South Central Health Trainer Hub
Health Trainer Services
Final Evaluation Report
“Keeping quality assurance in mind at each stage of development”
HTS Project Manager

Contents
1. Executive Summary page 1
2. Background page 2
3. Methodology page 3
4. Findings page 4
4.1 Purpose of the HT Service page 4
4.2 Recruitment and Retention page 6
4.3 Training and Accreditation page 9
4.4 Support for HTs page 13
4.5 Partnership Working page 15
4.6 Community page 17
4.7 HT Activities: Impact of the HT Service page 19
5. Main Recommendations page 24
6. Conclusions page 25

Appendices
Appendix A Interim Report Summary
Appendix B Evidence from Data
B.1 Purpose
B.2 Recruitment and Selection
B.3 Training and Accreditation
B.4 Support
B.5 Partnership Working
B.6 Community
B.7 HT Activities: Impact of the HT Service

Report by
Sue Crane MA Ed
Tricia Harper MSc

Commissioned by South Central Health Trainer Hub Lead
Dr. P. Edmondson-Jones, Director of Public Health, Portsmouth City PCT and
Joanna.chapman-andrews@nesc.nhs.uk

Acknowledgements
The members of Health Trainer Services that were able to take part in this evaluation
have generously shared their time and experience to benefit the wider HT service.
The evaluation team are grateful to all who have contributed to this report.

September 2008
1. **Executive Summary**

- **Health Trainers** (HTs) A total of 68 Health Trainers were identified. Very few are full-time, most are part-time employees, and some are volunteers. 30 HTs returned questionnaires.

- **Evidence:** The questionnaire stage has a response rate of 45% overall, with the highest return rates from Line Managers, Project Managers and HTs. Most of the data was provided by four HT services.

- **Purpose:** responding HT Services demonstrate understanding of and commitment to the purpose of the HT role in relation to reducing health inequalities

- **Recruitment:** Most HTs are recruited through community networks; none had been previously employed as a HT. NHS recruitment procedures can present difficulties for potentially suitable HTs. Pre-recruitment workshops are advised. The NHS is a good employer.

- **Training:** Core content is consistent, but delivered over wide-ranging timescales. Portfolios are used to demonstrate achievement of national competencies; they can be time consuming and there are different assessment processes. City and Guilds accreditation training has identified skills gaps and anxiety. 97% of HTs identified positive benefits of training; 90% are working towards accreditation; 87% are using City & Guilds Certificate for Health Trainers

- **Support:** There is evidence of a wide range of support for most HTs. A few are isolated.

- **Partnership Working:** there are formal partnerships related to workplace locations of HTs. There are informal partnerships being developed that link HTs to other healthcare providers.

- **Community:** HTs are recruited from local communities to work within those communities. This is viewed as a key attribute of the HT programme. HTs can be vulnerable; HT training needs to address relevant issues.

- **Health Trainer Activities: Impact of the HT Service:** there is rich data from the case study interviews which demonstrates the impact of the HT Service. The community based HT works with clients with complex needs, and liaises with welfare and other organisations to help clients. The HTs also have contact with people who need support in relation to housing, or drug abuse, and who are not ready for healthy living initiatives.

- **Recommendations:** each section has its own recommendations; section five has main recommendations.

- **Conclusion:** HT Services contribute to the reduction of health inequalities by signposting and by supporting direct access to services. They also improve the quality of care received by clients. There is less evidence in relation to individual behaviour change; however, the Dept of Health (DH) national Data Collection and Recording System (DCRS) will provide this in time.
Note:

A Health Trainer Evaluation Interim Report (5th August) has been submitted. Key findings from this are given in Appendix A of this report. A full Interim Report is also available. This Final Report takes up key themes from the Interim Report.

2. Background

The concept of the national health trainer programme was proposed in ‘Choosing Health: Making healthy choices easier’¹, and was launched in 2005 by the Department of Health (DH). Its purpose was to address health inequalities, and to ensure fair access to health services, given the restricted choice and opportunities available for the socially disadvantaged:

First, anyone who wants help to make healthier choices and stick to them will have the opportunity to be supported by a new kind of personal health resource, NHS health trainers. Choosing Health (p.103)

A recent publication, Health Inequalities: Progress and Next Steps² confirms a commitment to the role and remit of the Health Trainer:

Roll out Health Trainers to every community, and extend their reach with an additional network of health champions who will operate as an outreach team, facilitating uptake of Health Trainer services Health Inequalities (p. 68)

Health Trainers are often employed through the National Health Service (NHS) or with a partner organisation, or by involvement with a voluntary organisation. Nationally, some private sector companies such as Boots and the Royal Mail have developed a parallel Health Trainer Service (non NHS affiliated).³

Often they have dual roles where the health trainer role complements another role. Through the settings they work in, they should be proactively engaging their clients being both visible and accessible to local people.⁴

Health Trainers have to undertake a great deal of training to enable them to execute the role and demonstrate capability by producing a portfolio of evidence of competences which were developed by Skills for Health⁵.

The health trainer should be recruited from the local community and work alongside other health promotion services to tackle health inequalities through supporting individuals to make lifestyle/behaviour changes and improve health. Health trainers are not specialists; they are individuals who reflect the local communities and have knowledge of the local context, environment and resources. They would be known and trusted by those in the local community and have experience and understanding of what it means to live in, or be part of, that community. Health Trainers ideally would offer support to the most disadvantaged and to those who had difficulty accessing services. They are also located in specific communities such as probation and prison settings, where HTs are recruited from the ‘local’ population of ex-offenders and prisoners.

¹ Choosing Health: Making Healthy Choices Easier  DH 2004
² Health Inequalities: Progress and Next Steps  DH 2008
³ National Health Trainer Activity Report November 2007
⁴ Evaluation of the Early Adopter Phase of the Health Trainers Project in the North East 2006
⁵ Competences for Health Trainers Version 1.7 Skills for Health April 2006
A HT programme also provides a platform to encourage personal development of the Health Trainers whilst providing employment and economic growth in their local communities. The initiative offered opportunities for individuals to gain skills in public health work which could lead them into further careers. Related accreditation awards provide recognition of achievements and skills, and might be especially important to volunteers and those seeking to return to work.

