Behaviour change training delivered across Cheshire and Merseyside

A report mapping programmes and exploring processes

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Acknowledgements

Table of tables

Tables of figures

Abbreviations

ChaMPs	Cheshire and Merseyside Public Health Network
DH	Department of Health
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
PCT	Primary Care Trust

Explanations of terms

Trainer	Those who have delivered the behaviour change training.
Participant	Those who have received the behaviour change training.
Interviewee	Those who participated in telephone interviews.

Table of contents

Behaviour change training delivered across Cheshire and Merseyside: mapping programmes and exploring processes

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1 Executive summary

1.1 Introduction

Behaviour change interventions have the potential to produce a significant impact on major causes of mortality and morbidity. This research focuses on behaviour change training programmes which aim to develop the knowledge and skills of staff so that they are better equipped to help people change health-related attitudes and behaviour.

The Centre for Public Health at Liverpool John Moores University was commissioned by Cheshire and Merseyside Public Health Network (ChaMPs) to map behaviour change training programmes delivered across Cheshire and Merseyside. The research took place between November 2008 and June 2009 and provides a snapshot of activity during this period. Prior to commissioning this research, ChaMPs, alongside other local networks, commissioned the University of Chester to conduct a review of the evidence and best practice regarding behaviour change interventions and training. This research follows on from the review of evidence and identifies training programmes in Cheshire and Merseyside and compares them to the evidence of best practice. The approach taken to commissioning and delivering behaviour change training programmes was also explored. This research has resulted in the development of a document outlining top tips for commissioners and practical pointers for training providers, and a best practice checklist for behaviour change training programmes.

1.2 Methodology

The aim of the research was to support local areas across Cheshire and Merseyside to deliver evidence based best practice learning opportunities for behaviour change across the public health practitioner workforce. The objectives of the research were to:

1. Map behaviour change training programmes being delivered to the public health practitioner and wider public health workforce across Cheshire and Merseyside. This included identifying learning outcomes; target group; knowledge and skills of trainers; method of learning; evaluation and any evidence of effectiveness.
2. Establish a best practice framework to review programmes against.[1]
3. Map existing programmes against best practice.
4. Produce a summary report of current delivery.

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[1] It was not possible to produce one best guidance framework that was appropriate for all behaviour change training programmes because they varied greatly in terms of duration, level and the topics and interventions covered. Therefore, in consultation with the working group, a check list for best practice regarding behaviour change training programmes was produced.

5. Produce 'Top Tips for behaviour change training programmes'. This included reference to the Public Health Skills and Career Framework and community studies of best practice.

The methods adopted included the distribution of questionnaires to those delivering behaviour change training programmes and interviews with those who could provide an overview of the training being delivered and/or commissioned within their organisation. After comprehensive sampling, 21 questionnaires were completed and 11 interviews were conducted.

1.3 Key findings

1.3.1 Questionnaire findings

- A total of 61 training programmes were identified by the 21 trainers who completed questionnaires. A standard definition of behaviour change training programmes was provided, but not all submitted programmes appeared to adhere to this. This illustrates the difficulties in identifying less explicit behaviour change training programmes.

- The greatest number of trainers stated that they delivered training concerning smoking cessation, alcohol or weight management (all = 9 trainers). Four trainers stated that they provided training regarding mental health and wellbeing, or sexual health (both = 4 trainers).

- The greatest number of trainers reported delivering training regarding brief interventions (17 trainers) followed by motivational interviewing (15 trainers), brief advice (14 trainers) and social marketing (3 trainers).

- In accordance with the evidence base, a large proportion of the trainers stated that the training programmes they delivered incorporated discussion of healthy lifestyle issues with clients (19 trainers); developed knowledge and skills in dealing with clients' ambivalence and resistance to change (17 trainers); and enhanced participants' skills in listening to and understanding clients' concerns regarding behaviour change (17 trainers).

- Evidence indicates that an understanding of the theories that underpin behaviour change interventions can enhance the likelihood that participants will go on to use the approaches taught. The majority of the trainers stated that they usually included explanation of theories of behaviour change within their programmes. The most frequently cited theoretical model was the transtheoretical stages of change model (15 trainers). The effectiveness and appropriateness of this model has been strongly debated. It is not clear whether trainers provided participants with a critique of this model.

- The National Institute for Health and Clinical Excellence (NICE) recommends that behavioural change training should focus upon key competencies and skills rather than particular behaviour change theories or models. One of these key competencies was developing knowledge and skills in designing, implementing and evaluating interventions and programmes. Only six of the trainers specified that they aimed to develop this competency within their training programmes. However, it is perhaps only the most advanced programmes that would include these elements. Thirteen trainers said that they aimed to develop the key competencies of understanding the psychological, social, economic and cultural

determinants of health, and working in partnership with members of the target populations and those with local knowledge.

- Only four trainers stated that they used the Public Health Skills and Career Framework to help determine the learning outcomes for the behaviour change training programmes.

- The majority (18 out of 21) of the trainers stated that their training programmes usually enrolled 20 or fewer participants. The evidence suggests that limiting the number of participants to below 20 is good practice because it facilitates discussion and improves understanding of the issues.

- There is some evidence to suggest that follow-up support provided over the telephone is particularly cost effective. Ten of the trainers said that they provided such support. However, it is not clear whether this was provided on a formal basis or whether participants were simply told they could telephone the trainer with questions.

- Nineteen of the trainers stated that participants of their training programmes included employees of the NHS. There were 16 trainers who stated that participants of their programmes included employees from the local authority and 16 who stated that participants included those employed within the voluntary/community sector. There were only six trainers who stated that participants of their training programmes included those employed within the private sector.

1.3.2 Interview findings

Commissioners of public health training were invited to participate in interviews or nominate someone who could provide an overview of behaviour change training commissioned/delivered within their organisations/departments. Eleven interviews were conducted in total. At least one representative for each primary care trust (PCT) in Cheshire and Merseyside participated. This included commissioners, deliverers and coordinators of behaviour change training programmes. Only one representative from a local authority was interviewed.

- When discussing what assisted the commissioning of behaviour change training programmes, a common theme was the availability of national and local guidance (6 interviewees).

- Seven of the interviewees highlighted how informal the commissioning process was. These interviewees stated that they did not put the training out to tender or invite expressions of interest. Behaviour change training programmes were often provided as part of wider commissioned services such as smoking cessation and weight management services, rather than being commissioned separately.

- Five interviewees specifically stated that they considered it necessary for trainers to be able to draw upon their own personal experience of delivering behaviour change interventions. This relates to the evidence which states that 'credible experts' should be used to deliver training. It was considered by three of the interviewees to be useful if training programmes were delivered by a range of individuals to increase opportunities for inter-professional learning.

- Four of the interviewees stated that it was useful for organisations to have a consistent approach to training. Examples of how this was achieved included using the same materials (such as training presentations and reminder cards for practitioners) and theoretical models of behaviour change.

- A recurring challenge was securing the release of staff to attend the training, particularly nursing staff. This was highlighted as a challenge by eight interviewees.

- There was a concern amongst three of the interviewees that some managers and frontline staff did not consider behaviour change training to be particularly important and therefore did not participate in training themselves nor encourage team members to enrol on the training programmes.

- No examples of mandatory training programmes provided to the general workforce that were explicitly described as behaviour change could be identified. Furthermore, no specific examples of training programmes provided as part of an induction process were provided. However, two interviewees did describe plans to include an element of behaviour change in future induction procedures.

- Four of the interviewees stated that the behaviour change training needs were determined by local and national priorities and strategies. Only two of the interviewees stated that an assessment of training needs specifically in relation to behaviour change had taken place.

- Three interviewees stated that the restructuring of Cheshire local authorities should provide opportunities to discuss the best way forward for joined-up working in relation to behaviour change training.

- Four of the interviewees specifically stated that they did not have a good knowledge of the behaviour change training programmes being delivered across their organisation. However, the interviewee who did have such knowledge considered it important for ensuring a consistent approach and to prevent overlap and unnecessary repetition.

- The majority of the interviewees stated that they did not use the Public Health Skills and Career Framework as a tool to assess staff competencies in order to determine training requirements. However, three of the interviewees specified that they used the Public Health Skills and Careers Framework internally as part of professional development processes.

- Six of the interviewees stated that their organisations' training plan included behaviour change training. However, they were often referring to the inclusion of behaviour change training within the training and development prospectus which lists training available to staff, rather than detailed strategic training plans developed as a result of needs assessments.

- Seven of the interviewees stated that evidence regarding working towards NICE guidelines was not requested by commissioners, although it was often assumed that trainers would be working in accordance with these guidelines.

- Nine of the interviewees stated that evaluation forms were distributed to participants at the end of programmes (e.g. satisfaction questionnaires). There was no evidence provided of detailed evaluations which aimed to objectively

assess learning and long term behaviour change in the eventual recipients of the interventions.

- Six of the trainers collected some form of simple monitoring data which was considered to provide some indication of the effectiveness of behaviour change training programmes.

- Trainers' curriculum vitae and their professional development reviews were used as a measurement of trainers' appropriateness for delivering the training.

- Four of the interviewees provided some form of follow-up to the training programme at three and/or six months. This included the completion of questionnaires and/or discussions over the telephone.

1.3.3 Additional findings

- It became evident that those working within local authorities and the voluntary/community sector may not use the terms brief intervention, brief advice or motivational interviewing but may well use aspects of behaviour change interventions in their day-to-day work and include elements of behaviour change within training programmes. As a result training programmes that include aspects of behaviours change may be more difficult to identify within local authorities and the voluntary/community sector.

- Difficulties were experienced when attempting to identify those who delivered behaviour change training programmes within local authorities. This may be indicative of a lack of behaviour change training programmes being delivered by local authority staff and/or that behaviour change training is less explicit within local authorities than in the NHS.

- Top tips for commissioners and practice pointers for those delivering training programmes were developed from the findings of this research. This included a best practice checklist for behaviour change training programmes.

1.4 Conclusion

A total of 61 training programmes were identified via the mapping exercise. In general, the training programmes appeared to be in accordance with many aspects of the evidence base. They largely focused upon priority areas identified within the *Choosing Health* white paper. Many of them aimed to develop key skills for developing knowledge and skills in dealing with clients' ambivalence to change; and developing rapport and facilitating discussion with clients. The majority also incorporated an explanation of the theoretical underpinnings of behaviour change training to some degree. Most trainers included the transtheoretical stages of change model which has been widely criticised. It is not clear whether trainers also included a critique of this theory. Over half of the trainers stated that the training programmes aimed to address the NICE competencies of understanding the psychological, social, economic and cultural determinants of health, and working in partnership with members of the target population and those with local knowledge. Only a limited number aimed to develop knowledge and skills in designing, implementing and evaluating interventions and programmes. However, this may only be applicable for advanced programmes.

NICE has suggested that there is a lack of strategic approach to behaviour change across government, the NHS and other organisations and concludes that approaches to behaviour change are often uncoordinated. The interview findings suggest that this lack of a strategic approach may also be applicable to behaviour change training across some areas of Cheshire and Merseyside. In the main, behaviour change training programmes were being delivered as part of specialised services (such as smoking cessation and weight management) and generic behaviour change skills and competences were not always considered. There was a lack of knowledge of other behaviour change training programmes being delivered across PCTs and a lack of assessment of training needs in relation to behaviour change. Although there was an apparent lack of coordination of services, which resulted in some overlap and a potential lack of consistency, this does not mean that training programmes being delivered were of a poor standard. Indeed, the majority of the training programmes appeared to be delivered in accordance with the best practice evidence base. There were some examples where a coordinated approach to behaviour change training was adopted. This included assessing the needs of staff in relation to behaviour change training, a consistent approach and preventing overlap in training delivery. There were also examples of providers taking the initiative to deliver behaviour change training without being commissioned to do so.

