of Health Trainer services[18]
- extracts from *Reaching out – Community engagement and Health*[19] exploring the importance of, and benefits in, engaging communities in health promotion and health services
- NICE guidance on community engagement and health[20] aimed at supporting those working with and involving communities in decisions on health improvement
- the performance monitoring and accountability structures in the NHS that were emerging in 2008

Collectively these documents and quotes reference and reflect legislation, national policy and thinking relating to public participation, community engagement and health under the last Government stemming back to 1999, when '*Saving Lives, Our Healthier Nation'*[21] was published.

[17] Building the Evidence Base – Health Trainers Legacy Documents *(September 2010)*
[18] An Overview of Community Engagement policies and practices (Sostenga June 2009) (Health Trainers Legacy Documents - *September 2010)*
[19] *'Reaching out – community engagement and health' (IDeA 2008)*, http://www.idea.gov.uk/idk/aio/8681034
[20] NICE Guidance PH9 Community engagement (2008) http://guidance.nice.org.uk/PH9
[21] Department of Health: Saving Lives, Our Healthier Nation, 1999 – See http://collections.europarchive.org/tna/20100509080731/http://dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4118614

2.2.3 The policies of the Coalition Government 2010 and beyond

In 2010, consideration needs to be given to the policies and agendas relating to community engagement and Health Trainer Services that are emerging from the Coalition Government, and a number of emerging themes of potential future importance have been referenced below. The references are, by necessity, limited by the timing of this resource pack. Readers will need to update themselves as more thinking from the Coalition Government emerges.

Building the Big Society[22]expands on the philosophy that communities should be '*powerful enough to help themselves and their own communities'* – this underpins much of the Coalition Government's detailed policies. Given the extent to which the vast majority of Health Trainer Services already directly engage with their communities supporting the development of social capital within those communities and individual development, the Big Society's themes of empowerment, freedom and responsibility are likely to have resonance with what Health Trainer Services are already doing.

The initial Big Society publication has been further expanded in two related publications published in October 2010.

Building a Stronger Civil Society[23] recognises and values the ability of voluntary and community organisations to mobilise and support people, particularly those who sometimes struggle to find a voice. This strategy includes the Big Society Reform Agenda to empower communities. It has the strands of:

1. opening up public services
2. promoting social action through, amongst other things, the development of Community Organisers.

The strategy is accompanied by a consultation – *Supporting a Stronger Civil Society*[24]. This contains two quotes made by David Cameron in May 2010, which have relevance to the work of Health Trainer Services:

> *'The rule of this Government should be this: if it unleashes community engagement – we should do it. If it crushes it – we shouldn't.'*
>
> *' … the best ideas come from the ground up, not the top down. We know that when you give people and communities more power over their lives, more power to come together and work together to make life better – great things happen.'*

In addition to the documents related to the Big Society, there are also a number of other emerging policies and strategies that potentially have more specific

[22] http://www.cabinetoffice.gov.uk/media/407789/building-big-society.pdf
[23] HM Government, October 2010, Building a Stronger Civil Society: A strategy for voluntary and community groups, charities and social enterprises. See http://www.cabinetoffice.gov.uk/media/426261/building-stronger-civil-society.pdf
[24] Cabinet Office, October 2010, Supporting a stronger civil society: an Office for Civil Society consultation in improving support for frontline civil society organisations – see http://www.cabinetoffice.gov.uk/media/426258/support-stronger-civil-society.pdf The document contains three useful web-links for funding opportunities as follows: http://www.fundingcentral.org.uk , http://www.direct.gov.uk and http://www.improvingsupport.org

implications for Health Trainer Services in relation to community engagement.

The Coalition: our programme for government[25]
The Coalition agreement sets out the broad intention of promoting '*intelligent ways to encourage, support and enable people to make better choices for themselves*'[26]. There are a number of aspects here that are relevant to the use of community engagement approaches by Health Trainer Services.

- ***Coalition Commitment on Social Action*** - '*We will train a new generation of community organisers and support the creation of neighbourhood groups across the UK, especially in the most deprived areas*.'

  Health Trainer services often offer opportunities for volunteers (such as Health Trainer Champions) who encourage action in communities, help to build social capital, engage in community health activities and enable individuals to 'have a voice' in the development of local services.

- ***Coalition Commitment on Public Health*** – *'The Government believes that we need action to promote public health, and encourage behaviour change to help people live healthier lives. We need an ambitious strategy to prevent ill-health which harnesses innovative techniques to help people take responsibility for their own health'.*

  The qualitative and quantitative data gathered on Health Trainers (see section 5), indicate that the clients of Health Trainers are involved in making their own choices, are more confident being involved in their community, and more inclined to improve their skills in a number of areas.

- ***Coalition Commitment on Jobs & Welfare*** – *'Providing training and targeted support for those looking for work.*'

  The Health Trainer programme fulfils two roles here. Health Trainers support unemployed people to become healthier; Health Trainer Services recruit people from disadvantaged communities to become Health Trainers or Health Trainer Champions, often with the possibility that they will develop further given training and development support.

'A new approach to public health'
At a speech to the UK Faculty of Public Health's annual conference in July 2010, the Secretary of State for Health, Andrew Lansley, outlined a new approach to public health, the details of which are due to be published in a public health

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[25] Cabinet Office, May 2010, The Coalition: our programme for government http://www.cabinetoffice.gov.uk/media/409088/pfg_coalition.pdf
[26] For further information on this in relation to the health trainer programme see: Coalition and Health Trainer review document (RC, July '10)- Health Trainers Legacy Documents *(September 2010)*

White Paper at the end of 2010[27]. He stated that:

- behaviour change is the great challenge for public health
- there are a wide range of factors that impact on people's health such as: dysfunctional families, poverty, worklessness, weak family and community structures, mental illness
- the importance of self-esteem
- the need to build responsibility and innovation in local communities.

The Secretary of State set out his vision as:

> *'a new Public Health Service which rebalances our approach to health, ensuring we continue to respond effectively to public health emergencies and carry out the vital role of protecting the nation's health – while also drawing together all the elements we need for preventative action for health improvement – national leadership and strategy, local leadership and delivery and, above-all, a new sense of community and social responsibility'.*

These different aspects provide a clear indication that the focus and approach adopted by the Health Trainer programme on the twin approaches of behaviour change and community engagement are relevant under the present Government and will make an important contribution to the delivery of the new public health agenda.

In the speech, Andrew Lansley confirmed his intention to build on the findings of Sir Michael Marmot's review and his six proposed policy objectives. These are described below.

The Marmot Review - Fair Society, Healthy Lives[28]

This strategic review of health inequalities in England in 2010 and beyond can be seen to champion a social determinants approach to reducing health inequalities, which has clear links to community engagement and Health Trainer Services. The six policy objectives set out in the Marmot Review include the following objectives:

- strengthening the role and impact of ill-health prevention - with a priority placed on the prevention and early detection of those conditions most strongly related to health inequalities

[27] Faculty of Public Health Conference – speech by Secretary of State 7.7.10 http://www.dh.gov.uk/en/MediaCentre/Speeches/DH_117280

[28] Michael Marmot, February 2010, *The Marmot Review - Fair Society, Healthy Lives,* London, UCL, http://www.ucl.ac.uk/whitehallII/pdf/FairSocietyHealthyLives.pdf

- creating and developing healthy and sustainable communities - with a priority placed on improving community capital and reducing social isolation across the social gradient

- creating fair employment and good work for all - with a priority placed on improving access to good jobs and reducing long-term unemployment across the social gradient. Making it easier for people who are disadvantaged in the labour market to obtain and keep work.

Empowering individuals and local communities is a key theme across these policy objectives and they have been captured in the Marmot Review in a Case Study of a Health Trainer Service based at Hampshire Probation Services - '*Reducing health inequalities for those with additional needs*'[29]. This service employed ex-offenders as health trainers. The case study notes that the strength of this service comes from its ability to demonstrate:

- how for most of the ex-offenders employed in the Health Trainer Service, this was their first experience of employment

- as the health trainers have a similar background, live in the same community and have experienced some of the same health issues, they are more effective in working with the offenders in addressing their needs and empathising with their particular issues'

- the work of Health Trainers has included accompanying clients to local NHS services and community-based activities helping the clients to meet new people and also re-engage with their local communities.

The Butler Trust Health Improvement Award for Healthcare and Health Promotion Work was awarded to Portsmouth City Teaching PCT and the Hampshire Probation Service for this Health Trainer Service. It was given in recognition of the effectiveness of their partnership between the two organisations; the innovation of employing ex-offenders as Health Trainers; the significant positive impact Health Trainers have had on the health of offenders; and the life-changing experience that being trained and employed as Health Trainers has provided for ex-offenders.

The Marmot Review states:

> *'Initiatives using local health trainers, community health champions and community development work also show encouraging signs of empowering individuals to participate and take control of their health and well-being. The impact of such innovations on health inequalities has yet to be determined. However, the approach facilitates greater participation of patients and citizens and support in developing health literacy and improving health and well-being.'*[30]

[29] See page 144 of the Marmot Review.
[30] See page 155 of the Marmot Review

White Paper - Equity and excellence: Liberating the NHS[31]
The White Paper sets out the Government's long-term vision for the future of the NHS. The paper details how the Government plans to devolve power from Whitehall to patients and professionals:

> *'Patients will get more choice and control, backed by an information revolution, so that services are more responsive to patients and designed around them, rather than patients having to fit around services. The principle will be "no decisions about me without me".'*

In the press release of 12th July, 2010, Secretary of State for Health, Andrew Lansley, was quoted as saying:

> *'With patients empowered to share in decisions about their care, with professionals free to tailor services around their patients and with a relentless focus on continuously improving results, I am confident that together we can deliver the efficiency and the improvement in quality that is required to make the NHS a truly world class service.'*

Whilst the focus of the White Paper is the services that NHS patients receive, such as through primary and secondary care, Health Trainer Services are well placed to support delivery of the patient empowerment aspects of this White Paper. Health Trainer Services provide support and information to ensure clients can access local NHS and other community based services, they can facilitate and support clients to have a voice when it comes to sharing their experiences of those services, and they feed through information on the appropriateness and effectiveness of local services to inform the planning and development of services in line with client needs. In addition, some Health Trainer Services support individuals once they have received healthcare interventions to ensure that they understand and are able to carry out the necessary follow-up actions and change their behaviour accordingly.