**South Central Health Trainer Hub (SC HT Hub)**

There are nine PCTs in the South Central Hub, all of whom have been encouraged to participate in the delivery of the Health Trainer programme. In one PCT the Health Trainer (HT) Service is provided by a national voluntary organisation; in another PCT the HT Service is at planning stage and supported by a committed Steering Group. Two other PCTs are engaged in other Choosing Health activities and do not submit End of Year Report data to the SC HT Hub.

Currently there are six active HT Services in the SC Hub; four of these have related Probation HTs, and one also has a Prison HT Service. One of the services has recently re-organised three services into one, in line with a major PCT re-organisation, and this service has not submitted data to the evaluation.

One service was selected for an in-depth case study, and several services were contacted for a telephone interview. Other data has been collated from questionnaires sent to all active HT Services.

A total of 68 Health Trainers were identified in total. Very few work full-time, most are part-time employees and some are volunteers.

**3. Methodology**

This evaluation has taken the form of an extended case study, which offers a contemporary, real-life approach, uses several sources of evidence, and is particularly useful for evaluation purposes⁶. An illuminative approach⁷, described by Partlett and Hamilton, has been taken to identify factors important to the participants and their operational context within the HT Service.

This has been analysed using grounded theory methods, as this provides a simple, systematic method of analysis⁸⁹. A case study is not required to be a population sample, and is not therefore generalisable, however it can provide evidence from which learning which can be transferred to other similar situations.¹⁰.

**Data Collection** (details in Interim Report)

**Questionnaires**

127 questionnaires were sent out and 57 returned (45% response rate). The highest return rates were from Line Managers, Project Managers and HTs.

---

⁸ Glaser and Strauss (1967) The Discovery of Grounded Theory
⁹ Glaser and Corbin (1990) Basics of Qualitative Research
¹⁰ Yin, R.K. (2003) Case Study: research and design methods; Sage
68 questionnaires were sent out to HTs, and 30 (44%) were returned. 4 HT services have provided most of the data. Some of this data has been themed for analysis and included in this report.

Case Study Visit
One HT site was visited on 30th July, where a line manager and a HT were interviewed. Some topics had been identified as relevant and a semi-structured interview technique was used. This data has been themed and analysed for this report. Key issues were followed up in telephone interviews.

Telephone Interviews
Not all project managers contacted were available for telephone interviews; 4 respondents provided data. A structured interview technique was used, with optional supplementary questions for use when needed. This data has been themed and analysed for this report.

4. Findings

This section is structured around key themes that were identified using grounded theory approaches. Each theme has an appendix which includes data gathered from across a range of evidence bases including specific questionnaire responses; case study interviews and telephone interviews.

4.1 Purpose of the HT Service

The funding for the Health Trainer Service is provided to reduce health inequalities. All respondents indicated that this was the focus of their local HT service.

Several respondents also indicated that it was difficult to assess how well this purpose had been achieved. The DCRS, which will be in use by all respondents by September 2008, will give some standardised evidence.

Evidence from respondents also indicated awareness of the complexity of the task of reducing health inequalities, and also identified key features of the HT programme (see Background above).

Health Inequalities
- The service spec included recruiting HTs from the hard to reach groups that we are trying to target
- Addressing Health Inequalities, clients certainly come from TARGET groups and are helped.
- Hard to ascertain on broader scale, impact goes beyond clients to other community members and group.
- Based in community neighbourhoods and use post code data. They use data collection systems and monitoring

Community
- empowering local people to support others in the community to improve their health
- The service spec included developing a community service that is delivered in the community.

Partnerships
- delivered in the community through partnership working with other organisations
- Have a core team of employed, qualified HTs and develop partnership working
opportunities

Behaviour Change

- To recruit those individuals that need 1 to 1 encouragement in changing behaviour
- To support people in setting personal health goals and making healthier lifestyle choices
- To provide support for people on probation orders and help them adapt healthy lifestyles – change behaviour and take control of lives, reduce re-offending

Health Targets

- To provide Health Trainer Service to specific target wards and populations
- Early data - increased uptake of services particularly substance misuse, smoking cessation and dentist services in the probation setting; increase gym use / health club / step club / smoking cessation in the prison setting. This indicates that the model that we are developing is likely to be successful.
- Linked to inequalities work, preventing cardio vascular disease (CVD), meeting LAA targets

Development

- To maintain current level of service and look to gain investment to expand; Target other areas within locality
- To promote through County and Nationally

Concerns

Respondents were aware that it will be challenging to provide evidence of reducing health inequalities, and behaviour change:

- Richness of data is not fully known yet; data collation and reporting not as robust as it needs to be to reflect this, there have been lots of issues to sort out. Now looking at this aspect, DCRS will be in place very soon.
- To reduce inequalities in health probably too early to know!

Good Practice identified by Respondents (Questionnaire data)

- The service specification was specifically developed to deliver this overarching objective
- To improve health locally and reduce health inequalities. This is early days for the service (started client work April 2008) but I believe we are starting to achieve this
- Addressing Health Inequalities, clients certainly come from TARGET groups and are helped. Hard to ascertain on broader scale, impact goes beyond clients to other community members and group.
- Keeping quality assurance in mind at each stage of development

Good Practice Evidence

- Service Specification is shaped to reflect complexity of reducing health inequalities
- Quality assurance approach throughout process
- Improved data collection to provide standardised evidence
- Behaviour change in context of clients’ life and circumstances.

Recommendations: 4.1 Purpose of the HT Service

- Ensure Service Specification identifies complexity of context of HT Service
- Work in partnership to achieve targets
- Capture additional data via case studies; evaluation; newsletters to highlight complexity of HT activities and context.
4.2 Recruitment and Retention

Recruitment is a key process for the Health Trainer Service. It is acknowledged as one of the ways in which the purpose of reducing health inequalities can be achieved:

- Recruiting and training members of the (named) community to become Health Trainers, making it easier to reach and liaising with clients.

Recruitment from within local communities and specific communities of probation and prison has been effective. The Probation Service recruits HTs in conjunction with the NHS, and the Prison based HT service liaised with the PCT in relation to what was needed, and selected appropriate people to become HTs.

HTs working in community locations are either employed by their PCT, or are linked to a voluntary organisation. In both instances the recruitment of HTs has presented a challenge to existing recruitment procedures.

HTs have a variety of backgrounds (Interim Report). Some evidence reflects recruitment from within local disadvantaged communities:
- We have appointed more people without formal qualifications than with.