1.5 Recommendations

1.5.1 Top tips for commissioners of behaviour change training

1.5.1.1 Assess training needs regarding behaviour change

Conducting training needs assessments can identify gaps in knowledge and skills, and therefore determine the most appropriate form of training package to provide. All staff with roles that have the potential to change health related knowledge, attitudes and behaviour should be included in the assessment. Where possible this should include roles within the NHS, local authority and community/voluntary sector. Efforts should be made to identify the specific roles within these organisations that should participate in the training needs assessment. The Public Health Skills and Career Framework should be used where possible, to identify training requirements in relation to behaviour change.

1.5.1.2 Develop joint strategies for behaviour change training between the NHS, local authorities and voluntary/community sector

Choosing Health states improving health is everyone's responsibility. It is important that a consistent approach to behaviour change training is adopted across organisations. This helps ensure consistent messages are delivered to the public and all appropriate opportunities to positively influence health-related attitudes, knowledge and behaviour are used effectively.

1.5.1.3 Commission generic behaviour change training programmes whenever possible

Generic behaviour change training programmes develop knowledge and skills that can be applied to a wide range of public health topics including alcohol, smoking, obesity, sexual health, and mental health and well-being. There is an opportunity to increase efficiency by providing generic behaviour change training to larger numbers of staff rather than several packages that focus on specific public health topics. Training should be provided at a range of levels and could incorporate different delivery methods (including face-to-face and e-learning). Consideration should also

be given to whether the training is mandatory, forms part of induction processes or contributes to continued professional development.

Robust evaluation is crucial for determining the effectiveness of the training programme. This should include identifying and assessing:
- the processes involved in delivering the training
- the outcomes of the training on the professional behaviour of recipients

More advanced evaluations should include an assessment of health outcomes in clients receiving interventions from trainees.

1.5.2 Top tips for providers of behaviour change training

1.5.2.1 Promote the benefits of behaviour change training programmes to managers, commissioners and front line staff

Behaviour change interventions are an important means of reducing the risk of illness and early death. They have the potential to reduce the numbers of people who smoke; cut obesity, and improve diet and nutrition; increase levels of exercise; reduce alcohol consumption; improve sexual health; and promote mental health and well-being. For training programmes to be a success, they need to be commissioned and supported by managers.

1.5.2.2 Develop inter-professional and inter-agency learning regarding behaviour change

Inter-professional and inter-agency learning helps to create an effective public health workforce. It facilitates participants' understanding of other roles and encourages the development of effective collaborative working patterns. It is therefore useful if a number of trainers can contribute to the delivery of sessions.

1.5.2.3 Consider carefully the theoretical content of behaviour change training programmes

Evidence suggests that an understanding of the theories that underpin behaviour change interventions can enhance the likelihood participants will go on to use the approaches taught. The evidence does not support the use of one particular model or theory but promotes a focus upon the development of skills and competencies. For example, the effectiveness of one popular model, the transtheoretical stages of change model, has been widely debated.

2   Introduction

The use of behaviour change interventions has been widely promoted in public health literature due to their potential to produce a significant impact upon major causes of mortality and morbidity (National Institute for Health and Clinical Excellence [NICE], 2007). However, in 2007 NICE reported that there was no strategic approach to behaviour change across the government, NHS or other sectors (NICE, 2007).

This research focuses on training programmes which aim to develop the knowledge and skills of workers so that they are better equipped to help people change their health-related knowledge, attitudes and behaviour.

The Centre for Public Health at Liverpool John Moores University was commissioned by Cheshire and Merseyside Public Health Network (ChaMPs) to map behaviour change training programmes delivered across Cheshire and Merseyside. Prior to commissioning this research, ChaMPs, alongside other local networks, commissioned the University of Chester to conduct a review of the evidence and best practice regarding behaviour change interventions and training (Powell & Thurston, 2008). This research follows on from the review of evidence, and identifies training programmes in the Cheshire and Merseyside and compares them to the evidence of best practice. The approach taken to commissioning and delivering behaviour change training programmes was also explored. This has resulted in a document outlining top tips for commissioners, practical pointers for those delivering programmes and a best practice checklist for behaviour change training programmes.

3   Background

3.1   Government policy

The white paper *Choosing Health: Making healthy choices easier* presented an approach to public health that promoted individual choice (Department of Health [DH], 2004). It detailed three core principles; informed choice, personalisation, and working together. *Informed choice* refers to the desire of individuals to make their own decisions regarding aspects of their lives that impact upon their health, and which are informed by credible and trustworthy information. *Personalisation* is concerned with ensuring that services are tailored to individuals' lives, which includes the provision of sensitive, convenient and flexible services. *Working together* in effective partnerships across communities including local government, the National Health Services (NHS), business, advertisers, retailers, the voluntary sector, the media and faith organisations is key to allowing individuals to make healthier informed choices. The consultation which was conducted to inform the white paper, established six overarching public health priorities. These were:

- Reducing the numbers of people who smoke
- Reducing obesity and improving diet and nutrition
- Increasing exercise
- Encouraging and supporting sensible drinking
- Improving sexual health
- Improving mental health and wellbeing

The document set out how the NHS will increasingly focus upon a health improvement and prevention service which will support individuals in the choices they

make. It outlined a need to ensure that the NHS takes advantage of the millions of encounters that it has with individuals each week by ensuring that NHS staff have training and support to include health improvement activities in their day-to-day roles. A further priority outlined in the document was NHS staff members' understanding and skills in promoting health, and it was established that a comprehensive range of community health improvement services were to be developed. The white paper aimed to establish health as a population priority.

3.2 Cheshire and Merseyside Public Health Network

Cheshire and Merseyside Public Health Network was established in 2003 to develop partnerships and enhance capacity in order to promote and protect public health and wellbeing across Cheshire and Merseyside. The network aims to have contributed to the following by 2013:
- A reduction in alcohol attributable and alcohol treated harm
- Measurable reductions in smoking prevalence in deprived areas
- A reduction in obesity
- An increase in breastfeeding rates
- An improvement in environmental indicators
- An improvement in emotional health and wellbeing
- An improvement in antenatal Human Immunodeficiency Virus (HIV) screening rates
- An increase in Measles, Mumps and Rubella (MMR) vaccination uptake.

Other local networks have been established specifically focussing upon cancer and sexual health (Cheshire and Merseyside Sexual Health Network and Merseyside and Cheshire Cancer Network). ChaMPs also aims to support the work of these networks. Many of ChaMPs' aims coincide with the public health priority areas outlined in *Choosing Health* (DH, 2004) (i.e. alcohol, obesity, and emotional health and wellbeing). Behaviour change interventions could potentially contribute to achieving all of these aims.

3.3 Public Health Skills and Career Framework

The Public Health Skills and Career Framework *"is a tool for describing the skills and knowledge needed across all groups, domains and levels of the public health workforce"* (Public Health Resource Unit & Skills for Health, 2008, p.4). It is designed to be used by any individual who practises or participates in public health and any organisation that employs those who practise public health, including local authorities, the NHS, the voluntary sector and the private sector. The framework was developed to inform the skills and career development of everyone who contributes to improving or protecting health and wellbeing. It is anticipated that the framework will assist in the development of an appropriately skilled public health workforce. The framework represents the first time that standards for the whole of the public health sector have been brought together. It has been endorsed by the DH (in England, Wales, Scotland and Northern Ireland). The Public Health Skills and Career Framework Cube is displayed below (Figure 1). The framework itself incorporates competence and knowledge statements for each of the areas and levels displayed in the cube. Within the framework there are a number of knowledge statements regarding behaviour change (Public Health Resource Unit & Skills for Health, 2008).

Figure 1. The Public Health Skills and Career Framework Cube
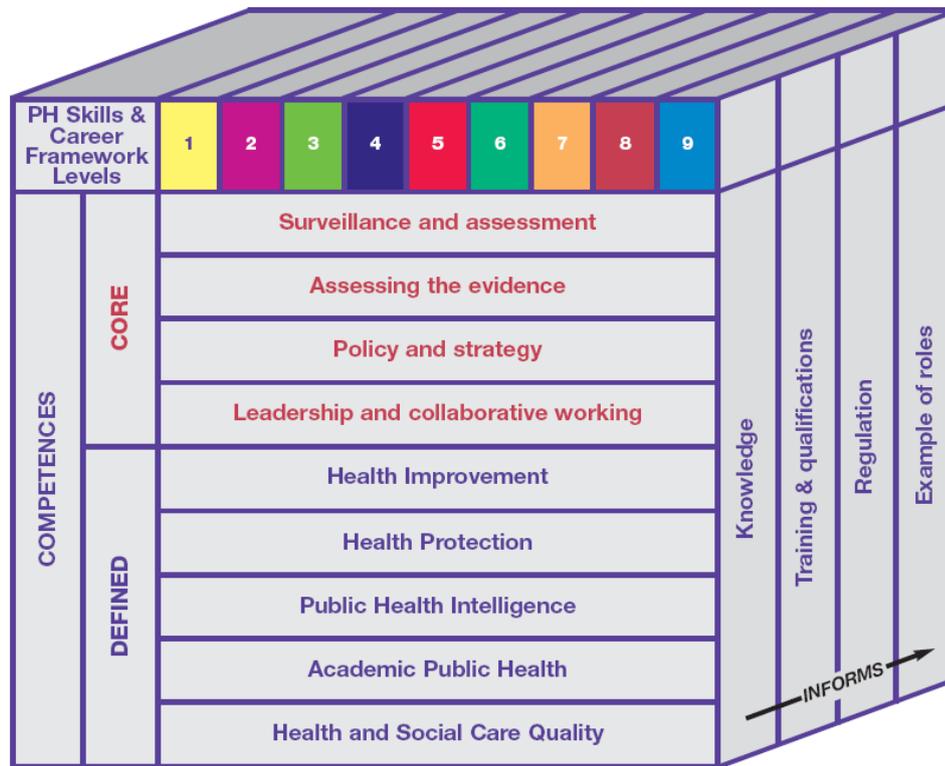
3.4   Behaviour change interventions

Individuals' behaviour is crucial to their health. The impact of smoking, lack of exercise, poor diet, and unsafe sexual practices are widely acknowledged. Individual behaviour is often easier to change than the social or environmental circumstances contributing to health. However, attempts to change behaviour have resulted in limited success. This may be because previous strategies have failed to adopt theories and principles of effective planning, delivery and evaluation (NICE, 2007). The four most commonly used methods employed to drive behaviour change are brief intervention, brief advice, motivational interviewing and social marketing (Powell & Thurston, 2008). Definitions of these four methods are provided in figure 2 below.

Figure 2. Definitions of types of behaviour change interventions

*"**Brief advice** describes a short intervention delivered opportunistically which is normally focused on a service user's reason for seeking help. It can be used to raise awareness of, and assess a person's willingness to engage in further discussion about, healthy lifestyle issues. Brief advice is less in-depth and more informal than a brief intervention and usually involves giving information about the importance of behaviour change and simple advice to support behaviour change."*

*"**Brief interventions** provide a structured way to deliver advice and constitute a step beyond brief advice as they involve the provision of more formal help, such as arranging follow-up support. Brief interventions aim to equip people with tools to*

change attitudes and handle underlying problems. As part of a range of methods, brief interventions may contain brief advice and may use a motivational interviewing approach in the delivery."