Liberating the NHS: Transparency in outcomes - a framework for the NHS[32]
The Government's White Paper, referred to above, set out how the Secretary of State for Health plans to hold the NHS Commissioning Board to account for delivering better health outcomes through a national NHS Outcomes Framework. The full consultation and engagement process on how the NHS Outcomes Framework should be developed (launched 19th July 2010) provides an opportunity for those working in the NHS, patients and the public to submit their views. Once released, the NHS Outcomes Framework may well have implications and potential opportunities for Health Trainer Services, especially if seen as a means of, supporting equality across all groups and helping reduce health

[31] Department of Health, July 2010, *White paper- Equity and excellence: Liberating the NHS,* London HMSO http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353
[32] Department of Health, 19 July 2010, *Liberating the NHS: Transparency in outcomes - a framework for the NHS*, London Department of Health http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_117583

inequalities, which is a theme being explored as part of the consultation process.

House of Lords Science and Technology Select Committee - Call for Evidence: Behaviour Change[33]

The inquiry amongst other things, under the chairmanship of Baroness Neuberger, will investigate, the policy implications of recent developments in research on behaviour change, whether current government behaviour change interventions are evidence-based and subject to appropriate evaluation, and the relationship between government, industry and the voluntary sector in promoting behaviour change. The Sub-Committee will also be considering the social and ethical issues surrounding the use of behaviour change interventions by government. The inquiry is relevant to Health Trainer services not only as an opportunity to demonstrate local success in tackling the key issue of obesity but also to demonstrate where this has been achieved through community engagement.

2.2.4 Conclusion

The examples of policy and government thinking outlined above, serve to illustrate the relevance of community engagement, as a key aspect of Health Trainer Services and the potential contribution they can make to helping deliver the national agenda on behaviour change, improving the health of the population and tackling health inequalities.

[33] *House of Lords Science and Technology Select Committee - Call for Evidence: Behaviour Change*, July 2010. http://www.parliament.uk/business/committees/committees-a-z/lords-select/science-and-technology-committee/inquiries/behaviour/

2.3 What does research say about the value of community engagement?

It is difficult to measure the effectiveness of community engagement in improving health, using the hierarchy of evidence as a measure of research quality, due to the large number of intervening variables and the difficulty of establishing causal relationships. However, there is an emerging and developing research base, including social capital and health and the links between community engagement and health. These are explored below.

2.3.1 Social capital

The term 'social capital' first emerged in the academic literature in the 1980s, although associated ideas had been considered long before the term 'social capital' itself was coined. Social capital can be defined as:

> *'... the social glue that helps people, organisations and communities to work together towards shared goals. It comes from everyday contact between people, as a result of their forming social connections and networks based on trust, shared values, and reciprocity (or 'give and take').' NE Social Capital Forum*[34]

Social capital is hence about:

- networks – the links between people which, when depicted diagrammatically, resemble a web
- values such as believing people benefit in a range of ways and are happier if they trust and support each other.

2.3.1.1 Types of social capital

Three main types of social capital have been defined: bonding, bridging and linking social capital[35].

- *"Bonding social capital* – connects people with a common identity, purpose (such as members of the same family, ethnic group, club or community organisation) or connects neighbours. Bonding social capital is the strongest type, linking us with friends and family and helping us to 'get by' in life.
- *Bridging social capital* - links together people with different interests and views (such as people in associations, trade unions, or fellowships) or from different but similar groups (such as age, ethnic or income). Bridging social capital involves the weaker ties we have with work colleagues and contacts, acquaintances and friends of friends. It can help us to 'get ahead' in life.
- *Linking social capital* – is where there are links and connections between

[34] NE Social Capital Forum: An Easy Guide to Social Capital accessed at http://www.ignite-ne.com/ignite/NorthEastSocialCapitalForum-sig.nsf/

[35] Ibid

people who have differing levels of power or social status (such as different social classes or political links). Linking social capital can be a way to get support from formal institutions or people in power."

Social capital is unequally distributed within society with well-educated people generally having more, particularly of the bridging and linking capital, whereas some poorer groups (but not all) have strong bonding capital but not much bridging or linking capital. This means they are less likely to have the connections to enable them to 'get on' in life or to make best use of services such as in health.

2.3.1.2 Social capital and health and wellbeing

In 1998, Lomas claimed that:

> *'... the extent to which we encourage interaction among the citizenry and the degree to which we trust and associate with each other in caring communities is probably the most important determinant of our health.'*[36]

Christakis and Fowler (2009) proposed that, in order to change health behaviours in communities, the message(s) should be focused on people near the centre of social networks as the behaviour is more likely to spread and social change will apply more generally[37]. This finding suggests that there is value in locating and working with key influencers and networkers in communities. Some Health Trainer Services have focused on such individuals, either in appointing them to Health Trainer or associated roles, and/or by the services seeking to work with these individuals in the community. The research relating to working with people at the centre of social networks might also be a driver for the Coalition Government's proposal for developing community activists.

In 2000, Putnam, one of the best-known writers on social capital, stated that the link between social capital and positive outcomes in health and wellbeing is better established than any other (such as a reduction in crime)[38]. The link to health and wellbeing includes, amongst other things, neighbours providing support for one another, noticing accidents or providing informal care. Putnam quotes a number of studies which show that '*people who are socially disconnected are between two and five times more likely to die from all causes, compared with matched individuals who have close ties with family, friends and the community*'.

Research undertaken for the Ascheson report suggested that health inequalities are not just underpinned by poverty but also by a sense of powerlessness[39]. That is, the social capital that is produced by communities being actively involved in their health and wellbeing can, in itself, prove to be an effective preventative

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[36] Lomas 1998 quoted in Campbell C (2001) chapter in Baron S, Field J and Schuller T (Eds) *Social Capital: critical perspectives,* Oxford University Press

[37] N Christakis and J Fowler, 2009, Connected: The amazing power of social networks and how they shape our lives, Harper Collins, London

[38] R Putnam, 2000, *Bowling Alone: the Collapse and Revival of American Community*, New York: Simon Schuster

[39] D Acheson (1998), *Independent Inquiry into Inequalities in Health*, The Stationery Office; M Whitehead (1995) 'Tackling Inequalities: A Review of Policy Initiatives', in M Benzeval et al (eds) *Tackling inequalities in Health, an agenda for action*, King's Fund. Quoted in Ben Rogers and Emily Robinson, 2004, The benefits of community engagement: A review of the evidence, IPPR: London.

tool.

Wilkinson has done much to establish the link between social capital and health inequalities in his work over the last three decades. One of the correlations that he has demonstrated across developed countries at a societal level is that between the level of trust in societies and the level of health inequality, the former reducing as the latter rises irrespective of the overall wealth of the country. So the UK for example whilst still wealthy as a country has relatively low levels of trust and high levels of inequality in health[40].

There have been a number of studies that have considered the links between different aspects of health and social capital, namely mental health and physical health, which are summarised below.

2.3.1.3 Social capital and mental health and wellbeing

Laverack (2009) has noted that:

> *'social support is generally accepted as an important determinant of and as having a beneficial effect on, health … for example people cope better with stressful events by sharing problems …'.*[41]

The importance of social support in times of crisis has been recognised for a long time with, for example, the sociologist Emile Durkheim establishing in 1897 that less integrated societies had higher suicide rates due to anomie – a sense of hopelessness caused by the breakdown of rules which leads to a loses of belief and sense of purpose[42]. Another well-known study by Brown and Harris in 1978 found that women who had someone close they could talk to when faced with a traumatic life event were less likely to become depressed[43]. More recent studies, such as Lin et al (1999), confirm the link between low social capital and depression[44].

Social capital is now always positive, however, such as when strong bonding social capital can be detrimental for the mental health of individuals, usually women, who are constantly providing emotional support for others. Those with a range of networks (bridging and linking as well as bonding) are likely to have the best mental health and are less likely to be depressed[45].

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[40] Wilkinson R and Pickett K (2009) The Spirit Level, London Allen Lane
[41] Laverack G (2004) 'Health Promotion Practice Power and Empowerment' London: Sage Publications
[42] E Durkheim, 1897, quoted in Ferlander S (2007) '*The Importance of Different Forms of Social Capital for Health'* Acta Sociologica 2007: 50: 115. See http://asj.sagepub.com/content/50/2.toc
[43] Brown and Harris, 1978, quoted in Ferlander S (2007) '*The Importance of Different Forms of Social Capital for Health'* Acta Sociologica 2007: 50: 115
[44] Lin N et al (1999) 'Social Support and Depressed Mode: a Structural Analysis' Journal of Health and Social Behaviour 40: 334-59
[45] Ferlander S (2007) '*The Importance of Different Forms of Social Capital for Health'* Acta Sociologica 2007: 50: 115

2.3.1.4 Social capital and physical health and wellbeing

Campbell (2001) noted that people living in communities with high social capital are more likely to be empowered and to have high levels of self-efficacy which in turn has a positive impact on their health and wellbeing[46]. Other studies have linked high social capital to lower levels of smoking, higher levels of physical activity levels and better diet[47]. Cohen et al (1997) even suggested that the common cold is less prevalent in more cohesive communities![48] Studies have also discovered that people survive and recover better from stroke and myocardial infarction when they have good emotional support although illness can in itself also decrease social capital as people become more socially isolated through the experience of being ill[49].