Advertising the Posts

NHS Jobs is not accessed by community groups. Information about posts has been sent out by email to community contacts, by poster and leaflet to community centres and by word of mouth through community networks.

Recruitment Process

NHS recruitment procedures have presented challenges:
- people applied who did a really bad job of filling in the application form
- they would have been ideal but they didn’t put their experience and things that I knew that they had on the form

The way in which the NHS recruitment procedure manages equality of opportunity can itself be a disincentive for some applicants.
- They put things in like “I hope you will invite me to interview because I have wanted to do something like this for so long and I think I am the perfect person for the job” and there is no evidence and they don’t get an interview.
- It’s just based on a personal statement and some people don’t know that they have to look at the person specification and address each point.
- It’s meant to be a fair process and everyone is judged on the same thing but people don’t know how to play that game and it’s not that fair.

Skilled applicants are also attracted to the posts:
- Applications from all levels, from no qualification or employment to degrees in nutrition and sport exercise

As are volunteers:
- Recruiting volunteer Health Trainers (Health Champions) for sign-posting clients to services

And the role itself presents challenges:
- Recruited new volunteers as our traditional volunteers don’t undertake any outreach work, so it is a very different approach.

Recruitment from Client Group

There are several benefits from achieving successful recruitment from local communities:
Applicants tick lots of boxes so are shortlisted, and when face-to-face at the interview it is very clear who knows the community and the community profile. I think that has been an achievement of the HT service in itself that local people are getting jobs and have a place in the health service so I think that is a strength. They will start to influence how services are developed. Hopefully this will bring expertise of the areas in to the NHS.

Retention
HTs have left for a range of reasons. Some have not taken up the post after interview and appointment because it conflicts with benefits or they have not fully disclosed information in relation to criminal offences.

Others leave for personal or family reasons. Some have left because the job is not meeting their expectations:
- Just graduated in nutrition but she said that it wasn’t for her and only stayed two or three months
- They resigned…..someone who had a degree and had a much more responsible job previously
- She had just finished a nutrition degree …she just found that there wasn’t enough for her to do and she was based in (name) as well which is quite a difficult area to crack.

Pilot sites did encounter attrition and met challenges recruiting to new roles in new locations:
- Interesting to know if that was the same elsewhere, and what attrition rates are like in other places
- It has been piecemeal development, from the initial pilot, some HTs have stayed and some have gone, and we have learnt about recruiting as we have rolled out the service.

NHS as an Employer
There are recognised benefits in having the NHS as an employer:
- Although we have had people who have left we have also had people who have stayed who might have not have been able to stay under a different employer
- They could very easily have ended up leaving the job but they didn’t because they had really good support from occupational health
- People have been able to keep their jobs and so all their investment of putting the training in hasn’t been lost
- Flexible employment options like terms time only working, flexible hours

And some difficulties:
- I think its difficult within the process of the PCT things seem to be on the verge of happening and then there is something that stops it happening, a recruitment freeze or a vacancy panel disbanded
- Then they had to re-write my job description because it was out of date and then it came out wrong, so it’s been a bit of a process.

Interim Report Data shows that most HTs are recruited through community networks; none had been previously employed as a HT. HTs have a range of previous employment experience including fitness/dance; health and teaching; community work and childcare. 77% of HTs have job satisfaction; 83% have identified career plans.

Concerns
The HT services are small and focused for their purpose, therefore long-term sickness can have a considerable impact:
A small team and you have got a number of people off then you can’t have such effective meetings supporting each other. In theory (they) are covering it but they are not doing any aggressive outreach or anything because they have their own clients and workloads to handle so there is a bit of a gap there.

The recruitment good practice gap, which has been addressed by a workshop in one area, raises wider issues for the HT Service:
- If we could write our own application form we could make the questions really explicit

**Good Practice identified by Respondents**
Respondents have developed ways to support the NHS recruitment process, and there are also examples of outreach into communities for step up opportunities:
- Recruitment day held which was advertised across the city in local press and community venues
- Recruitment workshop to tell people more about the role and adult learning to teach a session on how to fill in the application form
- Start getting people to work in health on a voluntary level and then they might be good candidates if jobs at the next level come up
- Recruiting and training members of the (named) community to become Health Trainers, making it easier to reach and liaising with clients

Respondents also value the commitment of the PCT to working within areas of deprivation:
- I think there is a commitment from the PCT they are giving people permanent posts as HT’s so I think that is promising
- I think that has been an achievement of the HT service in itself that local people are getting jobs and have a place in the health service so I think that is a strength

**Good Practice Evidence**
- Recruitment from within the relevant communities, with relevant advertising
- Support for the recruitment process with workshops
- Benefits of NHS as employer: flexible working; support to keep trained staff in post
- Development of volunteers in a potential step-up role and/or signposting role.

---

**Recommendations – 4.2 Recruitment and Retention**

- Ensure recruitment processes enable appropriate candidates to be appointed
- HT Services to develop their own application forms in conjunction with NHS or other employer
- Provide step-up processes i.e. recruitment workshops; volunteer working; open days.

---

**4.3 Training and Accreditation**

Each HT Service is founded on a training programme, approved by the DH, and designed to skill the HT workforce to provide this new service. However, each training programme is unique, as its detailed content has depended on the needs of the local community, client group and available NHS services.

Each local training programme also has to provide the HT workforce with specific skills, to meet the national competencies for health trainers. Some areas are also
providing training geared to meeting the requirements of the City and Guilds Health Trainer Level 3 qualification.

The former Health Trainer Hub for the South East region developed a HT Training Pack entitled: “A toolkit for developing core competencies” in 2006. The current SC HT Hub acts as a support and co-ordinator, and has provided guidance and materials for HT courses. A collaborative decision was taken not to develop a standard training course as so many elements of the training involved already existed in other forms of training provision (e.g. behaviour change, health promotion foundation certificate).

Data in the Interim Report indicates that there is no standard training period, and that initial training varies. This reflects that HT Services have evolved their own programme, using local, and sometimes regional or national experts to provide relevant training as and when they are available. Some HT project and line managers also provide some of the training.

Additional training, in relation to specific areas of need is arranged for on-going training sessions. These sessions are also a source of support for HTs (4.4 Support).

Some HT Services use a portfolio to demonstrate evidence of learning and achievement of competence, which is linked to the national competencies (Background above). Others are developing portfolios to help with City and Guilds accreditation.