*"**Motivational interviewing** is described as a process of exploring a person's motivation to change through interview in order to assist them towards a state of action. The techniques used are adaptations of counselling skills and particular attention is paid to the listening skills of the interviewer. Motivational interviewing can be understood as an approach which can be adopted for delivering a brief intervention."*

*"**Social marketing** describes a strategic approach, based on traditional marketing techniques, to delivering a programme of activities to encourage behaviour change. Emphasis is placed on understanding the life context and aspirations of individuals and their communities, which is then used to inform programmes that enable and encourage people to participate in positive health behaviour."*

(Powell & Thurston, 2008, p. v-vi)

Powell and Thurston (2008) conducted a review of the evidence regarding one-to-one behaviour change interventions, i.e. brief advice, brief interventions and motivational interviewing. The setting, personal circumstances of clients, staff attributes and the process of delivery all impact upon the effectiveness of behaviour change interventions. Furthermore, interventions which are underpinned by a clear and coherent theory are more effective than those without. The evidence suggests that behaviour change interventions may be successful in a number of different healthcare and community settings. The skills of the individual delivering the intervention are of greater importance than their formal role, and the likelihood of the intervention being effective is enhanced if those delivering demonstrate genuine concern for their clients. Interventions should also be client-led and tailored to individuals' stages of change[2]. Those delivering the intervention should facilitate discussions to consider why any relapses occurred (Powell & Thurston, 2008).

3.5   Behaviour change training programmes

Training is imperative to enable staff to effectively deliver behaviour change interventions. The mode of delivery and content of the training both influence the effectiveness of behaviour change training programmes. 'Credible experts', who are respected by participants, understand the context of participants' day-to-day roles and have established rapport with participants, help to encourage openness to the approaches put forward. The development of participants' communication skills also enhances the likelihood of effective interventions and should be a key focus of behaviour change training programmes. Training programmes that include evidence for the effectiveness of behaviour change interventions allow participants to feel confident that their work will be purposeful. Furthermore, participants of training are more likely to adopt interventions if they develop an understanding of their theoretical underpinnings. There is also evidence to suggest that training on specific public health topics (including but not limited to the priorities identified within the *Choosing Health* white paper [DH, 2004]) can enhance participants' competence and

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[2] The stages of change model describes the processes people go through in order to change behaviour, which includes pre-contemplation, contemplation, decision, action and maintenance (Prochaska & DiClemente, 1983).

confidence in delivering behaviour change training programmes; allow participants to reassess negative attitudes towards people's behaviour and enhance knowledge and understanding of different health behaviours. Training programmes which develop skills in assessing readiness to change, facilitating discussion and developing positive relationships enhance participants' confidence and result in more personalised interventions. Staff are also more likely to deliver consistent interventions if they learn how to deal with different groups of service users with specific needs such as young people, families, those with disabilities and those from black and minority ethnic groups (Powell & Thurston, 2008).

The methods adopted within training programmes also impact upon their effectiveness. Training programmes should be of relevance to participants' role and develop their existing knowledge. Delivering programmes in a workshop format enhances effectiveness by providing an opportunity to hold discussions with colleagues and for reflection. However, workshop settings are not comparable to situations within which participants of the training are going to be delivering the interventions, therefore on-site consultation from a trainer or peer is useful for providing an opportunity for practise, feedback and encouragement. The behaviour change training programmes should encompass both theory based teaching and sessions which allow participants to practise their skills. Role-play is a key tool that should be used for participants to practise their skills in delivering behaviour change interventions (Powell & Thurston, 2008).

NICE specifies that training should focus upon generic competencies and skills rather than specific models.

"These competencies include the ability to:

- *identify and assess evidence on behaviour change*
- *understand the evidence on the psychological, social, economic and cultural determinants of behaviour*
- *interpret relevant data on local or national needs and characteristics*
- *design, implement and evaluate interventions and programmes*
- *work in partnership with members of the target population(s) and those with local knowledge".*

(NICE, 2007, p.23)

4   Methodology

A working group for this research was established which included representatives from ChaMPs, the NHS, a local authority and Liverpool John Moores University. The group held monthly meetings and provided valuable suggestions regarding the feasibility and credibility of the methodology and assisted with the development of the document outlining top tips for behaviour change (Stredder et al., 2009). The research took place between November 2008 and June 2009.

4.1   Aim and objectives

The aim of the research was to support local areas across Cheshire and Merseyside to deliver evidence based best practice learning opportunities for behaviour change across the public health practitioner workforce.

The objectives of the research were to:

- Map behaviour change training programmes being delivered to the public health practitioner and wider public health workforce across Cheshire and Merseyside. This included learning outcomes; target group; knowledge and skills of trainers; method of learning; evaluation and any evidence of effectiveness.
- Establish a best practice framework to review programmes against[3].
- Map existing programmes against best practice.
- Produce a summary report of current delivery.
- Produce 'Top Tips for behaviour change training programmes'. This included reference to the public health carer framework cube and community studies of best practice.

4.2 Defining behaviour change training programmes

An explanation of behaviour change training programmes was developed through discussions with the working group (figure 3). This was necessary as behaviour change training programmes may take various forms. Through these discussions it became apparent that the terminology used within the NHS was not necessarily adopted by those working within local authorities and other organisations.

Figure 3. Definition of behaviour change training programmes

Behaviour change training programmes develop the knowledge and skills of workers so that they are better equipped to help people change their health-related knowledge, attitudes and behaviour.

Behaviour change training programmes may focus on one or more public health issue including, but not limited to, the following topics:
- Smoking cessation
- Alcohol
- Illegal drugs
- Food safety
- Healthy weight (obesity/exercise/nutrition)
- Sexual health
- Mental health/wellbeing
- Infectious diseases
- Fall prevention
- Driving awareness
- Home safety

Behaviour change training programmes may also include one or more methods/approaches including, but not limited to, the following:
- Motivational interviewing
- Brief advice
- Brief intervention
- Cognitive Behavioural Therapy
- Client centred conversations

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[3] It was not possible to produce one best guidance framework that was appropriate for all behaviour change training programmes because they vary greatly in terms of duration, level and the topics and interventions covered. Therefore, in consultation with the working group, a check list for best practice regarding behaviour change training programmes was produced.

- Eliciting behaviour change talk
- Reviewing lifestyle messages
- Raising clients' awareness of risky behaviours
- Goal setting
- Dealing with clients' ambivalence and resistance to changing their behaviour
- Effectively exchanging information with clients
- Discussing healthy lifestyle issues with clients
- Encouraging clients to take responsibility for their behaviour
- Social marketing

For the purposes of this mapping exercise training programmes had to include a substantial element of behaviour change. Programmes may have included other topics but behaviour change had to be a key aspect of the training programme.

4.3 Questionnaires

A questionnaire was designed by the research team to obtain detailed information about the behaviour change training programmes being delivered within Cheshire and Merseyside. Deliverers of the training programmes were invited to complete the questionnaire, in order to obtain sufficient detail. The questionnaire included sections on the behaviour change training programmes themselves, participants of the training programmes, follow-up support, evaluation and the trainers' perspectives. The content of the questionnaire was informed by the literature review conducted by Powell and Thurston (2008) regarding the commissioning of behaviour change training programmes; the NICE guidance regarding behaviour change (NICE, 2007) and discussions held within the advisory group.

Pilot questionnaires were distributed to individuals who delivered behaviour change training programmes outside of Cheshire and Merseyside. Fifteen individuals were invited to complete the pilot questionnaire (contact details for these individuals were provided by the advisory group), and four questionnaires were completed and returned (27%). The piloting of the questionnaire resulted in minor changes to the layout.

A list of roles within local authorities and the NHS was developed in consultation with the advisory group (Table 1). Individuals within these roles across Cheshire and Merseyside were contacted by email and asked to provide the contact details of individuals who delivered behaviour change training programmes within the NHS, local authority, voluntary/community sector and/or private sector. They were provided with the definition of behaviour change training programmes developed by the advisory group. The individuals identified as having delivered the behaviour change training programmes were then invited to complete a questionnaire.

Table 1. Roles of individuals initially contacted in order to identify trainers

NHS

Personal Assistants to Directors of Public Health
Heads of Training/Learning and Development Departments
Public Health Workforce Leads
Knowledge and Skills Framework Team Leads
Healthy Living/Promotion Managers
Heads of Provider Services
Alcohol Leads
Obesity Leads
Sexual Health Leads
Tobacco Leads
Chief Operating Officers
Education Leads
Healthy Schools Coordinators
North West Health Trainer Partnership Manager

Local authority

Workforce Leads
Drug and Alcohol Action Team Managers
Drug and Alcohol Action Team Commissioners
Heads of Leisure/Recreation/Culture
Environmental Health Managers
Crime Reduction Partnership Coordinators
Heads of Trading Standards
Directors of Adult Social Services
Directors of Children's Services
Youth Offending Team Managers
Tobacco Leads
Heads of Police Training and Development Departments
Heads of Police Human Resources Departments
Heads of Police Health and Safety Departments
Heads of Fire and Rescue Training and Development Departments
Heads of Fire and Rescue Human Resource Departments
Heads of Fire and Rescue Community Safety Departments
Heads of Fire and Rescue Resilience Units
Heads of Probation Services

The ChaMPs newsletter was also used to inform members of the mapping exercise (distributed to approximately 800 members). Those who delivered behaviour change training programmes were asked to contact the research team so that they could be sent a questionnaire to complete. Furthermore, delegates attending the continuing professional development event entitled *Behaviour change: From commissioning to practice* held in March 2009 were informed about the mapping exercise and provided with questionnaires which they could photocopy for their colleagues as necessary. Delegates were further informed that the questionnaire had been placed on the ChaMPs website.

One hundred and eleven questionnaires were distributed to those who were identified by their colleagues to be delivering behaviour change training programmes Nineteen of these individuals emailed to state that they did not deliver behaviour change training programmes and 19 questionnaires were completed and returned either electronically or via the postal system (34% response rate including emails indicating that the questionnaire was not relevant and received questionnaires).

Table 2 shows a breakdown of the response rates by type of organisation. The highest response rate (including returned questionnaires and emails that stated that the questionnaire was not relevant) was from individuals within the private sector (55%); followed by the voluntary/community sector (43%); local authorities (33%) and the NHS (17%).

Table 2. Questionnaire responses by type of organisation

Type of organisation	Number of questionnaires distributed	Number of questionnaires returned	Number of emails stating that the questionnaire was not relevant	Percentage of responses (including emails stating that the questionnaire was not relevant and returned questionnaires)
NHS	63	9	10	17%
Local authority	30	4	6	33%
Private	11	5	1	55%
Voluntary/community	7	1	2	43%
Total	**111**	**19**	**19**	**34%**

A further two questionnaires were completed and returned as a result of distributing the questionnaires at the Continuing Professional Development Event regarding behaviour change facilitated by ChaMPs. Therefore the total number of completed questionnaires returned before the deadline was 21. The data obtained via the questionnaires was inputted into the computer software package SPSS and descriptive data were presented in tables and graphs. Those who completed questionnaires were also invited to make any documents regarding the behaviour change training programmes they delivered, such as training manuals, materials distributed during training programmes and evaluation reports available to the research team.

4.4   Interviews

An interview guide was designed for use with those who could provide an overview of the behaviour change training programmes being commissioned and delivered by the NHS and local authorities within Cheshire and Merseyside. It was not deemed feasible to hold interviews with those who could provide an overview of behaviour change training within voluntary/community sectors or the private sectors within the available time period. However, interviewees employed within the NHS or local authorities were provided with the opportunity to discuss any behaviour change training programmes that they commissioned the voluntary/community sector or the private sector to deliver.

Within the NHS, commissioners of public health training within Cheshire and Merseyside were invited to participate in an interview or to nominate an individual or individuals to participate who could provide an overview of behaviour change training programmes within their organisations. The contact details of these commissioners were provided by ChaMPs.

To identify appropriate individuals within local authorities to participate, heads of the following services within Cheshire and Merseyside were emailed and asked to

identify someone who could provide an overview of behaviour change training within their department or organisations:

- Environmental Health
- Drug and Alcohol Action Team
- Leisure/recreation/culture
- Crime Reduction Partnerships
- Adult Social Services
- Children's Services
- Youth Offending Team
- Police
- Fire and Rescue

Six replies were received in response to these emails. However, when the identified individuals were contacted it was revealed that they did not actually deliver behaviour change training. In addition, a member of the research team attended the Greater Merseyside Health and Social Care Alliance meeting (which specifically focused upon training and development) to invite those who could provide an overview of behaviour change training within local authorities to participate in an interview. Contact was also made with local authority representatives from the Cheshire Health and Social Care Alliance Group; however, due to the significant restructuring that took place within Cheshire local authorities on the 1st April 2009, no representatives were available to be interviewed.