The experience of those working in this area would be that generally it is easier to access people in communities with strong networks and to ensure that information about health, activities and services is passed on. However, some individuals in strongly bonded communities can find themselves under emotional strain when many others seek their support, so high levels of bonded social capital can in some regards be negative. It can also be negative in terms of health for whole communities if the norms within those communities do not promote health and wellbeing (such as when drug use or smoking are accepted and expected activities). Peer pressure can also be a powerful influence so individuals can find it difficult to break away from the norms of strongly bonded communities even if they might wish to do so. Equally those working with communities can experience difficulty disseminating information or encouraging engagement with activities when the activities are inconsistent with community norms.

Health Trainers and Health Trainer Champions contribute to the development of social capital by introducing people to activities in their communities and supporting them to get and stay involved. Sometimes meeting other people in similar circumstances and engaging in activities with them develops into friendships and social networks outside of those activities. Health trainers are also setting up activities to bring individuals together and through this they are creating networks and providing opportunities for friendships to develop. It is this engagement with others, enjoying activities together and developing support networks, which is often key to individuals sustaining the changes they make on a personal basis to improve their health. And as has been evidenced above, just acquiring more social capital is in itself, positive for people's health.

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[46] Campbell C (2001) chapter in Baron S, Field J and Schuller T (Eds) *Social Capital: critical perspectives,* Oxford University Press

[47] See, for example: Trieber et al (1991) 'Social Support for Exercise Relationship to Physical Activity in Young Adults' = Preventive Medicine 20: 737-50; Lindstrom M et al (2000) 'Socioeconomic Differences in Smoking Cessation: The Role of Social Participation' Scandinavian Journal of Public Health 28: 200-8; Lindstrom M et al (2001) 'Socioeconomic Differences in Leisure-Time Physical Activity: the Role of Social Capital in Shaping Health-Related Behaviour' Social Science and Medicine 52: 441-51; Poortinga W (2006) 'Perceptions of the Environment, Physical Activity and Obesity' Social Science and Medicine 63: 2835-46

[48] Cohen et al (1997) 'Social Ties and Susceptibility to the Common Cold' Journal of American Medical Association 227: 1940-44

[49] Berkman L et al (1992) 'Emotional Support and Survival After Myocardial Infarction: a Prospective, Population-based Study of the Elderly' Psychosomatic Medicine 58: 459-71; Glass T and Maddox G L (1992) 'The Quality and Quantity of Social Support: Stroke Recovery as Psycho-social Transition' Social Science and Medicine 34: 1249-61.

2.3.2 Community Engagement

This section briefly explores the benefits of community engagement for health. Some of the potential barriers to community engagement and possible dis-benefits are also considered as are the links to emerging ideas, such as co-production and social return on investment.

2.3.2.1 The evidence for community engagement and health

There is a large and growing literature on community engagement that has been reviewed and summarised in two recent reports.

1. *The benefits of community engagement: a review of the evidence* was commissioned by the Home Office in 2004, and produced by the Institute for Public Policy Research[50].

2. *Community engagement in initiatives addressing the wider social determinants of health: a rapid review of evidence on impact, experience and process*[51] was commissioned by NICE in 2007 to inform the public health guidance that was being produced in 2008 on 'Community engagement to improve health'[52]. This evidence review was produced by a team from Lancaster University and led by Jennie Popay.

These two publications, (the latter in particular) have formed the primary sources for this section.

Popay et al (2007) found evidence to suggest that becoming more engaged was linked to feelings of being more empowered and having greater 'self-efficacy' (ie a belief in one's ability to exercise control in one's life). Both of these are in turn linked to improved health. The research team also found other, albeit weaker, evidence linking engagement to positive health outcomes.

The NICE public health guidance, which was informed by the work of Popay and colleagues, states that *'community engagement approaches may have a positive impact on a range of intermediate and long-term health outcomes'*[53] and that community engagement activities may have an '*impact on the appropriateness, accessibility and uptake of services*'. They may also '*have an impact on people's health literacy (ie their ability to understand and use information to improve and maintain their health)*'[54].

These quotes should be considered in the context that the focus of the work of NICE and the review team was engaging communities to help inform the commissioning and delivery of services. This is in contrast to the community engagement undertaken by Health Trainer Services where the purpose is

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[50] B Rogers & E Robinson, 2004, The benefits of community engagement: a review of the evidence, London IPPR http://www.communities.gov.uk/publications/communities/benefits

[51] Popay J (2006) Community engagement and community development and health improvement: a background paper for NICE See http://www.nice.org.uk

[52] NICE, 2008, Community engagement to improve health NICE Public health guidance 9, London NICE http://www.nice.org.uk/nicemedia/pdf/PH009Guidance.pdf

[53] See NICE 2008 - page 17

[54] See NICE 2008 - page 6.

generally to improve the health and wellbeing of the individuals concerned. Perhaps not surprisingly, Popay et al found that there were some dis-benefits to engagement in service planning and delivery for some people:

> *'community engagement activities may have unintended negative consequences for participants, including physical and emotional health costs, consultation fatigue and disillusionment.'*[55]

It seems likely that the health consequences of engaging with Health Trainer Services will be more positive given the primary motivation is to improve the individual's health and wellbeing and there is no expectation that clients will also become involved in service planning.

Popay et al also found evidence that community engagement '*may have a positive impact on 'bonding' and 'bridging' social capital and social cohesion'*. The NICE guidance states that community engagement approaches which treat communities as '*equal partners or which delegate some power to them – or provide them with total control- may lead to more positive health outcomes*.'[56] Their review links this to building social capital, empowerment and wellbeing and as has been described in the earlier section, there is considerable evidence to show that greater social capital in general leads to improved health outcomes.

There are however a number of barriers to people becoming engaged, especially when they are from a disadvantaged community. These include not having the '*cultural expectations, knowledge and language that accessing services requires*[57].' In addition, NICE identifies a number of organisational barriers to community engagement which have prevented various proposed approaches being implemented effectively in practice. These organisational barriers include:

- *'the culture of statutory sector organisations*
- *the dominance of professional cultures and ideologies in imposing their own structures and solutions on communities*
- *competing and conflicting priorities*
- *the skills and competencies of staff working in public services*
- *the capacity and willingness of service users and the public to get involved'*[58].

A wide variety of methods and approaches are being used in an effort to engage communities including '*community development, citizen's panels, citizen's juries, neighbourhood committees, community forums, community champion programmes, drama and music*'. Community development workers have pointed out that people will not suddenly be able or willing to engage just because a statutory body wants them to, rather it takes time to build confidence and trust, establish networks and community organisations, and enable people to find their voice and articulate their concerns. A workforce, such as that within Health

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[55] See page 6 of the review
[56] Also on page 6 of the review
[57] Health Services Journal: Popular Ideas: Community Involvement June 24th 2010
[58] See above reference to NICE.

Trainer Services, can play a part in this process through enabling people to gain confidence and take control over their own lives and then, if they wish to, become engaged in how services are delivered in the future.

The special supplement within the Health Services Journal focusing on Mutuality noted that, for effective community engagement, agencies and workers should:

> *'Be clear about why they are doing it*
> *Understand the communities they are trying to engage*
> *Be clear who the leaders are*
> *Have a plan and set clear, focussed goals*
> *Be aware of cultural difficulties'.*[59]

Further information on community development and engagement methods can be found on the Community Development Foundation website[60].

2.3.2.2 Community engagement - co-production

There are number of other concepts relating to community engagement which are being increasingly explored in the literature. 'Co-production' is one of these, which has been defined by the New Economics Foundation as:

> '*delivering services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. Where activities are co-produced in this way, both services and neighbourhoods become far more effective agents of change.'*[61]

The Health Trainer model can be seen as a co-production model given that it begins with the individual's needs and interest and Health Trainers enable individuals to determine the actions they wish to take. There is evidence that an empowering approach to the management of chronic diseases where users self-manage can lead to improved health outcomes and reduced costs[62] although some conditions are harder to self-manage and some people are less confident in doing so and will need more support[63].

2.3.2.3 Community engagement – social return on investment

There is also recognition that it is important to value the additional benefit to a community that may result from a service. This is known as 'social value' or 'social return on investment'. This would be demonstrated, for example, if an agency engaged a community in local decision-making leading to improved social capital which in turn led to improved health and well being[64]. Arguably

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[59] Health Services Journal: Mutuality, June 24th 2010
[60] See http://cdf.org.uk/web/guest;jsessionid=89E0A8D76FC6CCDFD2A4701DD17147BE
[61] New Economics Foundation, The Lab and NESTA, 2010, *Right Here, Right Now: Taking Co-production into the Mainstream*, London NEF – see http://www.neweconomics.org/publications/right-here-right-now
[62]See above references to NEF 2010, and HSJ, 24June 2010.
B Rogers & E Robinson, 2004, The benefits of community engagement: a review of the evidence, London IPPR.
[63] J Ellins and A Coulter, 2005, *How Engaged are People in their Health Care?* London: The Health Foundation
[64] For more information on social value visit: http://www.northwest.nhs.uk/whatwedo/socialvalueproject/

Health Trainers signposting and accompanying individuals to services which then increase the activities that individuals undertake might be building social capital in a way that has positive spin-offs for the community as well as helping the individual client. There are some examples of this in Appendix B.

