

# Introduction

This service specification is a NHS Standard Contract for Community Services and has been completed to provide a resource for the commissioning of Health Trainer Services. This document is based on national guidelines and underpinning principles of the service and therefore is a template and not based on an actual commissioning service. It has been further developed to incorporate the East Midlands approach to Health Trainer Services development established via the working and best practice shared across the [Partnership hub](#).

These underpinning principles and guidance should be applied to the commissioning of all Health Trainer Services regardless of the setting. It is the responsibility of the commissioner to include additional information such as aims that specifically relate to the community/ group that is being targeted, or any local information that will be needed to tailor the specification to a particular service and commissioning process. Health Trainer Services may also be developed in a number of settings depending on the nature of the service and the community/groups that are being targeted. Consideration will need to be given to whether a Health Trainer, Health Champion or combination model is being used.

The service specification is split into ten sections:

- Purpose
- Scope
- Service Delivery
- Referral, Access and Acceptance Criteria
- Discharge Criteria and Planning
- Self Care and Patient and Carer Information
- Quality and Performance Standards
- Activity
- Continual Service Improvement Plan
- Prices and costs

**The contract provides an important tool for assuring accountability between providers and commissioners and aids the improvement of performance and quality outcomes as advised by The Department of Health.**

**Please be reminded that this service specification is a template and not based on an actual commissioning service and must be localised to ensure that it relates to the service that is being commissioned.**

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# NHS Standard Contract for Community Services: Schedule 2 Part 1 Gateway Reference 10804

## 1. Purpose

### 1.1 Aims

The aim of the Health Trainer Service is to reduce health inequalities by improving health and wellbeing of targeted groups, communities and individual adults where the greatest health inequalities are experienced.

The Health Trainer Service will:

- Identify and engage with individuals from deprived communities or groups
- Enable individuals to make changes in their behaviour to achieve positive impact on their health and well being
- Support individuals to make more effective and timely use of health and well being services
- Increase capacity and capability, building a workforce from the communities and groups within which they will work with the right skills in place to tackle health inequalities

### 1.2 Evidence Base

Inequalities resulting in poor health incurs costs to the NHS for example in relation to hospital admissions and prescribing costs. People's lifestyles (e.g. smoking, physical activity, diet, alcohol consumption) affect the prevalence of cancer, coronary heart disease, diabetes, and respiratory conditions, and ultimately mortality rates amongst adults. Tackling these lifestyle issues within targeted communities and groups will in the long term save the public sector money and at the same time improve people's wellbeing.

The Health Trainer Handbook has been written for DH by the British Psychological Society. This has 24 referenced peer reviewed papers underpinning the theoretical base for Health Trainer practice. This can also be found on the [DH website](#).

Health Trainer Services are engaging and supporting adults to make health and well being related lifestyle change acknowledged on the [NICE web site](#) under "Behaviour Change" and "Community Engagement".

In addition the Governments document Health Inequalities: Progress and next steps refer to Health Trainers as a way of tackling health inequalities and closing the inequalities gap and identified the development of Health Champions to enable the Health trainer Service extend its reach. This can be found on the [DH website](#). Health Champions are also engaging communities as acknowledge on the NICE website, however their role does not extend to behaviour change.

NHS Health Trainer Programme Building the Evidence Base Draft Briefing Paper July 2008 provides an overview of our current evidence base on Health Trainers, together with ideas and guidance on how this can be developed further to demonstrate the positive outcomes and impact of health trainers on supporting lifestyle behavioural change and addressing health inequalities.

The national Data Collection Recording System (DCRS) facilitates the collection and reporting of the Health Trainer minimum data set (cross referenced with the general national minimum data set) This data is collected from Health Trainer services throughout the country (go to <https://nww.trainersinhealth.nhs.uk> and select 'training org' from the PCT list).

### 1.3 General Overview

Established from the Government's Choosing Health white paper (2004), Health Trainers are recruited from local communities and reach out to people who are in circumstances that put them at a greater risk of poorer health. They work with clients on a one-to-one basis to assess their health and lifestyle risks.

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Health Trainer Services are usually commissioned for a period of 3 – 5 years depending on local decision and work best when developed as a whole system approach.