Eleven interviews were conducted in total. At least one representative from each PCT in Cheshire and Merseyside was interviewed. Many of the individuals interviewed delivered the behaviour change training as they had been nominated by the commissioners of public health training. One representative from a social care training and development team within a local authority was also interviewed. Each interview lasted between 30 minutes and one hour. The interviews were all conducted over the telephone and were audio recorded. The interviews were transcribed verbatim and thematically analysed using the computer software NVivo (Grbich, 2007).

4.5 Development of best practice framework

It had been anticipated that a best practice framework would be produced to enable commissioners and deliverers of behaviour change training programmes to make an assessment of the appropriateness and quality of behaviour change training programmes. However, it became evident that it would not be appropriate to develop one framework for all types of behaviour change training programmes as they vary greatly in duration, level, topic and the types of interventions that they include. Hence, it would not be appropriate to compare programmes with such varying aims and objectives. It was deemed more appropriate to develop a best practice checklist for behaviour change training programmes. This was developed using findings from the review of evidence and best practice (Powell & Thurston, 2008) and this research (appended page 69).

4.6 Development of 'Top Tips'

'Top Tips' to highlight the most important recommendations for the delivery and commissioning of behaviour change training programmes were developed through discussions with the advisory group which drew on the findings presented within this

report. This was produced in a simple accessible format that will help public health practitioners and members of the wider workforce to deliver effective health promotion interventions (Stredder et al., 2009).

4.7 Ethical issues

Ethical approval to conduct this research was obtained from Liverpool John Moores University's Ethics Committee. Ethical approval from the National Research Ethics Service (NRES) was not necessary as members of a local Ethics Committee considered the proposal to be classed as service evaluation, which does not require ethical review (NRES, 2007). All participants were provided with a participant information sheet. All data will be held according to Liverpool John Moores data protection policy (Liverpool John Moores University, 2007). Participants were provided with the opportunity to view a draft of the findings before it was widely circulated to ensure they did not feel like anonymity was compromised.

4.8 Methodological limitations

It was not be possible to ensure that all behaviour change programmes being delivered within Cheshire and Merseyside were included in this mapping exercise. The mapping exercise provided a snapshot of activity during the period when the research was conducted (November 2008 to June 2009). There will undoubtedly be others that have not been identified. The research team were reliant upon those within the NHS and local authorities informing them of behaviour change interventions being delivered within the voluntary/community sector and the private sector. In addition, no interviews were held with individuals from the voluntary/community sector and private sectors but those employed with the NHS and local authorities were provided with the opportunity to discuss their experiences of commissioning behaviour change training programmes delivered by the voluntary/community sector and private sector.

5　Findings

5.1　Identified behaviour change training programmes

The behaviour change training programmes identified in the mapping exercise are listed in table 3. The details of 57 programmes were provided via the questionnaires. The details of an additional programme were provided in a questionnaire that was received after the final deadline and after the analysis had been completed. This training programme is listed below but not included in the analysis. An additional three training programmes were identified via the interviews, taking the total number identified to 61. It is not clear whether all identified programmes meet the definition of behaviour change training provided. For example some may include aspects of behaviour change but this may not be a 'substantial element' of the programme.

Table 3. Programmes identified through the mapping exercise

Trainers' organisation	Title of Behaviour Change Training Programme
Private	
Freelance trainer (Barbara Parratt)	Brief Intervention
	Motivational Interviewing
Freelance trainer (Dympna Pearson)	Behaviour Change Skills (part 1, 2 & 3)
	Group Facilitation Skills
	Behaviour Change for Weight Management
V A Health Associates	Brief Intervention
	Motivational Interviewing
	Lifestyle Health Information Training
Advocating Health Ltd	Health Behaviour Change
	Smoking Cessation
	Promoting Healthy Lifestyles
	Improving Self Care
	Healthcare Behaviour Change (advanced)
	Adult Weight Change
	Children's Healthy Weight Change

	Stress Management
	Health Anxiety
	Solution Focused Brief Therapy Techniques
G Ford Consultancy	Solution Focused Practice
NHS	
Knowsley NHS	Brief Intervention Training - Encouraging Healthy Eating & Physical Activity
	Smoking Cessation - Intermediate
	Smoking Cessation - Brief Intervention
	Supporting Clients to Make Health Related Lifestyle Changes: A Behavioural Approach
Wirral NHS	Choosing Health
	Brief Intervention
	Smoking Cessation Training Courses (level 1 & 2)
	Alcohol Screening Brief Intervention
Halton and St Helens NHS	Brief Intervention Training
Sefton NHS	Brief Intervention training (smoking cessation)
	Reducing Children's Exposure to Second Hand Smoke
	Alcohol Awareness
	Brief Interventions
	Assessment
	Behaviour Change Training (as part of the health trainers programme)
	Smoking Cessation Brief Intervention Training
Liverpool NHS	Life Coaching
	Life Skills
	Choosing Health
Cheshire and Wirral NHS Foundation Trust	Smoking Cessation Training (level 2)
Western Cheshire PCT	Generic Behaviour Change Training
	Smoking Cessation
	Alcohol Brief Advice Training to General Practices in Western Cheshire PCT
	Weight Management

Local authority	
Warrington Drug Action Team	Drugs Awareness
	Cocaine Awareness
	Train the Trainers
	Blood Borne Viruses
	Safer Injecting
	An Introduction to Mental Health
	Personality Disorders
	Counselling Skills
	Alcohol Awareness
	Reducing Overdose Deaths
	Minority Groups and Diversity
	Screening and Assessing
	Mental Health (level 2)
Warrington Local Authority	Positive Thoughts
Ellesmere Port and Neston Local Authority	Food Hygiene
Sefton Local Authority	Introduction to Motivational Interviewing
Voluntary/community	
Age Concern East Cheshire	Royal Society for Public Health - Understanding Health Improvement (Level 2)
Joint delivery	
Cheshire and Wirral NHS Foundation Trust /Wirral Borough Council Adult Social Services	Health Coaching

5.2   Questionnaire findings

Sixteen trainers stated that they delivered behaviour change training programmes that were topic specific (76%). Details of the topics are shown in figure 4. Of these, the most frequent topics covered were smoking cessation, alcohol and healthy weight (all = 9 trainers, 43%). Four trainers (19%) specified that they delivered mental health/wellbeing and four trainers delivered sexual health training (19%). Only one trainer (5%) specified that they delivered training that focused on each of the remaining topics; namely, illegal drugs, home safety, infectious disease, reducing children's exposure to second hand tobacco smoke, stress management, anxiety management and health anxiety.

Figure 4. Topics trainers focused upon
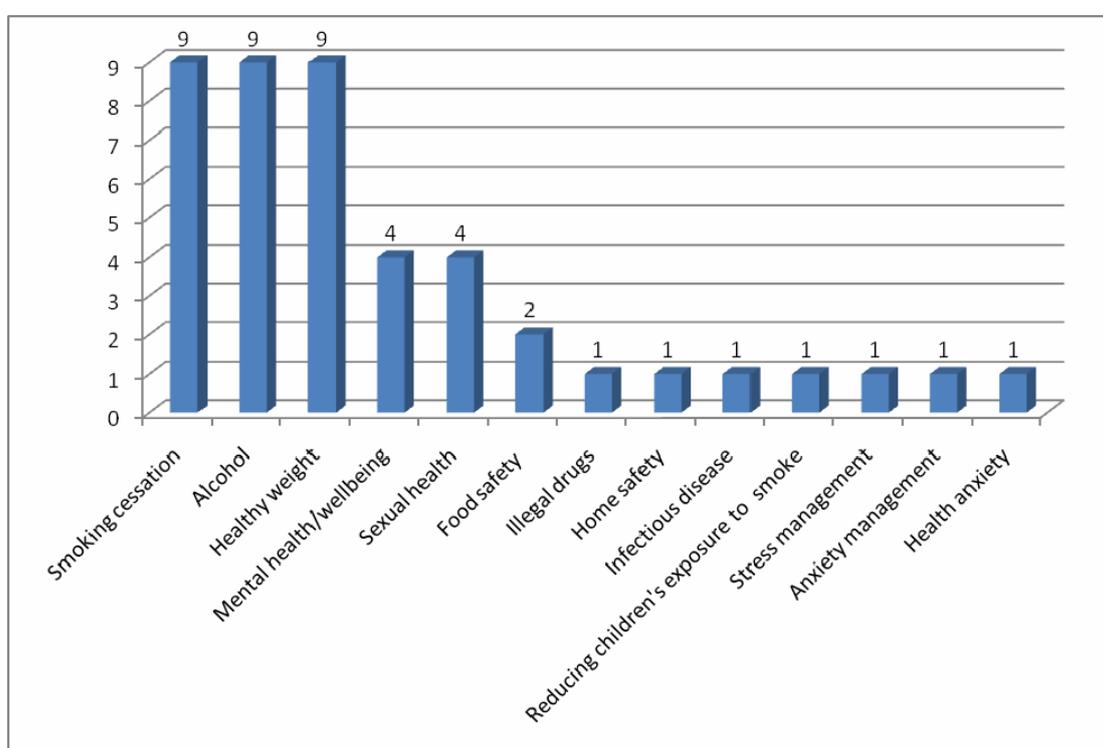
Trainers were also asked to state the methods/approaches/competencies that were included in their trainng prorgammes which are shown in figure 5. The most frequently reported competencies taught were signposting clients to appropriate services and discussing healthy lifestyle messages (19 trainers, 91%). There were four competencies which were taught by 17 trainers (81%), these were listening to and understanding clients' concerns regarding changing behaviour; reflective listening skills; dealing with clients' ambivalence and resistance to change; and effectively exchanging information with clients. Two competencies were identified by 16 of the trainers (76%); namely, reviewing lifestyle messages and goal setting. There were also two methods/competencies which 15 trainers stated they taught (71%), these were motivational interviewing and encouraging clients to take responsibility for their behaviour. Thirteen trainers (62%) stated they included eliciting behaviour change talk, raising clients' awareness of risky behaviours and understanding the influences of clients' behaviour within their programmes. Eleven of the trainers who completed the questionnaire stated that they included understanding clients' perceptions of risk within the training. The method/approach used by the

smallest number of trainers was social marketing (3 trainers, 14%). In addition, there were ten other methods/approaches/competencies reported: action planning; understanding and learning from relapse; relapse prevention strategies; coaching clients to develop problem solving skills; enabling vulnerable people to have more control; person centred care; helping clients make sense of their situation/condition; client empowerment and solution focused practice.

Figure 5. Methods/approaches/competencies included by trainers

- Signposting clients to appropriate services
- Discussing healthy lifestyle issues with clients
- Listening to and understanding clients' concerns regarding changing behaviour
- Reflective listening skills
- Dealing with clients' ambivalence and resistance to change
- Effectively exchanging information with clients
- Brief intervention
- Reviewing lifestyle messages
- Goal setting
- Motivational interviewing
- Encouraging clients to take responsibility for their behaviour
- Brief advice
- Eliciting behavioural change talk
- Raising clients' awareness of risky behaviours
- Understanding the influences on clients' behaviour
- Understanding clients' perceptions of risk
- Social marketing

Trainers were also asked to provide details of the theories/methods they included within their programmes which are detailed in figure 6. The theory/model included by the greatest number of trainers was the transtheoretical stages of change model (15 trainers, 71%). The second highest response was from trainers who stated that they were unsure whether their training programmes included a model or theory (4 trainers, 19%). There were two theories/models that three trainers (14%) stated they included in their programmes. These were the health belief model and social cognitive learning theory. The theory of reasoned action was included by two trainers (10%) and one trainer (5%) stated that they incorporated the diffusion of innovations theory within their programme. There were eight other theories/models which trainers stated they included in their programmes, each of these were mentioned by one trainer. They were: solution focused brief therapy; solution focused practice; self regulatory model of behaviour; psycho-social interventions; social network therapy; social enterprise; motivational behaviour techniques and the disease model of addiction. In addition, one trainer stated that, in accordance with NICE guidance, they discussed all theories but focused upon generic skills and competencies rather than on a specific model.