The review undertaken for the Home Office by Rogers and Robinson (2004) considered time-banks where people offer their time voluntarily to help others and are also able to call on the bank for support when they need it. Rogers and Robinson found that, in both the US and the UK, there had been benefits to health through the use of time-banks as well as this proving cost-effective for services. They reported that one GP in London believed the results to have been '*remarkable'* and that '*this alternative method of treatment has led to a lot of patients being taken off anti-depressants*'.

NICE conclude in their public health guidance on community engagement that:

> *'when it is done well, it can be extremely good value for money. If barriers to effective engagement can be removed, the approach is far more likely to be cost effective.'*[65]

2.3.2.4 The interaction between community engagement and behaviour change

The Coalition Government is keen that individuals and communities take responsibility for their own behaviours, including behaviour related to health. Dolan et al (2010) have produced guidance for the Cabinet Office and the Institute for Government that includes consideration of how social influence and norms affect individuals' behaviour[66]. This argues that:

> *'… the most effective and sustainable changes in behaviour will come from the successful integration of cultural, regulatory and individual change.'*

However, recent work by Rowson et al (2010) criticises Mindpsace for its insufficient consideration of the power of network structures and the extent to which they influence, or not, desired behaviour forms spreading:

> *'Behaviour change interventions are likely to be partially successful at best, unless the powerful influence of social networks is acknowledged'*[67].

They continue by noting that: *'understanding and utilising social networks should inform and can benefit any policy area'* and in doing so reference the public health benefits of such an approach. The combination of behaviour change, social networks and community engagement is a reflection of the approaches used within, and the value of, Health Trainer Services.

[65] See page 16 of the NICE Public Health Guidance no: 9

[66] P Dolan, M Hallsworth, D Hapern, D King and I Vlaev, 2010, Mindspace: Influencing behaviour through public policy, Cabinet Office and the Institute for Government: London – see http://www.instituteforgovernment.org.uk/images/files/MINDSPACE-full.pdf

[67] J Rowson, S Broome and A Jones, September 2010, Connected Communities: How social networks power and sustain the Big Society, RSA, London stress the limitations in solely in geographic terms. See http://www.thersa.org/projects/connected-communities

2.4 Conclusion

Health Trainers and Health Trainer Champions use skills in community engagement to reach marginalised groups and engage individuals in those groups to change their behaviour and hence improve their health. Later sections of this resource pack demonstrate how Health Trainer Services are effectively engaging with communities resulting in real benefits to health.

Much of the literature on the effectiveness of community engagement focuses specifically on engaging people in the planning and delivery of services. Whilst the skills needed to do the initial engagement are likely to be the same, there is currently only sparse information of Health Trainers engaging communities for a service improvement, although there is the potential for this to happen.

The next section explores in more detail a process model of the different stages at which Health Trainer Services engage with the communities they serve and the methods they use within those stages.

3. HOW DO HEALTH TRAINER SERVICES ENGAGE WITH COMMUNITIES?

3.1 Introduction

Health Trainer Services engage with communities to address health inequalities in a variety of ways including:

1. Connecting with people about health – engaging with individuals who do not currently use health services. This requires an understanding of the context in which people live and the challenges and barriers they face as well as the nature of the community and voluntary sectors in the local area. It requires skills of approaching and talking to people in their local area rather than waiting for people to contact the Health Trainer Service.

2. Connecting people into services – the Health Trainer Service itself and other services that will help people to improve their health and wellbeing (such as smoking cessation, benefits, transport, food availability). This can involve accompanying people to services if they do not have the confidence to attend on their own.

3. Developing group / family / social capital – through the knock-on effects of more engaged individuals taking control over their own lives and hence influencing the lives of their families, groups and communities (such as providing healthier meals for all the family, volunteering).

4. Improving services and facilities in the local community - through identifying issues with current services and facilities and: communicating this information so that it can be captured and fed into larger-scale service development; working in partnership with others to develop services or facilities; enabling the community to have a voice; or taking small-scale community action themselves.

Recognising the different ways in which Health Trainer Services engage with communities has led to the development of a community engagement process model, which is set out below.

3.2 The community engagement process model

The broad stages of the process that different Health Trainer Services use to engage communities are:

1. Planning the service

2. Engaging with communities on a community / group level to gain their interest in health

3. Engaging on an individualised and personalised basis

4. Developing family / group / social capital

5. Improving services and facilities in the community by:

    a. taking direct action

    b. working in partnership with others

    c. feeding back information on services and facilities

    d. enabling communities to have a voice.

Health Trainer Services may use Health Trainers for all of these aspects or might use different roles for different parts of the process such as: Health Trainer Managers doing some parts, Health Trainers doing others while Health Trainer Champions undertake the rest. There is no correct way of doing this as each service needs to plan what will work best for its own communities within the resources available.

The remainder of this section describes the process model in further detail bringing out the key points that have emerged at each of the stages. Appendix B provides examples of how different Health Trainer Services have engaged with their communities.

There is one further way in which Health Trainer Services engage with their communities which is covered in section 4 of this resource. This is through community capacity building by recruiting people from the community to the employed or voluntary posts within Health Trainer Services, developing the individuals and providing further support and development to other posts and career development either within or beyond Health Trainer Services.

Stage 1 Planning the service

The overall purpose of health trainer services is to enable individuals to change their behaviour, improve their health and wellbeing and reduce health inequalities. The planning stage for the development of services, whether initially or over time, includes both a consideration of the community(ies) that should be the focus of the services as well as the engagement methods to be used.

Decisions about which communities will be the focus of the services are likely to be made by commissioners informed by knowledge of the communities that would most benefit from health trainer interventions and the overall reasons for this (such as high mortality rate, high incidence of obesity, low percentage of individuals registered with GP services). The communities might be communities of place (such as a particular neighbourhood) or communities of interest (such as older people, men, a BAME community, travellers). Final decisions on the communities might also be influenced by the organisation(s) that is providing the services (ie some organisations may be in a better position to win contracts if they are already working in, or have contacts with, the communities whose

health needs have been identified).

Once commissioners have determined the community(ies) for whom the service is intended, they may also specify particular engagement methods they wish to use and the specific location of the services to be delivered. Alternatively commissioners may ask those who are bidding to provide a Health Trainer Service to propose locations and engagement methods.

The ways in which Health Trainer Services have incorporated community engagement into the planning of services have included consideration of:

- the location of Health Trainer Services and individual Health Trainers within those services (for example, ensuring that the service is located within venues that the communities already use, not expecting individuals to travel outside of the community to the service)

- designing services that meet the cultural, language and disability needs of clients

- the overall availability of health trainers and health trainer champions to the communities, including the hours and nature of work

- making close links and working in partnership with other services to promote and deliver services.

Health Trainers and Health Trainer Champions often undertake this detailed planning when services are in the development stage including mapping the different community services that are available, their location(s), their nature, their hours of opening etc.

> *Example*
> In Portsmouth, Health Trainers are hosted in community centres and voluntary sector organisations based around areas of known deprivation and targeted communities (such as BAME groups). Health Trainers began their work from their particular geographical base by exploring their locality, introducing themselves to formal and informal networks and discovering the range of provision in their 'patch'. This included working with grass-root groups, GP practices, statutory services and third sector provision. Using a structured information gathering and reporting approach, the Health Trainers developed a picture of services, support and materials within the city which has formed the basis of a services sign-posting resource. These maps are reviewed annually to ensure they remain up-to-date.
>
> An added bonus of this approach has been that other services and organisations within the city have been keen to access the intelligence developed by the Health Trainer Service because of its potential use as a sign-posting resource. The service is now selling its resource pack to other services and organisations, such as community podiatry services

and local pharmacists.

Example
An evaluation of the North Lincolnshire Health Trainer Service 2009-2010 revealed that, in 2007, 19% of the population lived in areas which ranked amongst the poorest fifth in the country and the gap between the rich and poor was continuing to increase. Additional funding for the Health Trainer Service was targeted at the five poorest wards in Scunthorpe and in these wards, those out of work (especially men) and BAME communities previously identified as having poor rates of service uptake. Health Trainers were allocated to a geographical area within the town and engaged with the communities through outreach work such as at schools, shopping centres, community groups, and by knocking on doors. Individuals are able to self-refer into the Health Trainer Service or they can be referred by other services.

Reviewing the success of this planning after a year showed that:

- just over 6% of their clients described their ethnicity as other than 'White British' in the context that under 3.5% of the population of North Lincolnshire are from BAME groups demonstrating that the initial strategy had worked in this area

- 39% of clients were men. Whilst this is a relatively high percentage of male clients and an improvement on the first six months of the programme, the rate is still not as high as had been hoped

- 61% of clients live in the areas falling into the two most deprived quintiles with 18% coming from three of the targeted wards demonstrating reasonable success in reaching the least advantaged communities.

Stage 2 Engaging with communities on community / group level
Once a Health Trainer Service is up and running, a key part of its work is to engage with communities on a community / group level to build trust, raise awareness of health and promote the service to the community. This can be a long process as some Health Trainer Services have found that the least advantaged communities are often wary of becoming involved with a service until they are sure it will continue in existence due to past experience of short-term projects without sustainable funding and concerns about developing reliance on, or commitment to, a service which then disappears.

Experience has also shown that some individuals are not keen to take-up one-to-one appointments initially due to:

- their perceived formality (eg young people)

- suspicion in discussing personal issues with people seen to be authority figures (eg mental health service users)

- individuals being more comfortable with ways of working where the focus of attention is not all on them.