As a new service, the HTs are discovering that they need training in additional areas to meet the needs of clients.

**Quality and Content of Training**

The quality of training is good; there are no criticisms of the training received by HTs. Expert resources are used to ensure relevant information is provided, and this also helps to develop local networks for the HTs. This includes health services and community services and links.

- A dietician did some of the healthy eating training then if they come across a client, maybe a pregnant woman with an iron deficiency, they could phone her up and get some support from the expert in that field
- Lots of people from the PCT have done training free for us
- Another independent trainer came in to do something on outreach work.

Key content includes:

- Behaviour Change; role of Health Trainer; improving skills; confidentiality; community profile; competencies; communication; developing relationships with clients; paperwork, health and wellbeing topics.

Key factors include:

- Understanding of theoretical base to interventions; developing and demonstrating competence; portfolio and workplace feedback; links between training and role.

One HT felt that they needed longer on the initial training period:

- Training period to short to learn skills required

Another found it

- Very comprehensive- behaviour change management; lifestyle issues; inequalities etc.

This could reflect individual learning needs, or a different approach taken by the local training programme.

---

[11] West Sussex PCT on behalf of the SE Health Trainer Hub
On-Going Training
There are areas of need that are identified by HTs once the initial training period is completed, and they are working with clients.

- We have been asked what training we think we need more of
- I would like training in domestic violence, suicide prevention and those sort of areas, self harm, all those sort of stuff which has not been covered yet which I have come across
- I know they want more training on mental health.

City and Guilds (see below) has also generated additional learning needs.

Portfolios
Not all responding HT Services use a portfolio to record progress and achievement of national competencies. Those who have not used one previously are working on bringing one in to support City and Guilds:

- Our health training doesn’t have a detailed portfolio like in other areas. We moved straight to the C&G award and their evidence collecting has been based on this.

Portfolios can be challenging, and need support:

- I feel a lot of time is spent on the portfolio and with more guidance we could be a little more efficient in collecting our evidence
- Evidence portfolios took a long time to sort out.

This has been recognised by those now preparing to bring in portfolios:

- I will be supporting HTs and motivating them to complete set tasks
- Specific support for HT’s might be needed to put together a portfolio.

HTs gather evidence to demonstrate achievement of national competencies, with the support of, usually, line managers and health trainer tutors who internally assess the evidence.

- A detailed portfolio is constructed and addresses all key national competencies.
- I assess their local accreditation portfolios (line manager)
- After complete portfolios then assessed by (Named HTT).

This needs to be a robust process, and sometimes involves an external validator

- Support tutor/assessor reviews evidence against competency (1-3 items expected for each criterion).
- Evidence of achievement for each competence must be produced
- Second review sample undertaken for internal consistency.
- First assessed by HT then by usual HTT followed by another HTT who doesn’t usually see these HT’s.

There are also concerns

- Still need to develop a system to sign off competence.
- Still waiting for results of portfolios. This has taken some time now.

Others are relying on the City and Guilds to provide assessment of competence:

- Competence assessed – through C&G accreditation.
Types of Evidence used to determine competence
There is some consistency in how HTs demonstrate they have achieved competence, as well as a wide range of additional processes.

<table>
<thead>
<tr>
<th>Evidence</th>
<th>Project Manager</th>
<th>Line Manager</th>
<th>HT Tutor</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Case Study</td>
<td>2</td>
<td>6</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Witness Statement</td>
<td>2</td>
<td>6</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Client Feedback</td>
<td>1</td>
<td>6</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>8</td>
</tr>
</tbody>
</table>

Other includes:
- Will also expect wider forms of evidence of activity.
- Surveys, acknowledgement and monthly reports
- All and photos, minutes of meetings, evaluations, presentations, diaries and record keeping
- Reflection/self assessment peer review
- Written tests/exercises
- Based on informal judgement of line manager.

The quality of the evidence will depend on how it is presented, and mapped to competencies. The number of competencies in the national competency framework determines that this will be a significant task in all circumstances.

Accreditation
The Interim Report shows that 27 HTs are working towards accreditation (90%) one HT is not working towards accreditation, and one doesn’t know. 26 HTs are using City & Guilds; two are using OCN; two HTs did not respond, and one HT who is using C&G is also doing a local accreditation (unspecified).

City and Guilds
There are concerns related to various aspects of the current City and Guilds award, and strategies to help HTs:
- It is a long leap from no qualifications to written C&G assignments.
- Assess literacy levels and run into the C&G with shorter assignments
- City and Guilds assignment require practice experience to complete appropriately, so this two stage approach seems to work best for local need
- From learning from pilot site, other HTs will commence approx 4 months after having client contact. This will give them some operational experience before studying for C&G.

There is evidence that HTs have needed additional support, which is now being built into the training for City and Guilds:
- In practise it went very well on the first unit and then people started to have difficulties and also we had quite a lot of absence with the HT’s
- In the end it turned out to be much more one to one, chasing people up and meeting them and seeing what’s happening
- There was one person in my group who was having serious difficulty and it was to do with existing skill levels.
- one of the things we didn’t do which but I think they are doing now, which is a good idea, is to assess peoples existing levels of skills, literacy, numeracy and so on.
South Central Health Trainer Hub

Other HT Services have had fewer problems:
- We got through it quite quickly because they had already done a lot of the learning so it was quite a lot of revision really and then focused on the assessment questions and what they would have to do to complete them.
- Our volunteers are self-selecting, and so far we have not had anyone not keeping up with the training.

And there are suggestions for improvement:
- I think the C&G award should be reviewed to include individual case studies and reports by other agencies on our performance.

The nature of the HT role, the national competencies and the need for evidence of ‘show how’ as well as ‘know how’ would suggest that a national vocational qualification would be an alternative approach for City and Guilds accreditation.

**Royal Institute of Public Health (RIPH)**
There are plans in some HT Services for HTs to do the RIPH certificate. Two HT Service reported that this has been a successful experience for them:
- We have also done RIPH; all of them did that quite easily.
- They all passed with credit.

**Concerns**
There are concerns in relation to portfolios and the additional support necessary for some HTs to prepare for the City and Guilds award.