The aim of the Health Trainer Service is to reduce health inequalities by improving health and wellbeing of targeted groups, communities and individual adults where the greatest health inequalities are experienced. Health Trainer (HT), Trainee Health Trainee (THT) and Health Champions (HC) recruitment and selection criteria should enable the identification and engagement of individuals from deprived groups and communities who work as HTs or HCs.

Health Trainer services support adults who want to make a change towards a healthier lifestyle but are unlikely to make and maintain this without individual support. These people may be found in geographical communities, communities of interest (for example reformed offenders) or groups of people who are at risk of illness, disease, disability and/or discrimination or other environmental factors that impact on their health and well-being.

Health Trainers are not clinically trained although their role and the service works in partnership with other local services clinical and non clinical and not just within the NHS.

Health Trainers have completed nationally accredited training (City and Guilds Health Trainer certificate level 3) and have been assessed as competent to undertake this work. In 2008 Health Inequalities Progress and Next Steps identified Health Champions as a way of extending the reach of Health Trainer Services.

Health Champions may also be part of a local Health Trainer service working to support clients by providing information, signposting and peer support. Health Champions have undertaken a Health Improvement qualification, for example Royal Society for Public Health Understanding Health Improvement Level 2 Award.

HT Services need to have an infrastructure which ensures dedicated supervision and management support for Health Trainers and Health Champions. It is recommended best practice that HTs and HCs are supervised and/or managed by those with an understanding of behaviour change, health related lifestyle issues and experience of managing and prioritising a caseload.

Services contribute to the national Data Collection and Reporting System (DCRS) that enables a broad in depth detail of the service to be captured and reported on at a local, regional and national level to demonstrate the impact and outcome of the service. The national Minimum Data Set is now an integral part of the DCRS.

## 1.4 Objectives

The key objectives of the Health Trainer Service are to:

- Develop and increase skills, knowledge and capacity for the promotion of health & wellbeing within local communities and communities of interest
- Support individuals to make more effective and timely use of health and well being services by signposting effectively, accompanying and supporting clients to access services where barriers may exist.
- Provide a skilled and flexible workforce to offer practical support to individuals wishing to change their lifestyle behaviour that is nationally accredited and part of the Public Health Career Framework
- Offer an accessible service that meets local needs
- Provide clear and up to date information on health and well being for service users
- Collect and maintain accurate records utilising the national DCRS
- Evaluate and monitor the service locally and make changes as identified

## 1.5 Expected Outcomes

The Minimum Data Set (MDS), which all Health Trainer Services should complete, provides a means of capturing a consistent set of data, specifically aligned to the core principles underpinning the Health Trainer concept, as set out in 'Choosing Health'. It has also been cross referenced to the [Department for Communities and Local Government: Single Set of National Indicators](#) (Oct 2007)

The minimum data set is intended to add to the existing body of evidence by focusing attention on those outcomes which represent the benefits this intervention can have for Health Trainers, their clients and local communities.

- Outcome 1 – Building the workforce with the right skills to tackle health inequalities
- Outcome 2 – Reaching the 'hard to reach' or “seldom seen, seldom heard”
- Outcome 3 – Deliver sustained health improvement through behavioural change
- Outcome 4 – Providing access to and encouraging the appropriate use and take up of NHS and other local services.

Health Champions contribution to Outcomes 1,2 and 4 only.

Additional outcomes include:

- increasing community engagement
- access to training and employment
- tackling worklessness
- reducing the number of people on benefits
- increasing community cohesion
- promoting healthier lifestyles
- increasing appropriate and timely use of services
- increasing well being
- increasing social capital
- increasing confidence and self esteem
- volunteering

## 2. Scope

### 2.1 Service Description

Models of provision vary widely according to local need and level of resourcing but should include:

- national qualification to City and Guilds Level 3 Certificate for Health Trainers and RSPH level 2 Understanding Health Improvement (for Health Champions and may also be used as part of induction for THTs) which is fit for purpose
- induction to the Health Trainer and/or Health Trainer Champion roles
- local information on inequalities and deprivation levels
- on-going support, supervision and continuing professional development
- data collection via the National Health Trainer Data Collection and Reporting System (DCRS)
- adding to the evidence base via case stories and local evaluation
- service infrastructure to support, develop and embed the service
- Language Literacy and Numeracy support were required
- whole service approach and partnership working

#### 2.1.1 Roles

##### Health Trainer

Health Trainers (HTs) have completed training and been assessed as competent against the following national competences (national occupational standards).