Health Trainer Services have reported a wide variety of different ways in which they have engaged with communities and raised awareness of health. These include:

- establishing a base in a setting on a regular basis in order to build up trust with the client group (eg libraries, pharmacies, housing, agricultural settings, SureStart centres)

- engaging with clients whilst they are using other services (eg GPs, mental health drop-in, stroke clubs)

- engaging with clients about health through informal discussions, such as over coffee or during other organised activities, such as painting or cookery classes

- setting up group activities to address the isolation of some individuals and offer opportunities through this route with the longer-term aim of working with people individually

- operating an informal drop-in session where individuals can access Health Trainers but are not committed to making appointments

- being available at venues / places / events to make contact with the community (eg Premier League football clubs, working men's clubs, coffee bars, agricultural settings, outdoor locations that the community uses)

- giving presentations at other services to promote the Health Trainer Service

- respecting clients who may wish to bring a friend or relative to their meeting with a Health Trainer

- supporting the organisation that is hosting Health Trainers to set up health-related activities for the community in response to expressed demand (eg Walking For Health, Tai Chi, weight management programmes)

- accompanying groups of clients to events and activities that promote their health and wellbeing

- publicity information such as posters, news articles.

Some Health Trainer Services also have formal referral routes either as the main way in which individuals enter the service or as one means of doing so. Where the only access route into Health Trainer Services is through formal referral routes, this will limit the service to those who are using the referring service. It will be important to ensure that this is consistent with both the overall aim of developing the health trainer service and also ensures that community(ies) for whom the service has been developed are actually able to access the service.

Stage 3 Engaging on an individualised and personalised basis

The main focus of Health Trainer Services has often been seen as the personalised support offered to individuals to enable them to change their behaviour. This is a major part of a Health Trainer's role but, as can be seen from the process model, is only one of the ways in which Health Trainer Services engage with communities. There are also other activities that Health Trainers undertake when working with individuals beyond the personal health planning.

These include, as part of the one-to-one support for behaviour change:

- signposting people to activities which will help them achieve and sustain their behaviour change goals (eg to be more physically active)

- signposting individuals to other services that are better able to meet their needs both within the health service (eg GPs, smoking cessation), local authorities (eg housing, rubbish collection), government services (eg benefits) and voluntary services (eg women's aid)

- accompanying people to services either to enable them to develop their confidence to attend the services alone or to provide individuals with other supporting skills (eg literacy, numeracy)

- supporting individuals with wider aspects that affect their health and wellbeing (eg registering with a GP, sorting out proper toilet facilities, helping individuals to apply for places at college)

- sharing skills and knowledge developed in their work.

Stage 4 Developing family / group / social capital
Health Trainer Services have become increasingly aware that behaviour change interventions with individuals have a wider impact as clients who change their behaviour then interact and behave differently with their families, friends and the wider community. For example, an individual who has learnt how to eat more healthily then provides healthier food for their families; or an individual working with a Health Trainer learns through this contact more about their own communities, recognises the knowledge and skills that others have in the community and then joins community groups.

Some Health Trainer Services have taken specific steps to build community cohesion and social capital as an integral component of their service, such as by organising client reunions and linking clients into community groups to support their behaviour change. The clients of Health Trainers have reported learning as much from one another as from the employed staff, being encouraged by what other members of the community have achieved and receiving practical support from making connections with others in their community. This has been reinforced in some recent qualitative research by Ball and Nasr (2010), which reported a 'ripple effect' being described by Health Trainers and their clients[68]

Stage 5 Improving services and facilities
Health Trainer Services improve services and facilities in the local community – through identifying issues with current services and facilities and then:

a. taking direct action

b. working in partnership with others

c. feeding back information on services and facilities

d. enabling communities to have a voice.

Stage 5(a) Taking direct action
Health Trainers and Health Trainer Champions do not have a formal role in community development. However they may take specific small-scale actions to benefit their communities when the information being received from a number of their clients suggests that this would be valuable to the community concerned. This is likely to be quite informal in nature and may be done in an ad hoc and opportunistic fashion.

For example, the Newcastle Health Trainer Service noted that many of the clients with whom they were working consumed large amounts of salt in their diets and whilst they could seek to work with individuals on this, there were aspects in the environment that limited the changes a Health Trainer, or a client of a Health

[68] Ball and Nasr, 2010, A qualitative exploration of a health trainer programme in two UK primary care trusts in Perspectives in Public health, Sage Publications – see http://rsh.sagepub.com/content/early/2010/05/28/1757913910369089

Trainer, could make. The Health Trainers concluded that if they could persuade the local food outlets to reduce the size of the holes in salt-cellars then this might bring a quick win in terms of salt consumption in the local community. They also found that when they talked this through with the owners and managers of the food outlets, this was generally well received and then adopted by the food outlets.

Volunteer Health Champions in North East Essex highlighted the difficulty local residents faced when trying to eat healthily because of poor access to affordable fresh fruit and vegetables in the area. This presented particular difficulties for families with young children and older residents. The Health Trainer Champions developed the idea of operating a weekly van to sell fruit and vegetables at low cost and with associated promotional events and activities to inspire people to incorporate more fresh produce in their diets. By staffing the van themselves, the Health Trainer Champions would also become known within the community as trusted sources of information, building up trust and awareness of health improvement services in hard to reach neighbourhoods. The volunteers christened the project "Fresh and Fruity".

Other examples include Health Trainers and Health Trainer Champions who have been in the position to extend the activities that are available to people locally to help them improve their health and wellbeing. For example, a Health Trainer Champion in a prison identified the need for separate gym sessions for new clients and worked with the prison team to provide these sessions.

Stage 5(b) Working in partnership with others

Through their contact with communities, Health Trainers and Health Trainer Champions also identify where there are no suitable services or facilities to meet the community's needs and can work with partners to address such needs.

> *Example*
>
> Two members of staff in the Newcastle Health Trainer Service (one from the Pakistani community and one from the Bangladeshi community) were already working in partnership with the local swimming pool to support women to attend a daytime women-only session at the pool. This was well attended by between 20-30 women during which the Health Trainers provide one-to-one behavioural change support. The women attending the session said there was a need for an evening women-only session for women and their children. The Health Trainers negotiated a pilot of four sessions, with the first two sessions provided free by the pool with a guarantee of female staff only. The Health Trainers produced fliers about the sessions and circulated them widely in the communities. The first week over 100 women came with their children, amounting to over 300 people altogether and the session had to be split in two for safety reasons. The vast majority of the women and their children were from BAME communities, some of whom had never taken their children swimming before. The session also increased the number of individuals that the Health Trainers can work with on behaviour change.

Example
The same Health Trainer Service has also been funded through the local Practice Based Commissioning Group to engage with BAME communities around healthy lifestyle change, as there are high incidences of long-term conditions, particularly diabetes, and poor take up-by these communities of the support services offered through primary care.

Example
The Portsmouth Health Trainer Service has been working with the Community Library service to provide a Healthy Eating on a Budget course consisting of 5 x two-hour sessions. This was identified as a need in the local community and also a means of engaging with possible new clients for both services. The course is based on the Eatwell plate, portion sizes, food labelling / hidden foods and pricing and food hygiene. On the course, everyone completes a food diary each week to assess understanding and learning and highlight those in need of more support. At the first session 12 people arrived of whom four were visually impaired (one with a hearing impairment too), one had had a stroke in the past six months, one had a mild learning disability and was unable to read any material from the Food Standards Agency while another disclosed an eating disorder. In other words, over half the group had immediate support issues and were offered signposting related to the general health issues that they raised. Two individuals who attended asked if visits could be made to their families to "show them the stuff" as well. By the end of the course, all 12 individuals had decided to work on individual Personal Health Plans.

The qualitative research by Ball and Nasr (2010)[69] noted that Health Trainers believed a key and unpredicted part of their work was determining the true incidence of public health issues within the community and the difficulty that many individuals had with understanding the information on health that they were given. For example, there were reports of individuals experiencing difficulty understanding what a vegetable is or being able to interpret a leaflet about services, healthy living etc.

Stage 5(c) Feeding back information on services and facilities
The four national competences for Health Trainers include a requirement that Health Trainers should identify issues with services during their ongoing work and feed this back to their employing organisation. This is also an expectation for Health Trainer Champions. The issues identified might relate to the Health Trainer Services themselves or issues that community members have with using other services designed to support their health and wellbeing.

The types of issues that might arise include:

[69] Ibid

- accessibility of the service including transport to and from as well as hours of opening

- issues with the service itself such as the welcome given by staff, the information provided being too difficult to understand or not in the individual's first language

- broader social issues that affect accessibility and use of the service such as fear of crime and anti-social behaviour in the area where the person lives leading to a fear of leaving the house in the evenings when the service is offered.

Stage 5(d) Enabling communities to have a voice

Some organisations have recognised and valued the knowledge and skills of the staff of Health Trainer Services and sought to draw on the close links that Health Trainer Services have with communities to help them develop other services and policies. This gives the targeted communities a voice in service and programme development and a means of involvement in other developments.

Examples of the different ways in which Health Trainer Services have involved communities in service and policy development include:

- focusing on members of distinct communities that public services wish to engage with and learning how best to do this

- learning from members of some communities why they have used services with the aim of being able to translate this learning to other services

- finding out from community members the reasons for them using, or not using, particular services through the use of such methods as focus groups, one-to-one interaction

- presenting information to community members in a way which they can understand and use

- gaining information from community members on the things that would help them take-up services

- communicating information about services which do not exist and the reasons for this

- bringing together users of services to reflect on their learning and identify how the service could be improved.

3.3 Conclusion on the Health Trainer Service Process model

This section has described the process model which Health Trainer Services use to engage with communities in the planning of their services, in gaining the interest and involvement of the communities, supporting individuals in communities on a personalised basis, developing social capital, and improving services and facilities. The process model serves to show that Health Trainer Services engage with communities in a variety of ways in order to change individuals' behaviour, reduce health inequalities and focus on the communities which are seldom heard and often disadvantaged in terms of public services and support overall.