**Good Practice identified by Respondents**
- Having assessor experienced in portfolio work
- Good guidelines for portfolio compilation
- Learning from other PCT areas through the S/C Hub Group

**Good Practice Evidence**
- Initial training content broadly consistent in content
- Additional training sessions developed according to needs
- Flexible and supportive response for HT learning needs
- Use of portfolios to demonstrate progress and achievement of competence

**Recommendations – 4.3 Training and Accreditation**
- Consider a SC Hub workshop to share best practice in relation to initial training and support for HTs and use of portfolios
- Develop good practice guidelines for portfolios that clarify, and simplify, the collation of evidence and local assessment processes
- Consider a designing a revised, simple to use, portfolio, mapped to National Competencies and City and Guilds award
- Provide basic skills training as necessary to support City & Guilds award
- Discuss potential for NVQ type award with City and Guilds
- Encourage uptake of RIPH as a first step award for HTs.
- SC HT Hub to ensure HT managers are aware of HT competencies linked to Skills for Life

---

12 RIPH recently merged with the Royal Society for the Promotion of Health to become the Royal Society of Public Health. The RIPH award a Level 2 Understanding Health Improvement qualification
4.4 Support for HTs

The evidence indicates that, for most HTs, there is a wide range of support available, and that this is accessed as needed.

40% of HTs see their line manager at least weekly, and almost all HTs have regular team meetings, network meetings and many have 1:1 support or supervision sessions. Other support processes include mentoring, and support from Health Trainer Tutors (HTTs), and course tutors.

59% HTs indicated that HTTs were a source of support, and 45% also stated that course tutors were a support (N=29). This could reflect that some of the HTs (7) were in the early stages of a training programme, and six others were still having some ongoing training. However, seven HTs from one of the well-established services also indicated that the HTT (4) and course tutor (2) were sources of support.

HTs, line managers and project managers also identified skilled support that was useful including:
- Wider Public Health team
- Health Promotion team
- City & Guilds Tutors
- Probation Officers
- NHS staff eg Smoking Cessation/Quitters; Nutritionist
- Workplace supervisor.

There is also support for HTs in their workplaces, whether based in the community or in the Probation or Prison services:
- Venues – children’s centres; libraries etc for meetings/clients
- Desk space and facilities
- Introductions to community groups/clients/colleagues
- Team meetings.

Support from the NHS includes
- Conditions of service eg flexible working; occupational health; payroll; HR.
- Training and management posts
- Funding for HT posts and other resources

13 Project and Line Managers identified the types and frequency of contact available for HTs. 12 respondents indicated that they see HTs frequently, varying between ‘daily’ to ‘monthly’ and one respondent indicated ‘occasionally’.

HT data mirrors this closely, with most HTs indicating that they have frequent and open access to project/line managers.

HT responses (27) reflects this overall positive situation, with most respondents indicating that the see a project or line manager ‘weekly, or more frequently as needed’. Two respondents indicated that they see their line manager six-weekly.

30 HTs also identified ways in which they provide peer support to each other:
- Informal contact for advice, sharing, helping as necessary (10)
- Regular / team meetings (9)
- Network meetings (8)
- Email / phone (5)
- Peer support group (3)
- Training (2)
Concerns: there are four responses that identify issues of concern:
- Isolation (2)
- Only support is from line manager
- Cancelled network meetings.

In addition, in Recommendations and Comments, HTs indicated other needs:
- Advice for dyslexia
- Continue to meet with other HTs
- Need more support.

**Good Practice identified by Respondents**

**Open door policy:**
- *Friendly atmosphere throughout*
- *When we want any help and advice we can call anytime*

**Safety**
- *Health Trainers can phone when they are working alone in an isolated area*

**Visibility of HT Service**
- *Our health lead has done a lot of ground work to raise the profile of health trainers*

**Mentorship**
- *A mentor scheme has been set up*

**Dedicated Line Management**
- *Line managed on a day to day basis by a probation service manager*
- *Manager with a main HT service role (not dividing time with other projects).*

**Training & Development**
- *I feel well supported and have had a good amount of training and clear pathway*
- *Ongoing support, supervision and workshops and network meetings provide continuous development and training*
- *Do more training within the community and to try and give people pathways into doing HT or similar roles as they come up.*

**Good Practice Evidence**
- Wide range of support available: team and network meetings; 1:1 supervision and support; mentoring.
- Peer support processes available eg network meetings; peer support groups
- Informal support networks developed
- Access to line manager and dedicated line management for HTs.

---

**Recommendations – 4.4 Support for HTs**

- Ensure adequate line management support for HTs
- Ensure that HTs who are the sole HT in their locality have additional support and contact to reduce isolation
- Prioritise Network Meetings for HTs
4.5 Partnership Working

There are two major partnership aspects to the Health Trainer Service:
- Formal partnership with community, voluntary and/or local authority organisations
- Informal partnership working with community and voluntary organisations and the NHS.

Formal Partnership
There are a range of different partnership arrangements for Health Trainer Services. These include:
- Membership of Steering or Stakeholder Group for HT Service
- Provision of facilities for HTs’ workbase
- Provision of line management support in the workplace
- Provision of facilities for HTs to meet clients.

Recruitment and Employment
For most services, the NHS pays the HT and they work under NHS conditions of service. One partnership included 28 organisations and, at one time, the HTs were managed by the partnership organisation.

One service has been commissioned out to an external provider, who now pays and line manages the HT Service, and works in partnership with local community organisations, and the local prison-based HT service.

The Probation Service HT Service has expanded and now has a dedicated Line Manager for four sites, where they work in partnership with the PCT and the external provider.

Working Relationships
Most services reported that they work well with their partner organisations, seeing them as an essential link between the NHS and the community:
- Excellent partnerships have been developed with the voluntary sector and community groups
- Look for opportunities to work with organisations that can help target specific groups eg probation / football club.

Informal Partnership
The HT Services have developed local networks which include community and voluntary organisations, and local NHS services.

Evidence indicates that HTs are able to improve access to services through developing informal partnership working with the NHS (see 4.7). As these networks have developed over time, the profile of the HT service has increased, and more referrals are made using these links.

Examples of Partnership Working:
National Voluntary Organisations:
- Age Concern; Mind; CAB
- British Heart Foundation.

Local Authority Services
- Sports / Fitness teams
- Social Services; Housing

Welfare Services
- Homeless Service; Benefits;
- Advice centres; Debt Advice; Legal Support; Job centre; Home Safety;
- Disability services; Libraries
Community Services

Community centres; Community Projects; Ethnic Minority Support Group; Children’s Centres; Befriending; Sure Start; Senior Citizens; Community Café

Health

Health Promotion teams; Oral Health Nurse; Community Nursing; Midwives & Health Visitors; Children’s Services Substance Misuse; Mental health Services; Specialist Services eg Cancer Support Groups; Lip-Reading Courses; GP Practices; pharmacies.