**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 and wellbeing**

**HT4 Manage and organise your own time and activities**

The nationally recognised training for HTs is the Health Trainer Certificate accredited by City and Guilds. (HTs trained early on in the programme may have undertaken a local programme of preparation but it is recommended that all HTs should attain or be working towards the national certificate).

##### Trainee Health Trainer

Trainee Health Trainers (THTs) are studying for the nationally recognised City and Guilds Certificate. Once they have completed this qualification, they will be able to work as a Health Trainer.

##### Health Champion

Health Champions (HCs) enable the HT service to 'extend its reach' into communities. They facilitate uptake of HT services and other interventions as appropriate this is often referred to as 'signposting and improving access to services', achieved by peer support and information giving.

HCs have undertaken health improvement training at level 2 for example Royal Society for Public Health (RSPH) Understanding Health Improvement award and are part of a HT service for support, access to resources, data collection and governance.

#### 2.1.2 Recruitment

Employment models also vary, from paid staff working exclusively for one organisation as a HT, through to volunteers. Others have aspects of the HT or HC role added to their substantive role to provide enhanced services. Models have also evolved 'in-house' through PCT recruitment and through partners such as local authorities, voluntary agencies and outsourced contractors who are often existing providers extending their reach and capacity.

HT, THT and HC recruitment and selection criteria should enable the identification and engagement of individuals from deprived groups and communities who work as HTs or HCs.

#### 2.1.3 Pay

A wide variety of agencies are currently delivering Health Trainer services. Where these are employed by the NHS, they are graded at Agenda for Change and based on national job

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profiles in which health trainers are specifically mentioned (page 4 as a linked job to Patient Support Officer)

[http://www.nhsemployers.org/PayAndContracts/AgendaForChange/NationalJobProfiles/Documents/Public\\_Relations.pdf](http://www.nhsemployers.org/PayAndContracts/AgendaForChange/NationalJobProfiles/Documents/Public_Relations.pdf).

#### **2.1.4 Training**

Training will need to be in the context of the service the HC, THT or HT is joining. The delivery of training (core and additional) will need to make specific reference to the policies, procedures and standards of that service.

##### **Health Trainers**

There are four National Occupational Standards (NOS) that have been developed for HTs. These NOS coupled with the content of the BPS handbook '*Improving Health, Changing Behaviour: NHS Health Trainer Handbook*' are the source of two national awards.

The national set of competences for HTs do not cover clinical procedures e.g. taking blood samples, blood pressure etc. HTs who are requested to undertake additional roles should be given training and assessed as competent by local processes. Any additions to the nationally agreed set of competences must be agreed locally and be subject to local clinical governance arrangements.

The City & Guilds level 3 Certificate for Health Trainers which is on the Qualifications and Credit Framework (QCF) covers all the NOS and content of the BPS Handbook. It is the nationally recognised training for HTs and assesses that an individual has developed the knowledge and skills necessary to fulfil the HT role.

Trainee health trainers (i.e. those undertaking the level 3 Health Trainer certificate) are assessed to see if they have developed the knowledge and skills necessary for the HT role. Their training which includes the City and Guilds and a variety of additional training uniquely allows them to deliver sustained improvement to the health of their clients through behavioural change.

##### **Health Champions**

The Royal Society for Public Health (RSPH) level 2 award 'Understanding Health Improvement' (UHI) is on the National Qualifications Framework (NQF) and is due to be transferred to the QCF. The award relates to some parts of the HT NOS but is more limited in scope than the HT Certificate. It is useful as part of the training for HTCs.

For both THTs HCs any literacy, language, numeracy or ICT needs should be supported prior to entry on the course along with any learning and study skills support.