The next section looks at another form of community engagement – community capacity building through workforce development.

4. HOW DO HEALTH TRAINER SERVICES BUILD COMMUNITY CAPACITY THROUGH WORKFORCE DEVELOPMENT?

4.1 Introduction

A key and unusual aspect of Health Trainer Services is that they have been designed to recruit and develop individuals who are from the communities targeted for the health trainer intervention. This is for a number of reasons including:

- the evidence base for behaviour change, specifically that individuals are more likely to change their behaviour if the person supporting is like them[70]
- the links between health, education and employment (and other social aspects) – in short those who are have a higher level of education or who are in employment enjoy better health and wellbeing[71]
- offering people a progression route to employment through the stages of learning about health (and related skills such as literacy, numeracy and study skills), developing knowledge and skills about improving health and wellbeing through to education, training and employment as a Health Trainer and then onto other posts.

This form of community capacity building includes:

- recruiting people into posts
- educating and training these individuals for the posts
- developing work and self-management skills in those who are not used to working
- supporting progression into other employment and further education.

4.2 Recruiting from communities

The Health Trainer National Workforce Audit (2009)[72] reported that recruitment and selection criteria for Health Trainers vary, but four characteristics were common:

1. a knowledge and understanding of the local community: in some cases recruits are expected to live in the community. There may also be some specialist knowledge or experience required, depending on the nature of the client group (eg a particular ethnic group, or age group) or the service

[70] S Michie, N Rumsey et al, 2008, Improving health: changing behaviour –NHS Health Trainer Handbook, Department of Health: London.
[71] See, for example, Department of Health, 2008, Health Inequalities: progress and next steps, DH: London.
[72] Department of Health: Health Trainer Programme Team, January 2010, The Health Trainer National Workforce Audit 2009, London, DH – Health Trainer Programme Legacy documents

the Health Trainer will deliver.

2. skills in communication and relationships: in some cases these skills require fluency in other languages

3. being motivated to help others in relation to their health

4. some knowledge and/or interest in health and health improvement.

The Audit also reported data on the ethnicity of Health Trainers and those in related roles. This showed that of the 1,721 individuals employed in Health Trainer Services whose ethnicity was reported, 78.5% classified themselves as White, 5.8% as Black, 11% as Asian, 0.8% as Mixed White and Black, and 0.2% Chinese. When these figures are compared with workforce figures published in 2008 on the staff who provide support to doctors and nurses in the NHS whose ethnicity was known, the figures for Health Trainer Services are encouraging in relation to the recruitment of individuals from Black and Asian communities[73]. The overall success of recruiting from different communities needs, however, to be looked at in the context of local services and the communities they have targeted for interventions and recruitment.

Services reported that amongst the minority communities targeted for recruitment were: BAME groups, Afro-Caribbean, Somali, South Asian, Eastern European communities, South American communities, Punjabi, Sikh and Muslim, travellers and gypsy populations. Most services reported that they were satisfied that their Health Trainer and Health Trainer Champion workforce was representative of the local community in which they work, in terms of ethnicity. There was however less satisfaction regarding the gender split with the majority (79%) of Health Trainers being female.

The Audit also sought information on the expectations of Health Trainer Services about the previous employment, experience and qualification of recruits. This clearly varied from service to service. However a number of returns indicated that previous employment is not necessary and a small number of services said they actively sought to recruit people who were unemployed from deprived postcodes. For example:

> *"Local people and originally around 70% from NEET [Not in Employment, Education or Training] category in order to reflect our local population and support people back into employment."*

> *"Two HTs were recruited who had no formal employment experience and left state benefits to take up employment as HTs. The individuals had no educational experience since leaving school approx 25 years ago, therefore they found the prospect of attending college to complete the City and Guilds course daunting. They were able to support each other through the weeks and successfully completed the course. Currently one HT is still working successfully as a HT and the other has taken up a promotion as a*

[73] NHS Figures 2008 for support staff - 77.7% White; 4.6% Black; 3.3% Asian; 1.6% Mixed); and 0.7% Chinese.

Community Development Worker."

Successes in recruitment reported in the Workforce Audited included recruiting from diverse groups, reflecting the local community, and high numbers of highly motivated and successful candidates making real breakthroughs with the local population. Particular successes reported included:

- recruitment from the Romany gypsy population (Yorkshire & Humberside)
- a single parent with 5 children and no previous salaried employment enjoying the experience and showing a marked improvement in confidence (North East)
- representation from faith communities, refugee, health charities and estate communities (London)
- a team with a variety of backgrounds and experiences that complement each other (South West)
- working with the Condition Management programme [supporting people on incapacity benefits to return to work] enabled one service to recruit several skilled candidates (Yorkshire & Humberside).

Appendix C provides a number of case stories of individuals who have been recruited from the communities that have been the focus of Health Trainer Services.

Health trainer services have reported particular difficulties with organisational recruitment processes that rely on information technology (such as the NHS Jobs website). This is because the communities they wish to recruit from either do not have the IT skills to access the site, they do not have access to IT itself, and/or the IT system does not provide the information that the service is seeking when it takes forward the recruitment process (such as identification of postcode for short-listing).

The methods that services have employed to overcome their difficulties include:

- offering education, training and qualifications to community members on health literacy or health improvement at a basic level and then seeking to recruit from that pool
- advertising in local newspapers including free ones
- open days and familiarisation events
- dedicated support workshops to help people apply for the posts
- advertising the posts through other community groups.

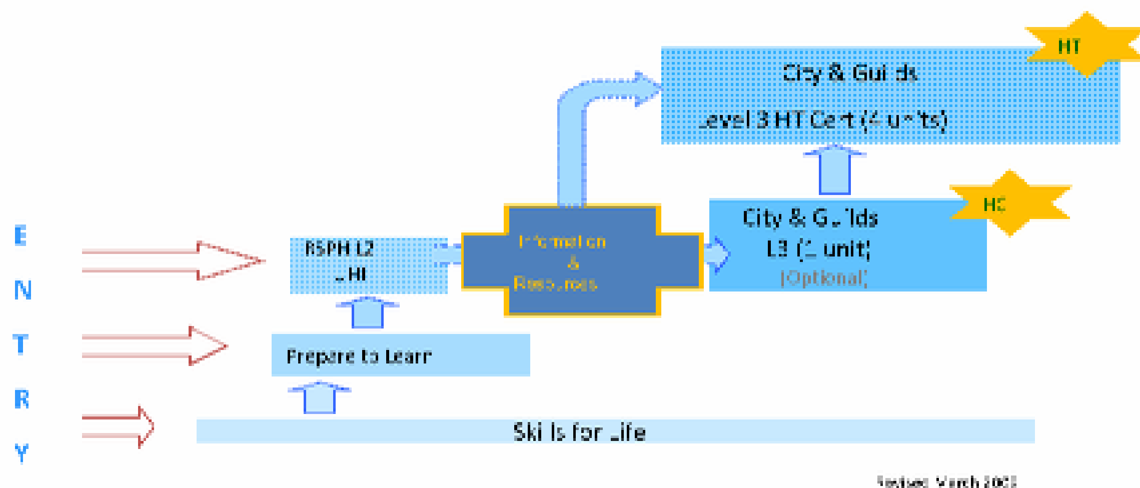
4.3 Education and training routes

The Health Trainer Service workforce is unique in that it is drawn from some of the most disadvantaged communities and groups. This means that the service has to pay particular attention to supporting the skill development of the potential workforce from often a fairly basic level.

Derbyshire County PCT, working with its partners in Derbyshire Library Service and Derbyshire Community Adult Education Service, has developed a learning pathway *Community Learning for Health*[74] designed to widen participation for health improvement in Derbyshire. This is an educational pathway that offers:

> *"a supported route for gaining the national HT qualification as well as a volunteer role of Health Champion (HC). This enables the recruitment of HTs and HCs from disadvantaged groups and communities and engagement of people in health improvement activities regardless of prior educational attainment or experience. This model demonstrates a 'widening participation in learning' approach to tackling health inequalities."*

This is illustrated in the diagram below.