Figure 6. Theories/models included by trainers
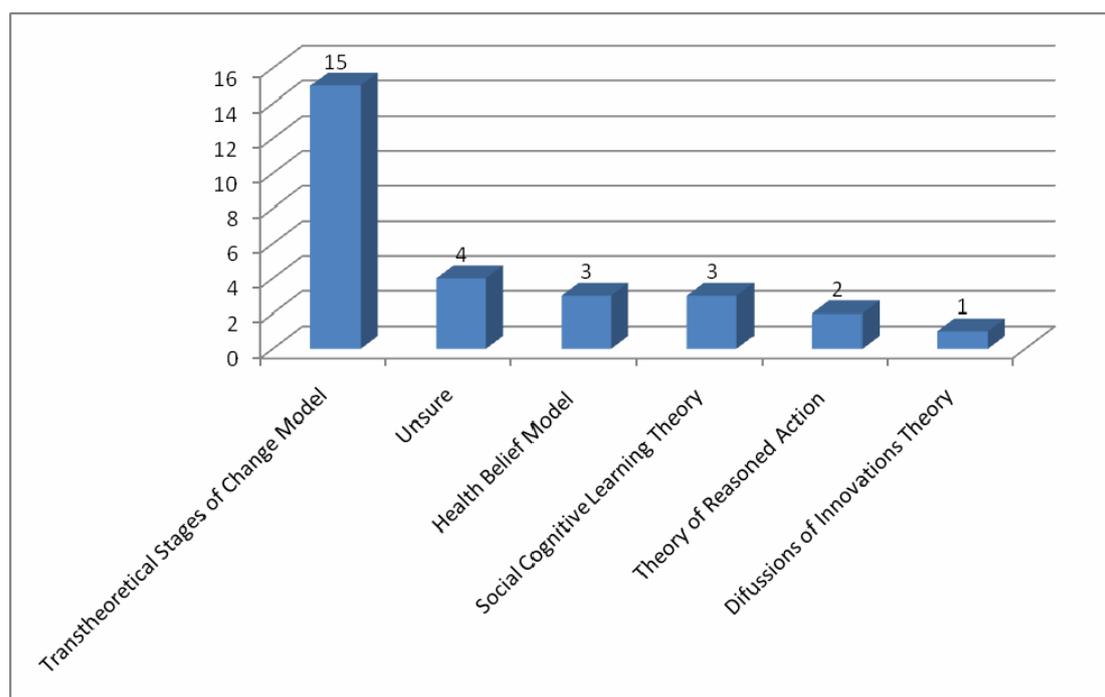
Trainers were asked to specify which of the competencies detailed within the NICE guidelines (2007) their training programmes aimed to develop. This is shown in figure 7. The two competencies that the greatest number of trainers (13 trainers, 62%) attempted to develop were regarding understanding the evidence on the psychological, social, economical and cultural determinants of health, and work in partnership with members of the target population(s) and those with local knowledge. Ten of the trainers (48%) stated that they aimed to enable those completing the training programmes to identify and assess evidence on behaviour change. There were nine trainers (43%) who stated that they aimed to develop competencies in interpreting relevant data on local or national needs and characteristics. The competency that the least number of trainers stated they aimed to address within their programme was to design, implement and evaluate interventions and programmes (6 trainers, 29%).

Figure 7. NICE competencies developed by trainers
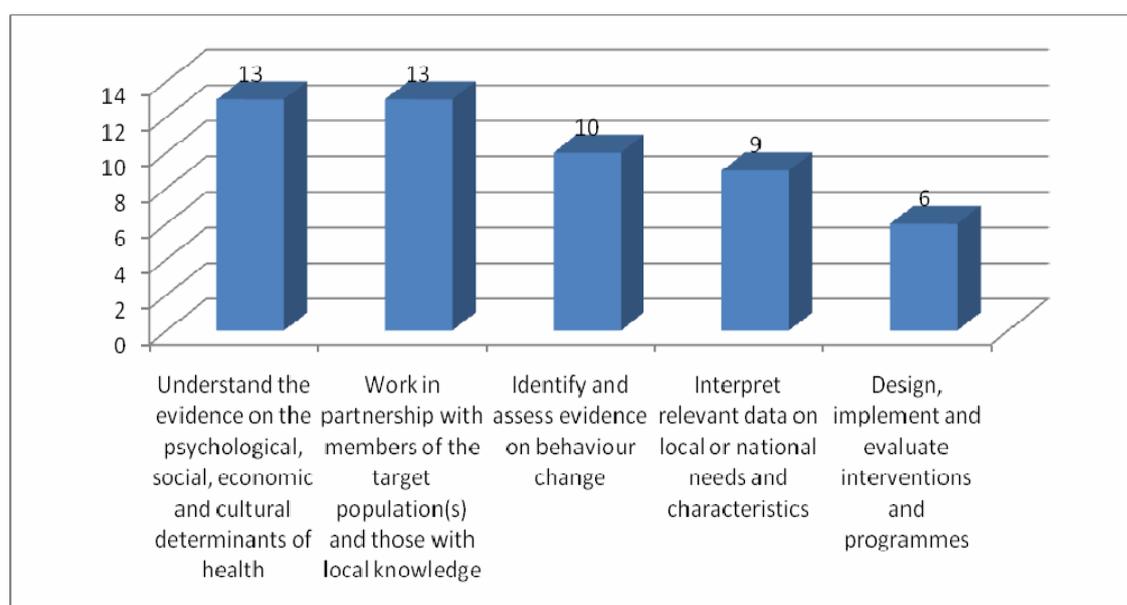
Four trainers (19%) indicated that they used the Public Health Skills and Career Framework to help determine the learning outcomes for the programmes they deliver. When asked to explain how they used the framework one trainer explained that they mapped learning outcomes to it. Two trainers stated that it was the Key Skills Framework that they utilised to determine outcomes for the programmes. One of these trainers listed the Key Skills Framework dimensions on promotional material for the training programmes and another assigned the Key Skills Framework dimensions to training outcomes. One of the trainers specified that they currently used the Key Skills Framework but would cross reference with the Public Health Skills and Career Framework in the future. Three trainers (14%) stated that they were unsure whether or not they used the Public Health Skills and Career Framework

Three trainers stated that they delivered behaviour change training programmes as part of an induction process (14%). In addition, three trainers (14%) stated that they delivered behaviour change training programmes that were mandatory. These programmes were: Core Programme Approach; Foundation Food Hygiene; and Smoking Cessation Brief Intervention Training for Midwives.

Figure 8 below displays the difficulty level of the behaviour change training programmes that were delivered. The greatest number of trainers specified that they provided behaviour change training programmes at a basic level (equivalent to college or high school) (17 trainers, 81%). There were 11 trainers (52%) who stated that they delivered behaviour change training programmes at an intermediate level (equivalent to university under-graduate) and six trainers (27%) who delivered training at an advanced level (equivalent to university post-graduate).

Figure 8. Difficulty level of programmes delivered by trainers
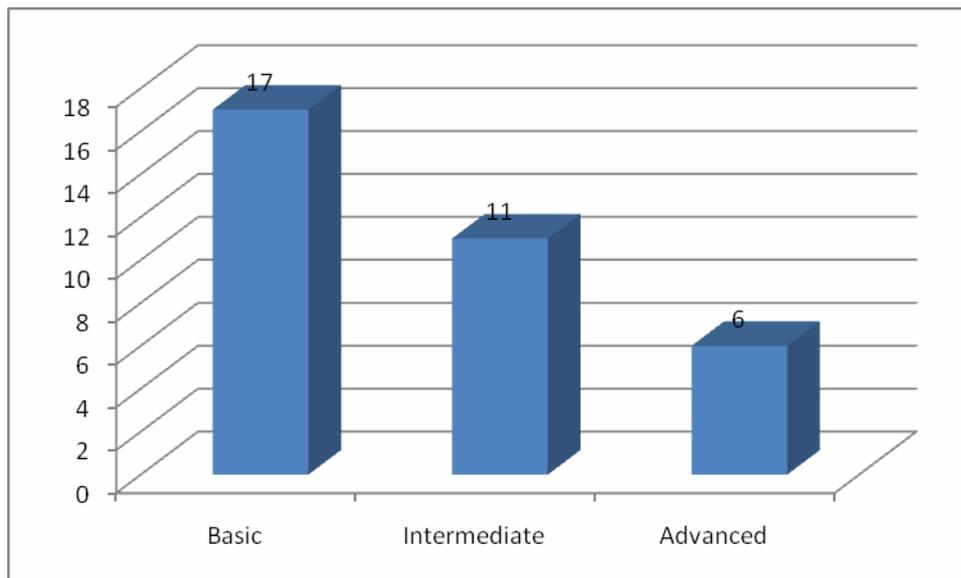
Figure 9 below presents data regarding how frequently the behaviour change training programmes were delivered. The most frequent response was, when requested (10 trainers, 48%), the second most common responses were once a week and once a month (both = 6 trainers, 29%).

Figure 9. How frequently trainers delivered programmes
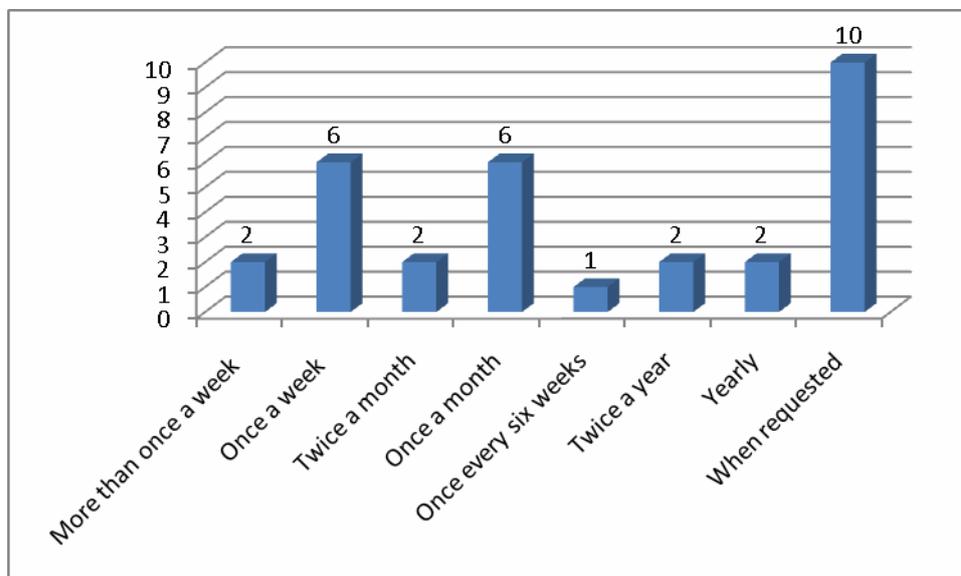
Figure 10 below presents the duration of the behaviour change training programmes. The greatest number of trainers stated that their training programmes typically lasted between one and four hours (8 trainers, 38%). The second highest number of trainers stated that their programmes typically lasted between ten and fourteen hours (6 trainers, 29%). This was followed by five to nine hours (5 trainers, 56%); and 15 hours plus (1 trainer, 5%).