##### **Training Programme**

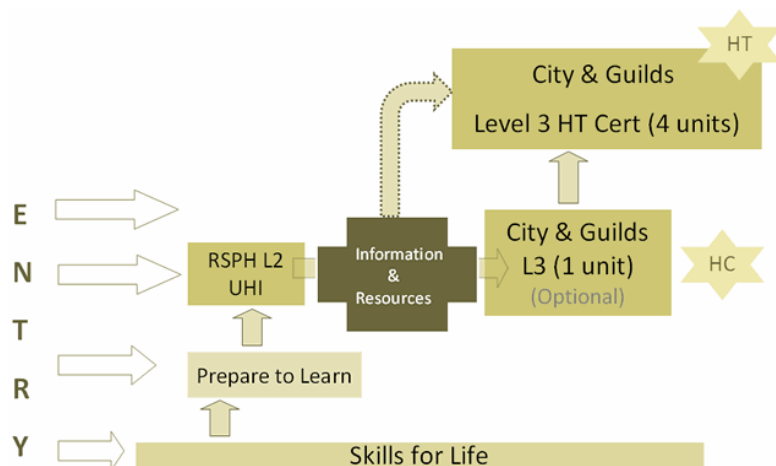
The learning and development menu encompasses the key components of learning, training and qualifications required for Health Trainers and Health Champions across the East Midlands from induction to post qualification. It offers tools and tips for Health Trainer Services on learning opportunities including suggested content, resources and learner flexibility. All education and training delivered and supported should take place within the context of a HT service and relevant resources made available for HTs and HCs.

Education and training provision should be flexible and tailored to the local setting – drawing on the relevant expertise from external or internal providers and the workforce existing skills and roles/responsibilities. Consideration should be given to non NHS settings and NHS mandatory induction and training made available where possible.

This Learning and Development menu which identifies the core and additional aspects of training considerations for Health Trainers, Trainees and Health Champions can be found on the [emphasis website](#).

#### **2.1.5 Career development**

HC and HT roles are often described as entry level opportunities for careers in public health. The HT role is identified at level 3 of the Public Health Skills and Career Framework and their role within this framework as a legitimate route into the public health workforce in various settings e.g. NHS, local government, partner service providers. The following recommended pathway approach for recruitment and selection of the workforce supports them according to their learning needs and career development aspirations.



Commissioners to determine how this pathway is applied i.e. service model commissioned to recruit Health Trainers and Health Champions or a service that starts with Health Champions to support the development of the workforce and pathway into Health Trainer roles

### 2.1.6 Supervision and management

HT Services need to have an infrastructure which ensures dedicated supervision and management support for Health Trainers and Health Champions. It is recommended best practice that HTs and HCs are supervised and/or managed by those with an understanding of behaviour change, health related lifestyle issues and experience of managing and prioritising a caseload. Supervisors / Mentors will need to be able to provide:

- Mentoring to assess progress towards achievement of competencies and assist or support HTs and HCs
  - To apply learning into practice
  - To develop learning relevant to particular areas of expertise
  - To develop skills e.g. communication, negotiating & influencing skills
  - To understand their role within the team
  - With decision making, personal development and self-evaluation of work
  - To develop positive attitudes and feelings of independence as a learner
  - To identify the starting point for a piece of work – an activity or some writing
- Helping HT's and HCs to understand the community in which they will be working i.e.
  - Helping them to network
  - Helping them to develop their knowledge of local services
  - Helping them to access local groups
  - Helping them to learn how to refer to services
- Helping HT's and HCs to gain relevant local knowledge and knowledge of the employing organisation operational management issues
  - Helping them to gain knowledge about annual leave \ sick leave
  - Helping them to gain knowledge of governance e.g. understanding the scope of their role, issues of confidentiality, ethical issues.
  - Give feedback on their performance
  - Helping them to manage their time and plan their work
  - Helping them to set realistic goals \ targets
- Ensure that the wider team in which the Service operate understand the HT and HC role and are supportive

### 2.1.7 Monitoring and Evaluation

To demonstrate and monitor the impact of Health Trainers Services, services should input to the Data Collection and Reporting System (the National Minimum Data Set is an integral part of the DCRS) and contribute to the evidence base more widely through collecting both health trainer and client case stories using the national templates for case stories.