Amongst the plans that Derbyshire has are:

- introducing a Health Literacy programme to communities and groups in Derbyshire

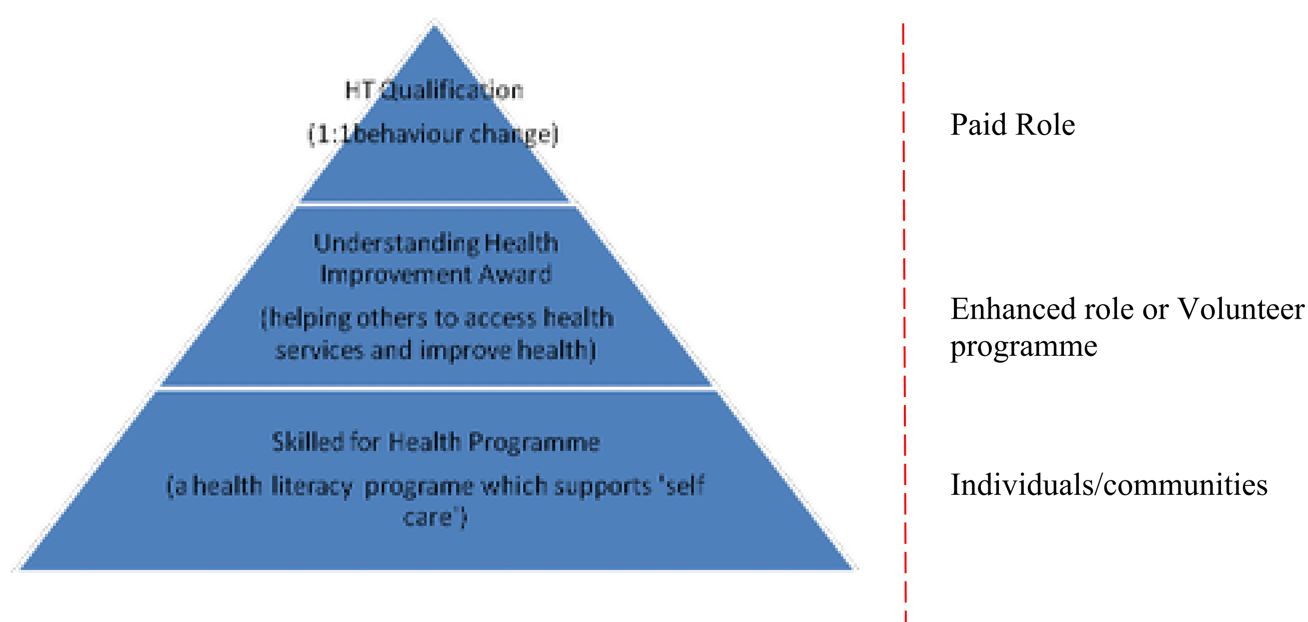
- increasing public awareness of the links between health and lifestyle whilst at the same time increasing qualifications / skills and improving employment opportunities

[74] M Murfin et al, 2009, *Community Learning for Health*, Derbyshire County PCT

- providing a progression route into employment for the Health Trainer Service.

The development model linked to progress into paid employment is shown below where:

> *"the pyramid demonstrates the vision of having a platform of increased health awareness and baseline of literacy, language and numeracy (LLN) on which to build qualifications and potential paid employment opportunities. Without this baseline it is hard to imagine how individuals will be able to take up health information, make informed choices or change their attitudes to lifestyle and health. Health literacy is a prerequisite for community engagement. Not only will this contribute to health inequalities work within the PCT it also helps deliver on other agendas such as worklessness and skills development and is suitable for engaging communities (including workplace & prisons), groups (including people not in employment, education or training (NEET) and families."*



A similar approach to that developed by Derbyshire County PCT has since been adopted in the National Health Trainer programme and work is underway with colleagues in the Skilled for Health programme to develop a health literacy qualification at level 1 in the Qualifications and Credit Framework. This is intended to increase the knowledge and skills of communities about health and wellbeing as well as providing a development pathway into Health Trainer Services and beyond.

Appendix D offers a resource for developing the community engagement part of Health Trainer and Health Trainer Champion roles as well as a manager / commissioner briefing on community engagement for Health Trainer Services.

4.4 Progression from health trainer posts

The Health Trainer Workforce Audit showed that the reasons for individuals leaving their posts within Health Trainer Services included: progressing into further education and training, full-time employment (many Health Trainer posts are part-time), or needing to withdraw for personal reasons such as a change in circumstances. The Audit noted that of the 152 individuals who provided reasons for leaving: 97 left for full time employment of which 48 left for other full time roles in health and social care, and 19 explicitly noted that job changes were promotions.

4.5 Challenges to developing the Health Trainer workforce

We should note at this point that exciting as it is for Health Trainer Services to develop community capacity through workforce development, this can bring a real challenge to human resource departments and the managers of Health Trainer Services in terms of how they are used to undertaking their work and their assumptions about how a workforce should act. This is because:

- recruiting people from the local community, particularly if they do not have formal educational qualifications, or are not in education, employment or training, has meant that different ways of attracting community members to apply for posts has needed to be found

- educating and training people with little confidence in their abilities, although these are often many and varied, has meant that learning providers need to be flexible in their approaches and develop pathways by which different individuals can achieve the desired standards

- managing new recruits into Health Trainer and Health Trainer Champion posts has proved challenging for line managers as the individuals might need different forms of / greater support than other workers

- a high turnover of staff is often looked on as a negative indicator of workforce management. However for the Health Trainer workforce this can be a positive indicator showing that the service is addressing health inequalities through individuals moving onto other employment or education and training where they will have wider possibilities and earn more money.

- supporting a lay workforce with a high turn over can at times conflict with pressures to meet targets in terms of client numbers and progression. This tension needs to be acknowledged by commissioners.

Given the evidence base and the vast difference that work as a Health Trainer or a Health Trainer Champion can make to individuals, these challenges should not be eschewed.

5. HOW IS THE EFFECTIVENESS OF COMMUNITY ENGAGEMENT IN HEALTH TRAINER SERVICES DEMONSTRATED?

5.1 Introduction

Since 2006 the Health Trainer programme has been gathering quantitative and qualitative data and information on all aspects of the development and delivery of local Health Trainer Services. The intention of this has been to demonstrate the impact of Health Trainer Services on improving health and tackling health inequalities.

This section describes how the data and information have been captured and offers some key findings of the positive contribution that Health Trainer Services are making in relation to community engagement. It also sets out recent plans for improving the capture and reporting of community engagement activities within Health Trainer Services.

At the centre of this is the work is the Minimum Data Set (MDS). This was built on the original concept of Health Trainers as set out in the White Paper, *Choosing Health*. It has provided a focal point for evidencing the success of Health Trainer Services and the Health Trainer programme.

5.2 A Minimum Dataset for the National Health Trainers - 'Evidencing Delivery'[75]

The Minimum Data Set (MDS) was developed to support the capture of a consistent data set focused on the outcomes that can be achieved through Health Trainer interventions. The outcomes can be of benefit to Health Trainers and Health Trainer Champions, their clients and local communities. The outcomes in the MDS are:

1. Increasing capacity and capability, through building the workforce with the right skills in place to tackle health inequalities.
2. Reaching the 'hard to reach'.
3. Deliver sustained improvement to the health of the people of England through behavioural change.
4. Providing access to and encouraging the appropriate use and take up of NHS and other local services.

Data fields have been developed as the minimum needed to show achievement against each of these four outcomes. In addition the MDS has been mapped against the national indicators to which Health Trainer Services might be expected to make a contribution[76]. These are likely to need review on publication of the pending national NHS Outcomes Framework (see section 2).

During 2010 consideration was given as to whether the MDS should be developed to include a fifth outcome relating to community engagement. After a review of existing data capture methods and findings, the Health Trainer

[75] A Minimum Dataset for the National Health Trainers - 'Evidencing Delivery' Version 1 (Dec. 2007 - Reviewed July 2010)- Health Trainers Legacy Documents (September 2010)
[76] The impact of Health Trainers on Other Government Departments' agendas and PSA's – Aug. 2009 - Health Trainers Legacy Documents *(September 2010)*

programme agreed that community engagement can be seen as an integral part of the existing MDS outcomes and as a result a fifth outcome focused on community engagement was unnecessary.

5.3 The national Health Trainer Service Data Collection and Reporting System[77]

The Data Collection and Reporting System (DCRS), commissioned by the Department of Health and developed and supported by Birmingham Primary Care Shared Services Agency (BPCSSA), is the recommended data collection reporting system for all Health Trainer Services. The system has been developed in consultation with Health Trainer Hub Leads and local Health Trainer Services. The original system was designed on the *Improving Health: Changing Behaviour Health Trainer Handbook* enabling the capture of service and client data at each stage of the behaviour change process. This provides valuable details of each individual client's experience from first contact with the service through to their last, as well as being the main mechanism for collecting and reporting on the MDS outcomes.

National reports from the DCRS are produced at regular intervals. The September 2010 report[78] shows that:

- there are 109 organisations actively using the system
- there are over 165,000 client records on the system
- there are 82 organisations registered to use remote access tokens with over 900 now distributed nationally (remote access tokens are for services operating outside the NHS)
- there are 15 organisations entering Offender Health Data amounting to 1,400+ clients
- workforce data is held on the DCRS for 130 Health Trainer Champions and 290 Trainee Health Trainers out of the total 1,750+ active Health Trainers.

The DCRS currently captures:

- client demographics (particularly postcode and community of interest) so that services can confirm whether the service is reaching the intended community
- signposting, referral source and referral to demonstrate the level at which services are working with other community services and supporting clients into local community services.

[77] *A system overview presentation is available from NHS sites on https://nww.trainersinhealth.nhs.uk.*
[78] BPCSSA, September 2010, Health Trainer DCRS National Hub Report September 2010 version 10, BPCSSA: Birmingham.

A review of the system showed that there were areas of activity undertaken by Health Trainer Services that were not being recorded in the DCRS due to its design. This included any activity that is not associated with an individual client, such as that undertaken to engage communities with the service on a group / community basis (eg promotional events, HT support events, HT follow-up events). This is may also be the main role of some Health Trainer Champions and trainee Health Trainers. To address this gap, development work was undertaken to identify the fields that could be included in the DCRS to capture this broader range of Health Trainer Service activity and potentially show its effectiveness.

In July 2010, version 3 of the DCRS was launched with the significant addition of an activities section relating to community engagement. Version 3 also included improvements to the recording of whether or not a client maintains their change. The added functionality is attached in Appendix E. An example form to capture the data to input into the DCRS is shown in appendix E(i) with a demonstration of the reports that can be run from capturing that data shown in Appendix E(ii).

5.4 Health Trainers National End of Year Reports

A base line activity report was carried out in 2006[79] followed by two end-year reports documenting Health Trainer Service activity. These reports present a broad range of data and information submitted by regional hub leads and local Health Trainer Services, including an overall picture of regional hub activity and the development of local Health Trainer Services over time. In the third of these annual audits (2008/9) it has been possible to make some comparisons with data from 2007-08 and 2006-07 to create a national picture of progress and change in relation to local service delivery, including community engagement.