Figure 10. Duration of programmes delivered by trainers
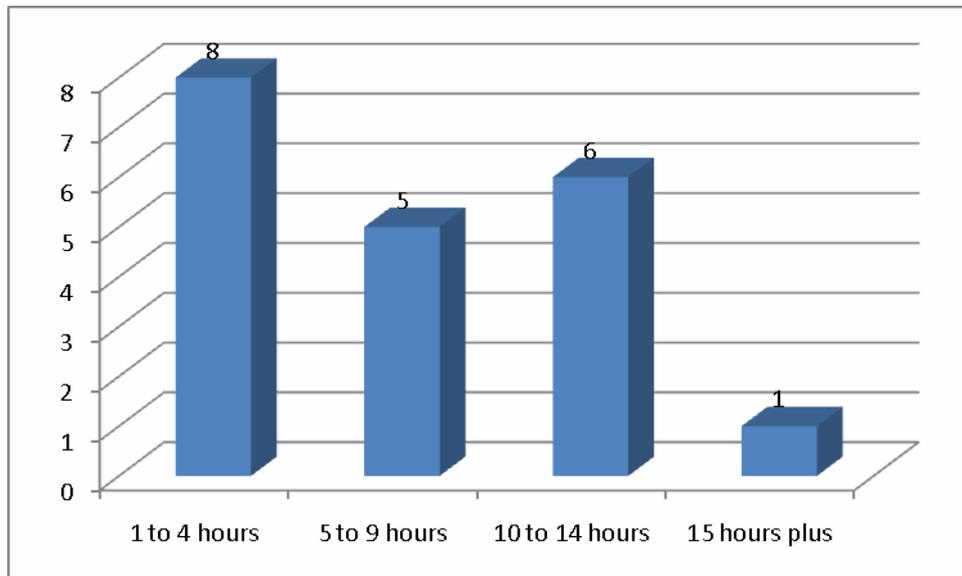
Figure 11 below displays the time of day that training programmes were usually delivered. The greatest number of trainers stated that they usually delivered their programmes in the morning (17 trainers, 81%). Fourteen trainers (67%) stated that they usually delivered programmes in the afternoon; six stated at lunchtime (29%); and three stated in the evening (14%).

Figure 11. Time of day trainers delivered programmes
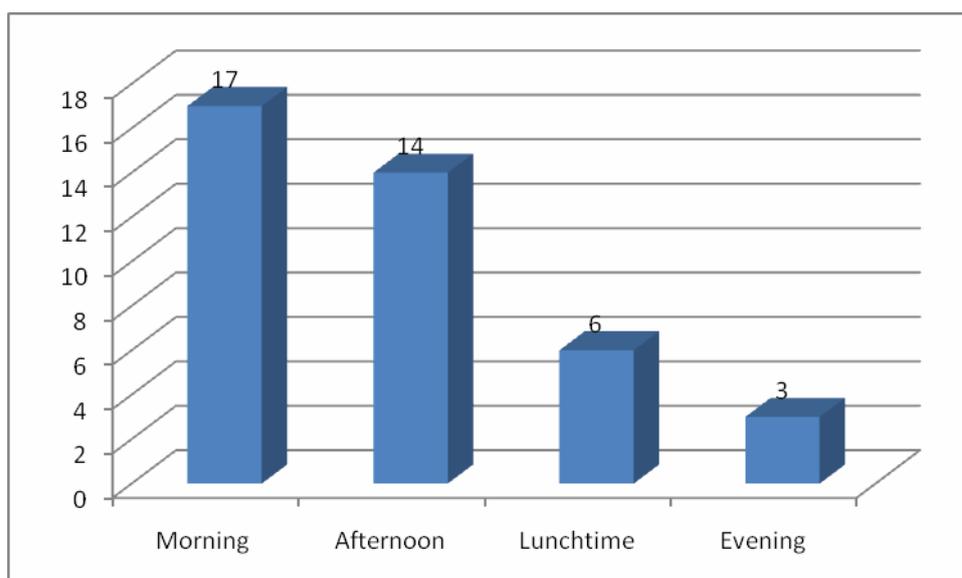
Figure 12 presents data regarding where trainers delivered the training. An equal number of trainers stated that they delivered training within NHS venues as within local authority venues (both = 8 trainers, 38%). There were five trainers who stated that they provided training within the participants' place of work (24%) and four trainers (19%) who stated that they delivered their training within community/voluntary sector venues.

Figure 12. Types of venues trainers used
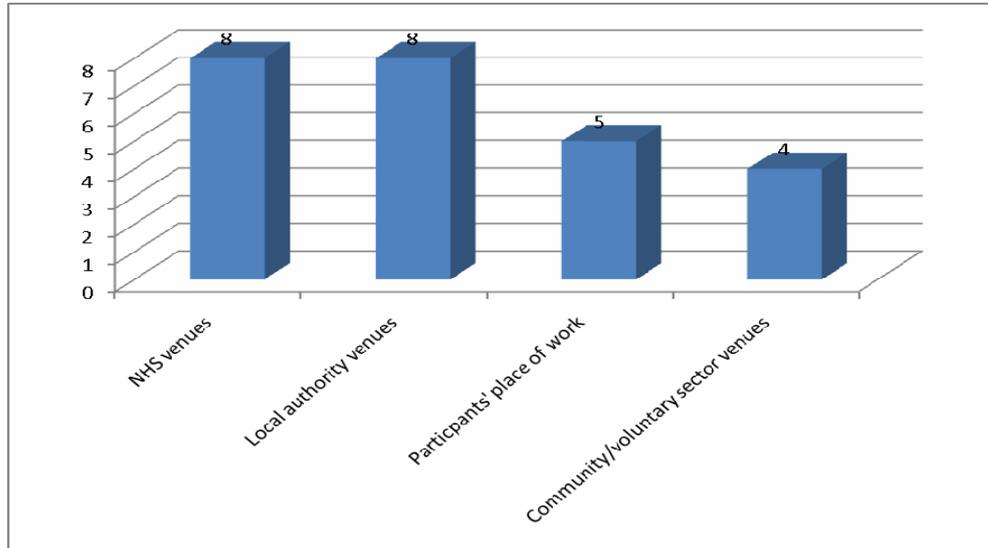
5.2.1 Participants

Trainers were asked to identify the type of organisations that participants were employed by (figure 13). The greatest number of trainers stated the participants of their programmes included those employed by the NHS (19 trainers, 91%). There were 16 trainers (76%) who stated that participants of their training programmes included those employed by the local authority and 16 trainers who stated that participants of their training programmes included those employed within the voluntary/community sectors (76%). Six of the trainers stated that their training programmes included those employed within the private sector (29%).

Figure 13. Types of organisations participants were employed by
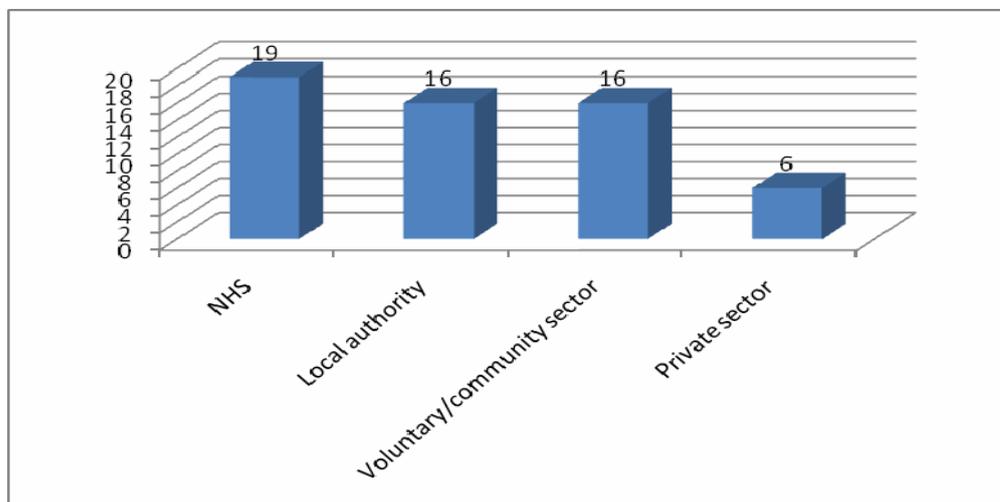
In addition, trainers were asked to specify which groups of staff their training was aimed at (figure 14). The staff group the greatest number of trainers stated that their programmes were aimed at was frontline staff (19 trainers, 91%). This was followed by managers and administrative staff (both = 6 trainers, 29%) and commissioners (1 trainer, 5%).

Figure 14. Groups of staff trainers aimed programmes at
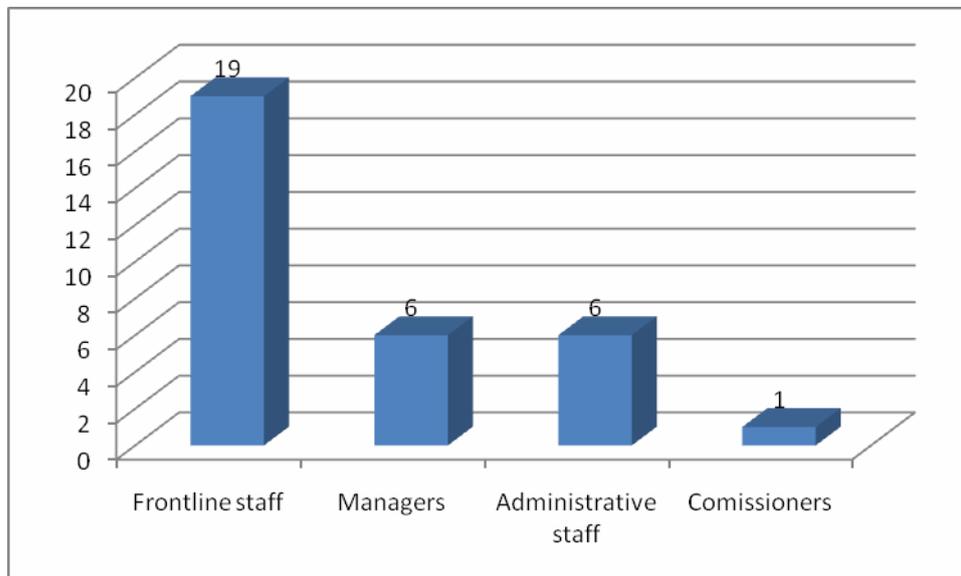
Furthermore, trainers were asked to state the roles that they aimed their programmes at (figure 15). The role that the greatest number of trainers stated their training was aimed at was nurses (16 trainers, 76%). This was followed by health visitors (14 trainers, 67%) and pharmacists (13 trainers, 62%). The roles that the least number of trainers aimed their programmes at were school counsellors (7 trainers, 33%), community wardens (7 trainers, 33%), teachers (6 trainers, 29%) and environmental health officers (3 trainers, 14%).