*Service may also include specific details on the type of service they are commissioning and any routes/links with regional hub and any additional monitoring/evaluation required.*

## 2.2 Accessibility/acceptability

The Health Trainer Service is not a universal service. It is an adult service offered to people aged 18 and over that should be accessible and make every effort to accommodate the needs of its clients. The Health Trainer Service is not a universal service. It is an adult service offered to people aged 18 and over from the seldom seen and seldom heard communities, geographical populations and/or individuals. The service is targeted in order to decrease the health inequalities gap and should be accessible to these groups, populations and individuals who suffer the most disadvantages or levels of deprivation. It is a client focused service that makes every effort to accommodate the needs of its clients.

In addition the service seeks client feedback to inform service design and be delivered in accordance with current legislation and local good practice.

All services should be in accordance with current legislation.

## 2.3 Whole System Relationships

Health Trainer Services should ensure robust partnerships with a range of agencies relating to the particular focus of the service in order to increase effectiveness and reach of the service and to establish the position of the Health Trainers within a network of lifestyle and other relevant services across the public, private and community sector.

## 2.4 Interdependencies

Health Trainer Services, in order to deliver a equitable, accessible service to local communities, groups and individuals should consider their relationship to all or a selection of the following according to the service being developed:

- Public Health
- Practice Based Commissioning
- Primary Care
- Local Authority Health and Well Being groups
- Local Strategic Partnerships
- Third Sector
- Target groups or communities
- Community engagement
- Strategic Health Authorities
- Expert Patients

## 2.5 Relevant networks and screening programmes

Health Trainer Services should ensure appropriate networks are established and referral pathways between the Health Trainer Service and other local services are in place to support clients.

In particular to local services available to support smoking cessation, healthy eating and other lifestyle services regardless of who provides them.

## 2.6 Sub-contractors

*Likely to include education providers for delivery of qualifications.*

*Potentially will include the sub contracting of other organisation and settings to delivery HT service depending on the commissioning model.*

### 3. Service Delivery

#### 3.1 Service model

Models of provision vary widely according to local need and level of resourcing but the core service pre-requisites include.

- Based on the BPS Handbook
- Based on the national role definitions
- Management and supervision provision
- Based on the national qualifications
- Targeted service tackling health inequalities

#### 3.2 Care Pathways

To be locally determined, please see the national template for guidance:

##### Health Trainer Client Pathway

###### 1. Referral

Client identified through referral network  
(e.g. General Practice, community settings, voluntary organisations)