Education

Adult Learning Services; Colleges; Schools and pre-schools.

Police

Churches

Developments

As the HT programme develops, there will be new partnership arrangements

- NHS PCT is very committed to this service and will be the support in training and embedding HTS into the community through the LAA and LSP
- There has just been recruitment for a part-time post in a recovery based mental health organisation.
- Working with Community Pharmacy (CP) Lead re: Partnering with C.P to train HT’s with their units
- There are also going to be some more posts in the estates, possibly some of them based in doctors’ surgeries.

Concerns

Some potential partnership working will not materialise, which can lead to disappointment:

- representatives from the different community venues where the HT’s were hoping to be hosted; some of them came off and some of them didn’t.
- (name) who have just ducked out.

Sometimes it is the PCT who cannot maintain the partnership:

- We have had NHS links with our PCT PH team, but there has been a difficult patch for them, and we are hoping to start up regular meetings again soon.

Good Practice identified by Respondents

- Look for opportunities to work with organisations that can help target specific groups e.g. probation / football club
- Look for opportunities to get added value e.g. volunteer HTs / workplace HTs that can be supported by employed HTs
- Find individuals within organisations that can champion HTs
- The service has developed in a way that it works across organisations and boundaries.

Good Practice Evidence

- Partnership working helps PCT to link with community in order to reduce health inequalities
- Wide range of partnership working developed to respond to local needs
- Dedicated line management in partnerships eg Probation
- Extensive community and welfare informal partnerships developed to meet needs of clients
Recommendations – 4.5 Partnership Working

- Continue to develop formal and informal partnership working
- Ensure adequate line management support for HTs in partnership settings

4.6 Community

The HT Services are located within communities in order to achieve their purpose of reducing health inequality. These can be locality communities, e.g. on a housing estate, and at community centres. HTs also work in non-locality communities. These can be communities of purpose, for example, probation or prison. They are also based in voluntary organisations working with specific groups of people, such as older people, and parents.

‘Community’ emerged as a key theme in the evaluation findings, and it is worth examining, as this is the bridge over which the HT works, bringing access to health, and sometimes other services, to their clients. HTs are recruited to meet the needs of the community in which they will work, sometimes living and working within a particular locality or belonging/relating to a non-locality community of purpose.

This has raised issues in relation to recruitment and retention, and also impacts on the range of health trainer activities.

Non-Locality Communities

In communities of purpose e.g. Probation, Prison there are clear referral routes for non-health issues such as debt, housing, family welfare etc. The HT will be aware of these, and can signpost clients to these services as required, so that the support provided by the HT in these situations is focused on health and well-being issues. HTs in these settings work with the support of the wider community in which they are based:

- The HTs are integrated within the probation service as members of staff
- At (named) Prison prisoners are trained as HTs as they live within their community 24 hours a day they are always available to other prisoners.

Evidence also suggests that, in voluntary organisations, HT activity will also be focused on health and well-being:

- They can signpost to local services, but mostly do behaviour-change work with clients. They can also refer to their voluntary organisation for other concerns e.g. housing, debt etc.

Locality Communities

In locality communities, evidence suggests that the role of the HT is multi-purpose, and that clients, or potential clients, are not able to address health and well-being because they have other priorities to manage in their lives.

It can also take time to build relationships, and some of the non-health information and support given will be an initial part of the process leading to health-related behaviour change.

- Working with groups and other agencies to promote health within the community
- HTs are very aware of the need to maintain, update and continue to develop their community profiles
- In deprived areas they haven’t got the money to go and shop. They are living on a budget, on their income support and a lot of them are addicted to drugs or drink.
Recruitment
This is discussed in 4.2 above, and all HT services face challenges in this area. For locality communities there are additional issues:
- Recruiting and training members of the (named) community to become Health Trainers, making it easier to reach and liaising with clients
- She is so well networked; she really linked in with existing community development projects so she has quite a lot of good support there in terms of people being around and helping her out.
- He lived not on the estate but basically he was part of the estate community just housed off the estate but really I would say he was from this area because of social networks and growing up.
- Recruitment from local community / target group is very important and has been flagged up by recent recruitment experience. Applicants tick lots of boxes so are shortlisted, and when face-to-face at the interview it is very clear who knows the community and the community profile.

Development
The HT Service is working in a range of ways within communities, and is becoming a community itself.
- I am also trying to find out more about career pathways in the NHS and go to jobs fairs at the local schools and linking in with the learning communities project
- Have started to build a client base in rural villages and feedback indicates that they are achieving the aims and objectives set within the work programme.
- Involving HTs actively in the development of the service

Concerns
The wider agenda encountered by the locality community HTs, especially those living in the area raises issues (see 4.7):
- management of personal / professional boundaries
- training needs & network links
- Management support and supervision.

Good Practice identified by Respondents
- The service to be delivered from a community setting by an organisation that knows and understands the target group and how best to access them.
- The process has allowed health to be moved from the confines of the NHS into the community building Health knowledge and expertise in the community
- Other prisoners feel comfortable about speaking to them as they are not staff
- The HTs are integrated within the probation service as members of staff

Good Practice Evidence
- Recruitment from within the relevant community
- HT Service working with complex needs
- Partnership with community organisations essential and valued

Recommendations – 4.6 Community
- Ensure recruitment processes enable appropriate candidates to be appointed
- Ensure training for HTs addresses issues about working within your community
- Develop wider networks for locality community HTs to enable signposting to welfare support as precursor to health and well-being
4.7 HT Activities: Impact of HT Service

The impact of the Health Trainer Programme, to reduce health inequalities, is being monitored through the DCRS. Not all HT Services are using the DCRS at the present time. Rich case study data complements statistical information and illuminates the roles and responsibilities of the HTs. This identifies impacts for individual clients, HTs and the HT Service.

There are common areas of activity in Health Trainer Services, relating to specific aspects of health improvement and access to services:

- Smoking Cessation
- Fitness and Healthy Walks
- Weight Management
- Sexual Health
- Substance Misuse (alcohol and drug abuse)
- GPs
- NHS Dentists

Some services have developed, or are seeking to develop, links with Mental Health, Pharmacy Checks and CVD risk programmes.