Health Trainer National End Year Report 2007/8 [80]

This report gave an indication of community engagement being a key phase in the local development of services and a necessary precursor to the behavioural change intervention. It also signalled that community engagement may be a potential factor in securing long term sustainable behaviour change, as well as its use in reinforcing the underlying principles of the Health Trainer concept. Following the publication of this report, the national Health Trainer programme identified the need to increase its understanding of how best to support community engagement as an integral part of Health Trainer Services.

[79] National Health Trainer Activity Report, Wilkinson D, Jain P, Hyland L, Michie S, CORE UCL, Nov. 2007- Health Trainers Legacy Documents (September 2010)

[80] National Health Trainer End of Year Report 07/08, Smith D, Gardner B, Michie S, May 2009 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_100724.pdf

Health Trainer National End Year Report 2008/9 [81]
The community engagement aspects to emerge from the End of Year Report 2008/09 included:

- Health Trainer Services reported that their services:
    - target those living in areas with the highest indices of deprivation
    - target those from disadvantaged communities and those with lowest life expectancy
    - frequently target people from BME communities, older people, the unemployed, asylum seekers, refugees, those living in rural communities, and men.
- Health Trainer Services determine who the target groups in their area are by identifying:
    - geographical targets (communities of place) such as wards with high deprivation levels and lowest life expectancy, Neighbourhood Renewal areas
    - those who face barriers to accessing local services
    - those with or at high risk of cardio-vascular disease (CVD).
- Linking with other services and partners generates referrals and a means to access target groups, for example:
    - referral by GPs and other health professionals, including clients with risks from CVD, obesity and being overweight
    - third sector, voluntary and community organisations offer Health Trainer Services a means to access target groups such as: adult services users, carers groups, Age Concern and Home-Start.

Many of the case stories produced by Health Trainer Services also demonstrate how Health Trainers and Health Trainer Champions engage with communities on a practical level. This is considered in the next section.

[81] Health Trainers National End of Year Report: 2008- 09, Smith J, Gardner B, Michie S, Jan. 2010 (awaiting gateway approval)- Health Trainers Legacy Documents *(September 2010)*

5.5 Health Trainer Case Stories[82]

In 2009, a case story approach was developed and piloted to enable Health Trainer Services to gather qualitative evidence and information about their achievements. This case story tool for local and regional use was accompanied by a selection of case stories. The case stories are split into two main groups:

- clients addressing the key priorities of: healthy eating, physical activity, smoking cessation, alcohol and emotional wellbeing
- people working in Health Trainer Services – Health Trainers and Health Trainer Champions.

The initial case stories were reviewed in a systematic way using the case story tool to provide a range of different information about Health Trainer Services, including how services were engaging with communities. These are described below.

The forms of community engagement

1. Health Trainers frequently connect clients into local services such as: gym sessions, bereavement groups, GPs and smoking cessation services.

2. Health Trainers frequently encourage the uptake of local services by accompanying their clients to these services.

3. Health Trainers connect with people about health by attending events where their target groups will be, such as community meetings and open days at local schools.

4. Other services in the area refer clients to Health Trainer Services, such as: Job Centre Plus, support groups for the unemployed, a learning disabilities social group.

The effect of community engagement activity on others in the community

1. Health Trainers bring together people with similar issues, either through introducing them to other existing services or by creating a group themselves, such as a Health Trainer Service setting up a walking group.

2. The interventions of Health Trainers with a client benefit the health of others connected to the client, such as a client referred to a Health Trainer Service received support themselves and the Health Trainer gave the client's son information on a young carers' group which he then attended.

[82] Health Trainer Case Stories: Selection from Volume One, CORE UCL, HT Central Team, July 2009- Health Trainers Legacy Documents *(September 2010)*

3. Clients who achieve their goals feel empowered to support others, such as clients who become volunteers in their local community.

Developing a workforce that will effectively engage with communities

1. Services recruit from:
    a. people living in deprived areas
    b. those who have previously worked in a volunteering role, such as a volunteer with the Samaritans, a Citizens Advice Bureau advisor
    c. those with a background in community support roles, such as health workers, community workers and family support workers
    d. those who have worked previously with the target communities, such as a spokesperson for the Gypsy & Traveller community, a manager of an Age Concern day centre, a support worker at local SureStart service.

2. Services train and support the Health Trainer workforce to carry out the role effectively by:
    a. providing all Health Trainers and Health Trainer Champions with initial training
    b. offering further training once Health Trainers and Health Trainer Champions are in their role
    c. encouraging support from colleagues through team meetings
    d. offering support to the workforce in the form of supervision from management and coordinators.

A revised version of the case story tool was published in September 2010 to capture qualitative data on all parts of the Health Trainer Service including community engagement.

5.5 Assessing the Value for Money of Health Trainer Services

The Health Trainer programme commissioned a report *Assessing the Value for Money of Health Trainer Services*[83] to help identify an approach and methodology for assessing the value for money of Health Trainer services. Based on a set of agreed assumptions, the usefulness, limitations and potential of the approach and methodology have been tested through application to a small number of Health Trainers Services. Whilst the approach is still new, it is encouraging to note that community engagement aspects have been identified within the Social Impact Matrix developed and are given a value when assessing the Value for Money of a service. This is shown in Appendix F.

In reviewing the potential value and usage of this social impact matrix locally however the report notes (on page 9) that:

> *"it needs to be thought through for each local service, recognising that there is no such thing as a 'typical' HTS. This should help in the design of new*

[83] Lister G, April 2010, *Assessing the Value for Money of Health Trainer Services* - Health Trainers Legacy Documents (September 2010)

services and in providing a common core for all qualitative and economic assessments. While the framework is intended to provide a common way of evaluating HTS impacts and benefits, it is not intended to limit innovation If this matrix does not recognise all the benefits of a particular HTS it should be developed or adapted."

The sharing of learning between services using this approach will help identify those elements of community engagement practice that are accepted as adding 'value for money'.

5.6 Other potential sources of information to demonstrate effective community engagement in practice

There are a number of other sources and reports that can be reviewed for information on how Health Trainer Services are engaged in community engagement activity in addition to the specific ones described above. These are described below together with links to enable direct access.

IDeA, April 2010, A glass half-full: how an asset approach can improve community health and wellbeing[84]

An example from a Health Trainer Service given on page 11 as follows:

> *'Recruited where possible from communities who do not normally interact with health agencies and professionals, health trainers are employed, trained and resourced to support people who want to make changes to their lives. Using the techniques of 'motivational conversations' and 'active listening' they support people to overcome their hesitations and start to make the changes that they decide they want to make. The Yorkshire and Humberside Regional Health Trainers Programme has found that "through the process of becoming more empowered as individuals many health trainer clients become more engaged in their community and build better social networks. This in turn supports them to sustain the lifestyle changes they have made". They have also discovered that this has sometimes led to people acting together to make healthy choices easier, for example, setting up a food co-operative or working with the local council to improve access to the local park.'*
> See http://www.yhtphn.co.uk/about-ht.html

Smith J, Gardner B and Michie S, April 2010, Health Trainers: National Data Collection and Reporting System (DCRS) Report[85]

Drawing from data produced by the DCRS, this report illustrates Health Trainer and client activity relating to the four MDS outcomes over two financial years (April 2007-March 2008; April 2008-March 2009). The report provides the first documentary evidence of the behavioural and health gains experienced by clients using the HT service.

[84] IDeA, 2010, A Glass half Full http://www.idea.gov.uk/idk/aio/18410498
[85] Included in the Health Trainers Legacy Documents, September 2010

Department of Health, 2009, Implementing the Health Trainer Service for Offenders in Prison and Wider Community Settings - A resource guide, V17 -02/04/09 [86]
This guide is intended to act as an aid for those, from Primary Care Trusts, Prisons or Probation services, wanting to establish offenders as Health Trainers in offender settings. It offers information and practical guidance on getting started, together with some context in relation to the Offender Health agenda.

Database of Local evaluations to provide access to ideas and information contained within surveys, reports and evaluations being undertaken or completed locally
Fully understanding and recording the contribution that community engagement makes to the delivery of Health Trainer services still requires local services to reflect on and carry out in-depth analyses of the full impact of the community engagement element of their work. There are many other lines of enquiry from an evaluation perspective that may also need to be pursued (see Appendix G).

The current database of local evaluations provides a central record drawn from information provided by Regional Hub Leads and local Health Trainer Services. The evaluations have been categorised according to the aspect of the Health Trainer Service that is the focus of evaluation together with a brief summary of key findings and recommendations. Details on how to obtain copies of complete evaluations are also available[87].

Database of external research and evaluations
In an attempt to keep track of external research and evaluation related to Health Trainer Service activity, this database provides a record of requests for HT information to support MSc, PhD and other research projects. Attempts have been made to secure details of these activities including requests for abstracts and final copies[88].

Conclusions

Work to date demonstrates that community engagement is an important aspect of Health Trainer service development and delivery. To reinforce this contribution, community engagement activity needs to be monitored, recorded, reviewed and shared in order to increase understanding of its significance in supporting behaviour change, which is at the centre of the Health Trainer role.

Both qualitative and quantitative methods can be used to create a rounded and representative account of Health Trainer activity at all stages of the community engagement process model. Ultimately this can be used to demonstrate the improvements in health and wellbeing outcomes for individuals, families and communities made by Health Trainer Services.

[86] Included in the Health Trainers Legacy Documents, September 2010
[87] Included in the Health Trainers Legacy Documents, September 2010
[88] Similarly, included in the Health Trainers Legacy Documents, September 2010.