Client referred to service

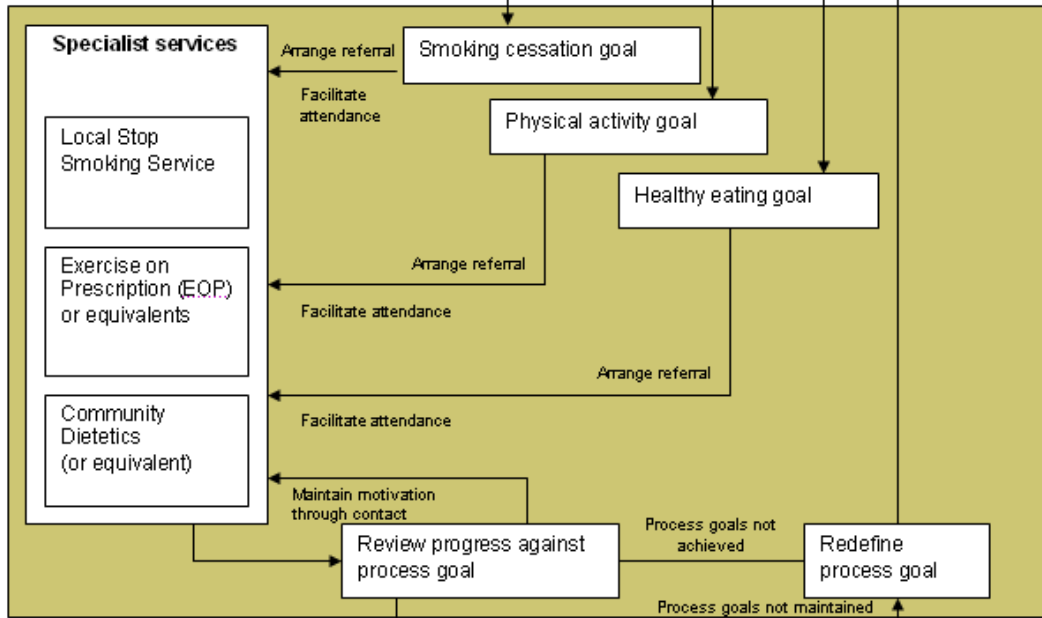


###### 2. Assessment and Goal Setting

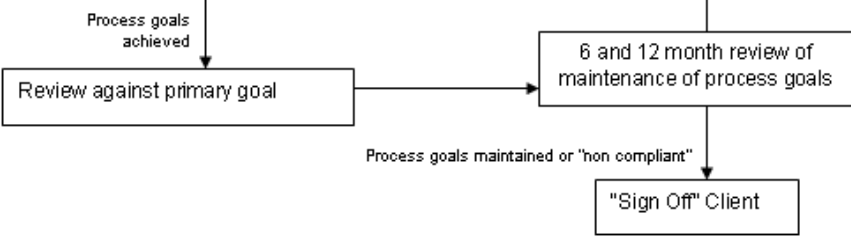
Define individual's primary goal  
(defined through assessment, e.g. feeling better, looking better)



Define process goals  
(what needs to be done to achieve primary goal)



###### 3. Review



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## 4. Referral, Access and Acceptance Criteria

### 4.1 Geographic coverage/boundaries

To be locally determined based on health inequalities data (communities and groups) from both NHS and local authority sources

### 4.2 Location(s) of Service Delivery

To be in accessible local locations at venues to suit the needs of locally determined target communities and groups.

### 4.3 Days/Hours of operation

Flexible provision that meet the needs of target communities and groups – may include out of normal working hours.

### 4.4 Referral criteria & sources

- Adult service (18 yrs and over)
- Services should be actively engaging the community to seek clients
- Self referral should be available and referrals from other agencies as appropriate
- Clients who DNA should not be excluded from the service at a future point in time
- Language, literacy and numeracy skills should be taken into account when determining contact methods
- Services will need to develop specific referral criteria, depending on the focus of the service

### 4.5 Referral route

Referrals will be managed and coordinated by the Health Trainer service. Appropriate referral routes should be in place that enables the client pathway. Clients can self refer to the service – this requires consent and motivation to change which should be assessed by the Health Trainers

### 4.6 Exclusion criteria

- Individuals under the age of 18
- Exclusions in accordance with legislation
- *Further exclusions to be locally determined - to reflect client group the service is targeting and those it is not*

### 4.7 Response time & detail and prioritisation

- To be locally determined
- Local services should be mindful of the barriers clients may have in making self referral. It is recommended services should aim for a response time with 48 hours and consideration also be given to providing appropriate responses to clients whose first language is not English.

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## 5. Discharge Criteria & Planning

Health Trainer services seek to move individuals through a process of change, enabling them to become independent of the support provided by Health Trainers. Health Trainer services contact individuals for a follow-up/maintenance check to ascertain attrition.

Evidence suggests for the 1:1 Personal Health Planning maximum contact 6-8 sessions over 6 months period for each health goal. A case review is undertaken with clients who require additional sessions. To this end, it is suggested that the generic service will offer up to 8 reviews per client personal health plan. Recognition should be given to the needs of the target group which may be complex and isolated clients may have no alternative mechanisms of support.

## 6. Self-Care and Patient and Carer Information

An Equality Impact Assessment will be undertaken and the service adjusted as necessary to meet the needs of all clients.

The service will provide information to all users of the service, in a range of formats depending on need. Methods to implement this to be determined and monitored locally.

DH approved information on lifestyle topics is offered to clients (where local determined issues and offer suitable training). Health Trainers do not provide their own advice or specialist guidance on lifestyle topics.

Self care principles and processes are inherent to the Health Trainer approach – “Becoming your own Health Trainer – BPS Health Trainer handbook”.