Specific Health and Wellbeing Topics
This data reflects some of the key activities listed above. It also includes work with clients which illustrate the flexibility of the role, and ways in which HTs respond to client needs:

- **Another lady is very disabled but she has actually learnt to swim so I got her to go to a pool where they have a class for disabled people and she is now doing 20 lengths**
- **I'm seeing a lady that's got bi polar and she has been in hospital for 2 years and she wants help with shopping, healthy eating and doing a menu**
- **A guy was being seen at home, which is something we don’t normally do, he couldn't get up because he was fairly overweight he had to be seen at home and it was obviously going to take a long time to make a difference with him.**

And HTs can influence the way HT clients engage with other health professionals:

- **When I go to the doctors it will probably be different because they will know that the person needs help with weight loss or giving up smoking or they might have sexual health problems or drinking and you are there to support them.**

There are implications for the management of HT time:

- **We didn't have a lot of demand on the service at the time so we said that we would work with him and just take a bit longer over it. Eventually we did stop with him. He was making some progress and had ideas on how to progress on his own.**
- **Took a client to a sexual health clinic and that takes as long as it takes.**

Client Contact
The time allocated for client contact varies, as time is given to building the client relationship. The type of contact varies depending on client needs.

- **there is a nominal period of three months when they would see them as required**
- **It varies. It can be an hour to an hour and a half on the first session getting to know the client and then it depends on what they want to do.**
- **If they are doing an activity it might be an hour if they are just catching up it might be half an hour.**
Just one or two have had more complex problems that we have seen for a bit longer
Some you sort them out with a gym and they are just gone

This presents challenges at both ends of the spectrum – those who need longer than three months (or six weeks in some services) and who might have high level contact time putting pressure on a busy service; those who come once or twice and who might not easily be captured in the data.

However, the client’s needs are the focus of the service:
- We keep them on our books for three months and then if at the end of it the doctor thinks or if we think that they still need more help then we can take them on for another three months. We don’t just say well that’s it we can’t help you after the three months.

Where HTs meet with clients also varies according to need:
- It’s good because a lot of client’s don’t want to come into here, for privacy and confidentiality so the good thing about the role is that you can go and meet them for a cup of coffee, tea or whatever in (named area) which is the nearest place, if they don’t feel comfortable.
- I approached the doctors’ surgeries and asked them, is there any space, is there a room, is it possible for me to go along? So I went and did a presentation there the other day and now they’ve agreed for me to have a room one afternoon a week and they can refer lots of patients to me.

The ability to respond is affected by capacity within the service:
- Workloads do vary, some have more clients than others, but our capacity is really unknown, individual capacity is different – FT or 16 hours.

Referrals and Outreach
HTs now refer to a wide range of local health and community services, where they have sometimes had to invest time and effort to build relationships and trust:
- Some clients come through referrals with their GPs or other health professionals (practise nurse, occupational therapy, health visitors and a midwife); we have a referral system for that with forms that they don’t usually use but they just phone up or use some method that they’ve invented
- the HT’s doing their own community outreach, putting out a lot of fliers and posters, going along to groups
- I know one went to a Tai Chi group for older people and got quite a lot of clients from that. She had to go and do quite a lot of Tai Chi before they trusted her
- One went to a parenting course and gradually got to know the other parents on the course and she got quite a few clients from that; it was quite a long process to win their trust.

HTs are also developing new working relationships with health providers:
- Mental health – they didn’t even know we existed. I’m seeing a lady … when I rang to speak to her support worker she said “we didn’t even know you existed – I know two other people on (named area) that I could refer to you”.
- people are actually trying to get to know you, like occupational health

And they are developing a reputation within the community:
- from word of mouth from people that have had a HT themselves
- now when I go out and about I hear “yeah my friend had a health trainer to help to lose weight” and I think well that’s good so people are becoming more familiar and know what it is so that’s good.
They have quite a high profile now – the new team are finding that people know about the service and are asking to see them.

Signposting
Questionnaire data indicated that Signposting has been an important aspect of the HT role, and further evidence supports that:

- Being a health trainer is really good because you can signpost them to the agencies that they need to see and support them – see them weekly and say “how did you get on – how are you feeling this week?”

And the transition to behaviour change can be challenging:
- From the beginning there has been a discussion about this – there is an initial discussion, which will usually lead to some signposting, which itself is important to capture, but it can be a struggle to get clients as on-going.

An example of extended signposting, where support is given to a client to enable her to access relevant services, shows how important the signposting element of the HT role can be:
- It ended up that she had cancer and I went to the hospital with her when they told her and she had no family or friends around here, she was a Chinese lady. I said that I had taken her to the hospital and there’s a centre there that’s for you now that you know and they will help you with everything, with housing etc it took me two weeks to get her to go to the doctors and another two weeks to get her to go to the hospital for a scan. That was difficult – was I going to break through, was I going to get her to go and get her sorted out but in the end I done it and I was really pleased that I did do it and she’s ok now she’s getting treatment

There are also wider benefits to the community that are not captured:
- Many ‘non-clients’ are also sign posted and given information.

Improved Quality of Care
The case study HTs have developed informal partnership working links with health service providers which have directly affected the care received by clients:
- Things like that for elderly people, just to ring up and make an appointment for them where they have been messed around,
- another lady had an appointment not until September and she could hardly walk on her foot so she wanted to rearrange the appointment and have it brought forward but she said she had rang and put on hold. I rang up and she has an appointment next week now and they sent her a letter this morning.

Other Issues
Clients
The needs of the clients in local communities have been beyond those initially addressed by the HT Service:
- what I’m finding over the two estates is that a lot of them can’t even think about those things yet because they have so many other problems such as debt, housing issues, trouble with their children so all those other things
- they know they have got health problems but they can’t address them before they address the other problems.
- that is affecting their health where they can’t get in and out of the bath and I will take them on as a client.
Locality based HTs
HTs working with voluntary organisations, probation and prison services have clearly defined roles and boundaries. The client might have a link to a key worker (e.g. Probation) or can only be referred to health provision (e.g. Prison). The HT Service located in a voluntary organisation has a clear referral pathway to one-to-one work for health improvement issues, with other advice available from the organisation itself (see 4.6 Community).