Figure 15. Roles trainers aimed programmes at
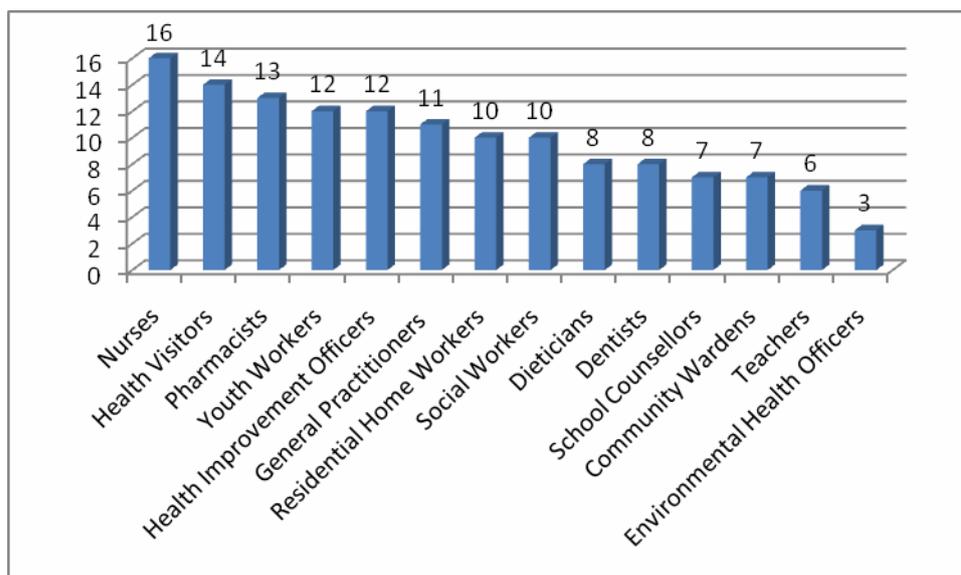
Trainers specified other roles and groups of staff that they aimed their training programmes at:

- adult social care and community services
- breast feeding coordinators
- care assistants
- children and young people's team
- community care practitioners
- community physiotherapists
- community safety teams
- criminal justice teams
- day centre workers
- fire and rescue
- food and health workers
- food handlers
- health trainers
- home care workers
- housing associations
- lifestyle teams
- mental health teams
- midwives
- occupational health nurses
- occupational therapists
- peer mentors
- pharmacy counter staff
- physical activity coordinators
- police
- primary care staff
- sexual health teams
- smoking cessation workers
- speech therapists
- students
- support workers
- volunteers
- workplaces
- YMCA/homeless teams
- young carers' project workers

Trainers were asked to state how many participants usually attended their training programmes (figure 16). The model response was 11 to 15 participants (11 trainers, 52%). Seven of the trainers (33%) stated that between 16 and 20 participants enrolled on their training programmes on average. The remaining categories (i.e. six to ten, 21 to 25 and 35 plus) were each selected by one trainer (5%).

Figure 16. Number of participants enrolled on trainers' programmes
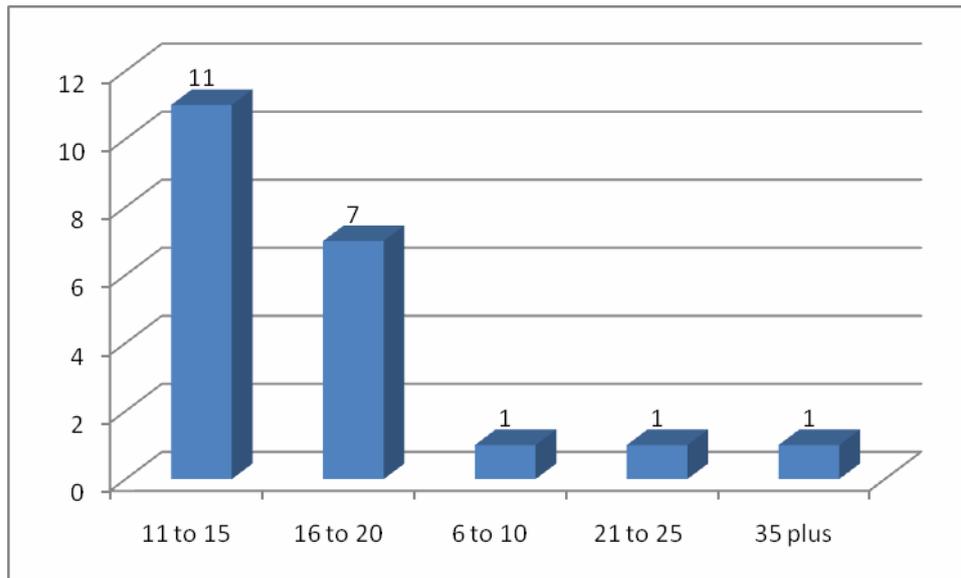
All 21 trainers (100%) stated that between one and three trainers facilitated each training programme. Fifteen of the trainers (71%) stated that they usually made attempts to tailor the behaviour change training programmes to participants' level of knowledge. When asked to provide further details regarding this, five of the trainers (24%) stated that they changed the content of their training according to the role of the participants. Two trainers (10%) stated that the group discussions provided an opportunity for the training to be tailored to the participants' roles. One of the trainers stated that they assessed participants' knowledge prior to training programme and altered the content accordingly.

Five of the trainers (24%) stated that they usually assessed learners' knowledge in advance of the training. Seventeen of the trainers (81%) stated that the participants' occupation was usually taken into account when designing training programmes. When asked to explain how, three of the trainers stated that tasks and tools such as case studies and role-plays were designed to be appropriate for their roles. Four of the trainers stated that they would consider the typical level of knowledge of individuals within the roles that were participating in the training and adapt the content of the training accordingly. One trainer stated that they would ensure all learning styles were accounted for.

Fifteen of the participants (71%) specified that they advertised the training programmes that they delivered (figure 17). The modal source was the PCT training prospectus (5 trainers, 24%). Four trainers used bulletins/newsletters and emails to advertise (19%). There were three trainers who used the organisation's intranet for advertising the programmes. Two trainers used their education and training departments, word of mouth or conferences/meetings. There was one trainer who specified that they used the internet and one who used flyers (5%).

Figure 17. Methods trainers used to advertise programmes
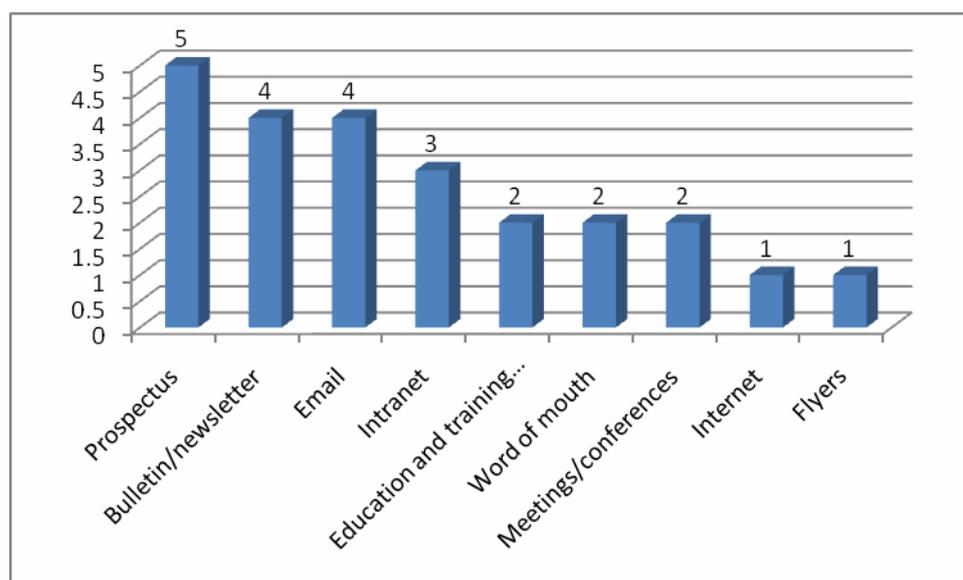
5.2.2 Knowledge and skills of trainers

Trainers were asked to specify the qualifications, skills and knowledge that they believed assisted them to deliver programmes. A wide range of qualifications at a variety of levels were specified. The most frequently cited qualification was teacher training (8 trainers, 38%). This had taken various forms and included qualifications in adult and further education. Seven of the trainers stated that their Masters degree had supported them (33%). The subjects of their Master's degrees included health promotion, applied public health and solution focused brief therapy. Seven trainees also stated that courses regarding behaviour change interventions had assisted their preparation as a trainer (33%). This included training in motivational interviewing, solution focused brief therapy and general behaviour change techniques. The completion of courses and workshops which focused upon behaviour change interventions was mentioned by seven of the trainers (29%). 'Train the trainer' courses were considered by six of the trainers to have assisted them (29%). Topics covered within these programmes were understanding health improvement and motivational interviewing. There were five trainers who specified that their Degrees had assisted them; the subject of their Degrees included assisting professional practice, health promotion, applied biology, and sport and exercise science (24%). Four trainers discussed their Diplomas which were in counselling and environmental health (19%). Furthermore, four trainers mentioned their professional qualifications in nursing, counselling and dietetics (19%). There was one trainer who had a professional doctorate in health psychology which they considered to have supported them to deliver effective behaviour change training.

Eighteen of the trainers stated that their professional experience helped them to deliver effective behaviour change training programmes (86%). Of these, 13 described their experience of delivering behaviour change interventions (62%) and five discussed their experience of training in general (24%).

Five of the trainers stated that their training skills supported them to deliver effective training programmes (24%). This included skills in assessing and designing interesting and effective training programmes; designing and tailoring training that is

appropriate for participants; and managing groups. Other types of skills specified by trainers included interpersonal, communication, counselling and management. One trainer stated that they were open minded which they considered to support the delivery of behaviour change training programmes (5%).

5.2.3 Follow-up support

Sixteen of the trainers (76%) stated that follow-up support was usually provided after the training programme had finished. Of these 16 individuals, ten specified that the training was provided over the telephone (48%); seven provided follow-up support face-to-face (33%) and six stated that their follow-up support was provided by email (29%) (figure 18). An equal number of trainers stated that they provided this follow-up support at structured intervals as those who stated they provided it as and when required (both = 7 trainers, 33%).

Figure 18. Format trainers used to provide follow-up
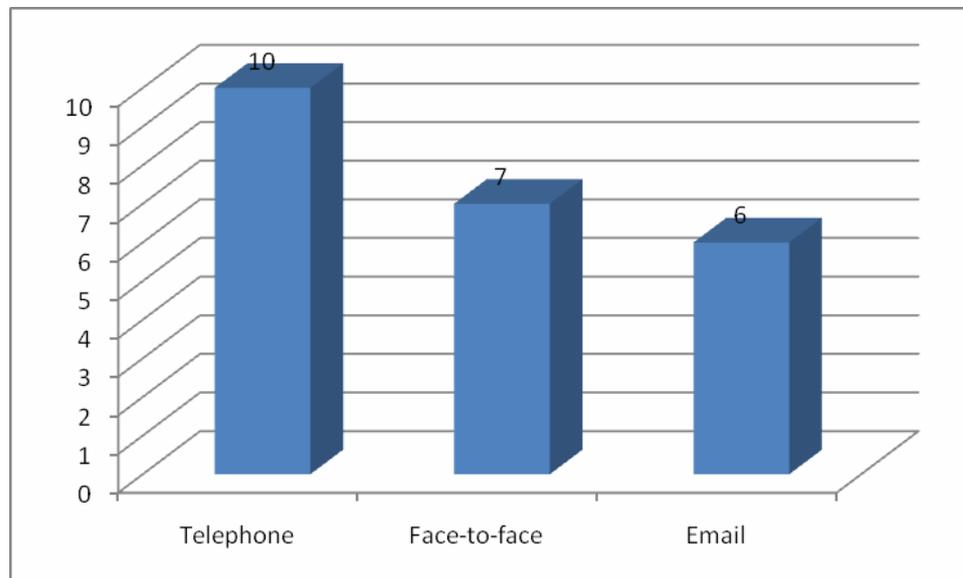
Trainers also reported the approaches they used to provide follow-up support (figure 19). Four trainers (19%) stated that on-site follow-up support was provided. Four trainers (19%) also stated that they provided outreach follow-up support. Three specified that they used peer consultation as a means of follow-up support (14%).