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## 7. Quality and performance standards

Quality & Performance Indicators	Quality & Performance Indicators	Method of measurement	Threshold	Report Due
<b>Infection Control</b>	N/A			
<b>Service User Experience</b>	Client feedback on the service	Client satisfaction questionnaire to be completed by clients (with support where needed)  Complaints about the service to be recorded by provider and PCT complaints officers?		
<b>Improving Service Users &amp; Carers Experience</b>	Client feedback on the service	No of clients rating the service as good or very good		
<b>Unplanned admissions</b>	N/A			
<b>Reducing Inequalities</b>	Clients accessing the service who are from the most deprived groups and communities  Health Trainers and Health Champions recruited from the communities in which they work	Analysis of clients by Postcode, community of interest or other descriptor as relevant to the service in DCRS Analysis of HT and HC demographics and recruitment and selection practices		
<b>Reducing Barriers</b>	Service to be delivered in a range of venues across localities and offered at a range of times, including outside normal working hours of 9am-5pm	DCRS to record postcode and minimum data set which includes key client demographic information		
<b>Improving Productivity</b>	Collection and monitoring of minimum national data set through DCRS and provider records	No. of clients accessing the service  No. of clients achieving at least one behavioural change goal  No. of clients supported in working towards achievement of goal  No of Health Trainers and Health Champions recruited		
<b>Access</b>	Clients offered an initial appointment within ...and a choice of appointment setting  Applying the pathway approach to recruitment and selection of Health Trainers and Health Champions	DCRS Outcome 1 data Analysis of recruitment and selection practices and attrition rates		
<b>Care Management</b>	Clients work with HT to develop a Personal Health Plan	DCRS		
<b>Outcomes</b>	National minimum data set 1 - 4			
<b>Additional Measures for Block Contracts:-</b>	Locally determined			
<b>Staff turnover rates</b>	Recognise the positive outcomes for health inequalities for career progression and recognise tensions as its operationally difficult to manage.	DCR		

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<b>Quality &amp; Performance Indicators</b>	<b>Quality &amp; Performance Indicators</b>	<b>Method of measurement</b>	<b>Threshold</b>	<b>Report Due</b>
<b>Sickness levels</b>	Locally determined			
<b>Agency and bank spend</b>	Locally determined			
<b>Contacts per FTE</b>	Locally determined			

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## 8. Activity

Activity Performance Indicators	Threshold	Method of measurement	Consequence of breach	Report Due
Those related to Outcome 1 - Recruitment - Education and training - HT, HC demographics		DCRS and case stories		
Those related to Outcome 2 - client demographics				
Those related to outcome 3 - behaviour change		DCRS and case stories		
Those related to outcome 4 - increasing uptake and access to services		DCRS and case stories		
Those related to numbers of: <ul style="list-style-type: none"> <li>• clients seen</li> <li>• contacts</li> <li>• assessments</li> <li>• sign postings</li> <li>• PHP plans</li> <li>• HT and HC recruitment activity</li> </ul> <p>Targets should be set appropriately to account of roles and lead in period for THTS</p>		DCRS		

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### Activity Plan

The provider will work with the commissioner to develop and agree an annual service delivery plan which is measured against agreed objectives and timescales outlined in this service specification.

## 9. Continual Service Improvement Plan

The Commissioner will require the Health Trainer service to develop throughout the period of the contract to meet agreed number of clients and projected increases. Meet the set targets and outcomes.

Senior staff within the service will be expected to contribute to and support any evaluation of the Health Trainer service by attending regular meetings and providing data as requested, and agreeing service developments and improvements as highlighted through any evaluation.

Monthly, quarterly and annual returns to be agreed locally.

## 10. Price and costs

### 10.1 Price

Basis of Contract	Unit of Measurement	Price	Thresholds	Expected Annual Contract Value
Block/cost & volume/cost per case/Other_____*		£		£
Total		£		£

*\*delete as appropriate*

### 10.2 Cost of Service by commissioner

Total Cost of Service	Co-ordinating PCT Total	Associate PCT Total	Associate PCT Total	Associate PCT Total	Total Annual Expected Cost
£	£	£	£	£	£

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