In a local community the HT, who might live within that geographical area, has to manage a new and challenging situation:
- what’s come out is you just get stopped and asked about everything and anything really; which I think is really good.
- I had a young girl come into me yesterday and I just know her as a neighbour but she knows my job and she was chatting and she had been hit by her boyfriend and she’s seven months pregnant. I said that she can’t let that happen and she said “I just can’t put up with it.” Luckily enough a health visitor was here so I spoke to the health visitor and she spoke to the girl.
- I did have a problem with a lady, letting her know the boundaries. I learnt my lesson there because I live at the top of this road and she was at the bus stop waiting for me to come to work and I was like “let me get to work first.”

This evidence indicates that these issues are being well-managed in this context, where HTs have a background in voluntary community work (Case Study data).

There is a clear demand for this low-level intervention in localities, where the HT is signposting and supporting members of the community (who are not necessarily ‘clients’), and it would be useful to be able to capture this level of informal HT activity.

Impact
The impact of the service for clients within the community setting is clear from case study evidence above:
- It’s really rewarding when you see the difference you have made to their lives and how you’ve helped them to change.

HTs also provide feedback to the service to improve its effectiveness and impact:
- I’ve fed that back at team meetings and the cards as well that we give out – that we didn’t think they were right because you know it just showed an orange and like a maze of smoking, drinking, sexual health – that sort of thing.

HTs have experienced personal growth and development, and increased confidence and self-esteem:
- When I had to go and do that presentation in front of ten doctors the other day I thought “oh my God, how am I going to do this?” I was so nervous and then I thought “no, I know what I’m talking about – I am going to go in there and do it
- it’s really challenging but it’s just really nice to be able to help people.

HTs are aware of areas where they do not directly make an impact:
- I wish as well that we could work with under 18’s because its 18 upwards and then you see kid’s of about 12 upwards whose diet is diabolical and they don’t get any advice at home, or any education, so its just a vicious circle – they are just going to grow up and carry on doing the same thing.
Concerns
The HT Service, in local communities, needs to have strong network links to other benefit and welfare support groups, mental health and substance misuse services to be able to signpost and support a wide range of clients.

HTs also need to have good supervision and support, in order to ensure that they maintain role boundaries and are not overwhelmed by difficult to meet demands.

There needs to be particular awareness of the vulnerability of HTs who live and work in the community, in relation to recruitment and training.

Good Practice identified by Respondents
Managers
- Involving HTs actively in the development of the service
- Many people with mental health issues assessed
- Provide support: finding accommodation for homeless, taking people to Gymnasium and working with them for some weeks, escorting clients to Dentists/Doctors/NHS Sexual Health Clinics
- Very often the health trainer will accompany the client to the service. Rather than just signpost them. Many clients lack confidence and this provides additional support
- HTs can work really closely with PE dept to alter prisoner’s lifestyles and improve fitness. As they live within their community 24 hours a day they are always available to other prisoners. Other prisoners feel comfortable about speaking to them as they are not staff

HTs
- Never giving up on a client
- Being a good listener, being supportive, helping clients achieve their goals.
- Our health lead has done a lot of ground work to raise the profile of health trainers
- One HT gave examples of positive outcomes for clients:
  - Weight loss with some clients,
  - Lifestyle issues resolved with disabled client
  - Elderly lady very underweight helping to improve this, and referring to GP.
  - Improved physical activity with client who has Parkinson’s
  - Made contact with a new client who is suffering after death of husband, starting Pilates and hoping to meet others.

Good Practice Evidence
- The HT Service is meeting its purpose, and has impact on clients and local services
- The HT Service is responsive, and has had the capacity to be flexible to meet client needs
- Clients receive signposting and support to access services that will improve their health
- The HT service receives referrals from other healthcare professionals
- HTs can influence the quality of care provided to clients
- Clients are helped with social and welfare issues where this has an impact on their health and well-being
- Links with GP surgeries; primary health care team; mental health; occupational health services and pharmacies widen access and support for clients
Recommendations – 4.7 Impact of HT Service

- Line managers need to ensure that there is regular support and supervision for HTs working with complex client needs.
- Ensure boundary and role issues are addressed in HT Training programmes.
- Extend working with local GP Practices and Pharmacies to improve links with other health initiatives eg CHD Risk programme.
- Capture low-level interventions by HTs and review take up of other HT services over time.

5. Main Recommendations

Purpose

- Ensure service specification identifies complexity of context of HT Service.
- Quality assurance throughout process.

Recruitment

- Ensure recruitment processes enable appropriate candidates to be appointed.

Training

- Consider designing a revised, simple to use, portfolio, mapped to National Competencies and City and Guild award.
- Encourage uptake of RIPH as a first step award for HTs.

Support

- Ensure that HTs who are the sole HT in their locality have additional support and contact to reduce isolation.

Partnership

- Ensure adequate line management support for HTs in partnership settings.

Community

- Ensure training for HTs addresses issues about working within your community.

HT Activities

- Line managers need to ensure that there is regular support and supervision for HTs working with clients with complex needs.
6. Conclusions

The data indicates that the HT services in the SC Health Trainer Hub area are contributing to the reduction of health inequalities by:

- signposting to other services
- supporting direct access to other services for clients challenged by their life circumstances, and by
- providing opportunities for employment for some HTs.

There is evidence to indicate that they also improve the quality of care received by clients, by supporting them when they are disadvantaged by the health and social care system.

There is also evidence to support the requirement to keep quality assurance in mind at each stage of development (HTS Project Manager), particularly in relation to training and support for the HT workforce.

There is less evidence in relation to individual behaviour change on lifestyle issues. However, the DCRS will monitor this over time, and provide robust data in due course.

There is evidence of HTs supporting behaviour change in relation to factors that directly affect health and well-being, including registering with or accompanying a client to a GP or dentist for treatment.

There is a need to ensure that HTs are supported and trained to deal with complex issues alongside delivering behaviour change and signposting services.

Appendices (separate documents)

Appendix A Interim Report Summary
Appendix B Evidence from Data
  B.1 Purpose
  B.2 Recruitment and Selection
  B.3 Training and Accreditation
  B.4 Support
  B.5 Partnership Working
  B.6 Community
  B.7 HT Activities: Impact of the HT Service

Data Governance
No personal data has been stored on computer. This complies with the Data Protection Act of 1998

Sue Crane
Tricia Harper
Joanna Chapman-Andrews
South Central Health Trainer Hub

September 2008