Figure 19. Approaches trainers used to provide follow-up
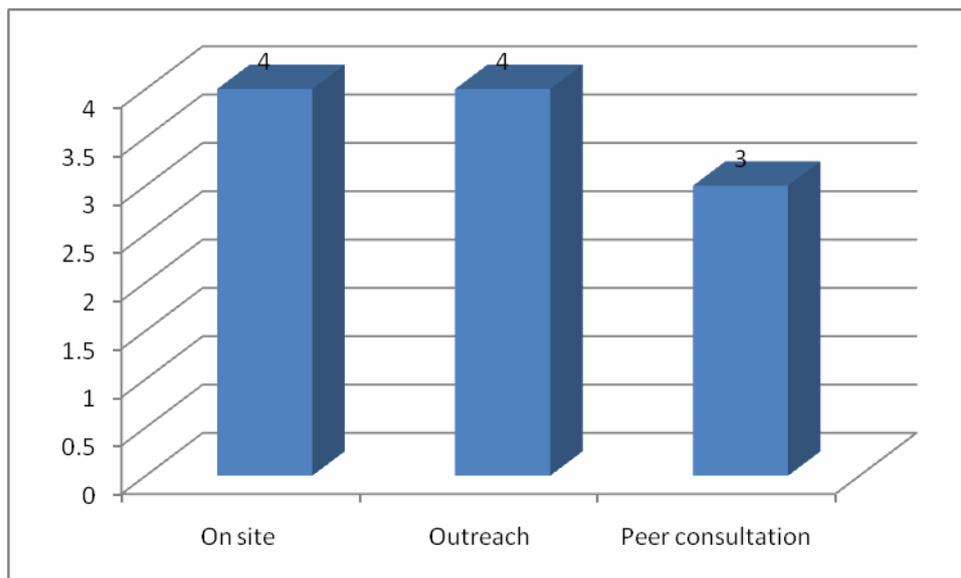
5.2.4 Evaluation

Eighteen of the trainers (86%) stated that they usually evaluated the training programmes that they delivered. Only one of these trainers (5%) stated that this was externally led. All eighteen of the trainers who usually conducted evaluations of their programmes stated that they used the findings to inform future programmes.

Trainers were asked to identify the methods used to evaluate the behaviour change training programmes that they delivered (figure 20). The greatest number of trainers adopted questionnaires as a method of evaluating their programmes (17 trainers, 81%). There were five trainers (24%) who specified that they used focus groups and five (24%) who used individual interviews.

Figure 20. Methods trainers used to evaluate programmes
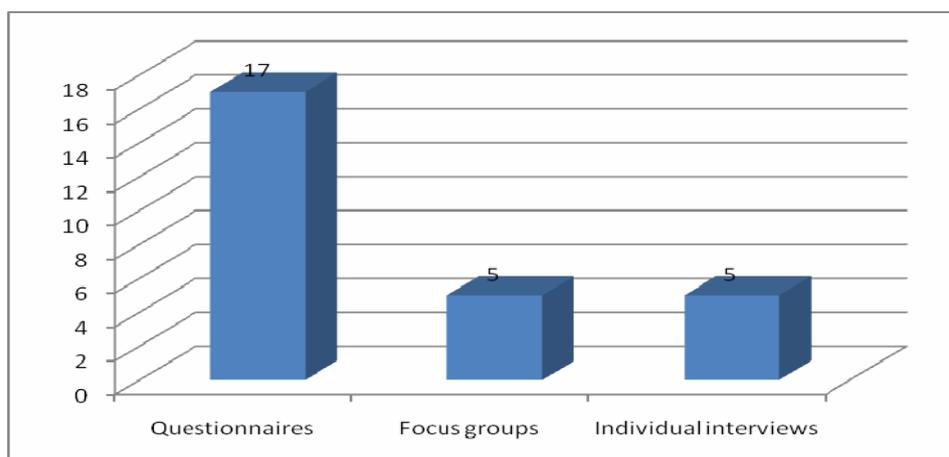
5.2.5 Trainers' perspectives

Trainers provided details of what they perceived to be the most successful aspects of the training programmes. These included the following:

- interactive nature of the training (6 trainers, 29%)
- tailoring of the training to participants' needs (4 trainers, 19%)
- practical nature of the training (4 trainers, 19%)
- approaches taught being easily applied to participants' work (3 trainers, 14%)
- group discussions held between programme participants (3 trainers, 14%)
- evidence based nature of the training (2 trainers, 10%)
- experience of the trainer (2 trainers, 10%)
- experiential elements of the training (such as the use of video examples featuring real clients) (2 trainers, 10%)
- role play (2 trainers, 10%)
- motivating nature of the training (2 trainers, 10%)
- provision of accompanying information (1 trainer, 5%)
- addressing barriers to changing behaviour (1 trainer, 5%)
- client-centred approach (1 trainer, 5%)
- co-facilitating training programmes (1 trainer, 5%)
- discussing communication skills (1 trainer, 5%)
- participants' desire to learn (1 trainer, 5%)
- programmes' ability to engage all (1 trainer, 5%)
- individual attention for participants (1 trainer, 5%)
- interesting format of the programmes (1 trainer, 5%)
- mandatory nature (1 trainer, 5%)
- ability of programmes to raise awareness (1 trainer, 5%)
- inclusion of a range of learning styles (1 trainer, 5%).

Trainers also provided details of the aspects of the behaviour change training programmes that they would like to improve. These included the following:

- follow-up procedures (7 trainers, 33%)
- increase the number of participants (3 trainers, 14%)
- allow more time for interaction (3 trainers, 14%)
- accreditation (2 trainers, 10%).
- inclusion of more models and approaches for behaviour change (2 trainers, 10%)
- trainers receiving more training (2 training, 10%)
- increasing the availability of DVD material (2 trainers, 10%)
- administrative procedures (1 trainer, 5%)
- assessment of learning (1 trainer, 5%)
- using evidence of good practice from other programmes (1 trainer, 5%)
- increasing number of trainers (1 trainer, 5%)
- increasing post-course work (1 trainer, 5%)
- increase pre-course work (1 trainer, 5%)
- making the training more fun (1 trainer, 5%)
- using more innovative exercises (1 trainer, 5%)
- the use of toolkits for frontline staff (1 trainer, 5%)
- the introduction of a framework of good practice (1 trainer, 5%).

5.3 Interview findings

The interviews provided useful insights regarding the commissioning and delivery of behaviour change training across Cheshire and Merseyside. A number of key themes were identified. These were:

- Assisting the commissioning of programmes
- Barriers to commissioning programmes
- Process for commissioning programmes
- Assisting the delivery of programmes
- Barriers to the delivery of programmes
- Mandatory programmes
- Assessing the need for programmes
- Barriers to developing inter-agency programmes
- Assisting the delivery of inter-agency programmes
- Outcomes of inter-agency programmes
- Levels of programmes
- Modes of delivery for programmes
- Overall approach to programmes across organisations
- Participants of programmes
- Use of Public Health Skills and Career Framework
- Types of programmes
- How programmes link into training and development plans
- Using evidence and guidance to inform programmes
- Monitoring and evaluating programmes
- Assessing the quality of the trainers
- Assessing the impact of programmes on participants

A number of sub themes were identified for each of these key themes. Each key theme and sub theme is described below. Quotations are also included for illustrative purposes.

5.3.1 Assisting the commissioning of programmes

Interviewees identified areas that supported the commissioning of behaviour change training programmes within their department or organisation. These included the availability of national, local and professional guidance; commissioners having a good understanding of behaviour change; and working closely with service managers.

5.3.1.1 The availability of guidance

Six interviewees discussed how national guidance informed the commissioning of behaviour change training programmes. In particular, national guidance regarding smoking such as that provided by the Health Development Agency (now part of NICE) was deemed to inform the commissioning process by ensuring it was on the agenda and standardising services and training. Other guidance that was mentioned included the guidance for commissioning behaviour change training developed by the University of Chester (Powell & Thurston, 2008) and NICE guidance regarding behaviour change at population, community and individuals levels (NICE, 2007).

> *"It is always useful when we have either got NICE guidance or there has been some work done either locally or regionally."*

5.3.1.2 Commissioners having a good understanding of behaviour change

One interviewee stated that their understanding of behaviour change programmes supported their ability to successfully commission them.

> *"I think for me, it's about I have got a good understanding about behaviour change."*

5.3.1.3 Commissioners having a good working relationship with service managers

It was stated by one interviewee that their positive working relationship with service managers enabled them to commission appropriate training.

> *"I guess the thing we do in terms of any of our training and development delivery is we work really closely with the managers within our services. So what we tend to do is take our lead from them in terms of the identified needs of the staff group. So where there is a sort of new need or an identified gap within our provision, we will sort of have discussions with them around what is it we need and what does it* [the training] *need to look like."*

5.3.2   Barriers to commissioning programmes

Participants discussed a number of barriers to commissioning behaviour change training programmes, namely; a lack of quality control; the introduction of the 'commissioner and provider split' within PCTs; a lack of resources and a lack of understanding.

5.3.2.1 A lack of quality control

Two interviewees perceived a lack of quality control to be a barrier to commissioning behaviour change training programmes.

> *"What would be really useful I suppose if almost, because potentially you are commissioning in the dark, it would be quite nice to know if people were almost like accredited by you know Department of Health or whoever it might be. So that you knew that the people who were potentially going to commission your training were bona-fide, they do a good job and all those sorts of things because actually there is some recommendation that comes with them."*

5.3.2.2 The introduction of the 'commissioner and provider split' within PCTs

Two interviewees described how the PCTS had only recently divided into provider and commissioner services and therefore systems for commissioning training had not been fully developed.

> *"It is all very new, the training isn't; we have been doing it for donkey's years, but this whole industrial scale type training and the sort of like commissioning people to do it…the whole commissioning spec is very different to how it was done before."*

5.3.2.3 A lack of resources

Two interviewees stated that a lack of resources was a barrier to commissioning in terms of finance and staff members.

> *"It is very much in the resources that we have got, but there is no additional funding, we will have a thousand pounds probably"* [to deliver behaviour change training across the PCT].

5.3.2.4 A lack understanding

One interviewee specifically mentioned a lack of understanding as a barrier to commissioning behaviour change training programmes.

> *"I would say understanding of the need really. I would say at all levels, people delivering, for example practice nurses or health visitors, because they become task orientated with what they have got to do they see behaviour change as an add on rather than part of the role. Then you have got managers that don't have that understanding of the requirement and then us as an organisation perhaps our understanding of what are those needs and how do we commission that, it seems like quite a big task."*

5.3.3 The process for commissioning programmes

Interviewees provided information about the processes for commissioning behaviour change training programmes and services within their organisation/departments. The most frequently occurring sub theme was the informal nature of the commissioning process. Other issues discussed were that behaviour change training programmes were not being commissioned and that internal trainers were frequently used.

5.3.3.1 Informal commissioning processes

Seven of the interviewees discussed how the commissioning processes for behaviour change training programmes used within their organisations were informal. Interviewees stated that they often did not put the training out to tender or invite expressions of interest. There were a number of situations which had led to individuals and organisations being commissioned to deliver behaviour change training including being recommended by other organisations; previously providing services or training; the establishment of a positive working relationship with the commissioners and/or because they were deemed to have provided training successfully in other organisations. In one instance, the interviewee planned to commission a freelance trainer after meeting them at a continuing professional development event.

> *"I met somebody who has delivered it* [behaviour change training] *freelance, well it is much more cost effective than having to develop our own programme. Really, it was just a case of contacting her and setting up a date which was mutually convenient and that was the process really."*

5.3.3.2 Programmes were not commissioned by the PCT

One interviewee highlighted how the PCT did not commission any behaviour change training programmes.

> *"We* [provider services] *are not commissioned by PCT commissioners for any behaviour change training. The training that I do within our team is because I identified personally the need for it and I actually used the generic health promotion budget to provide some training. So my commissioners do not commission behaviour change training from the provider services…It is very short sighted that…they are throwing quite a lot of money at programmes but not actually commissioning training."*

5.3.3.3 Internal trainers were used to deliver programmes

Two of the interviewees specifically stated that behaviour change training programmes were delivered by internal members of staff and were not commissioned.

> *"So at the moment all the behaviour change training is sort of delivered in house."*

5.3.4   Assisting the delivery of programmes

Interviewees discussed issues relating to training programmes' organisation, content and delivery which were considered to assist the success of behaviour change training programmes. In terms of the organisation of the training, interviewees discussed how incorporating training into teams' core work; providing training within staff meetings; holding face-to-face discussions; being well organised by training and development departments and using the 'train the trainer' approach to 'spread the tentacles of behaviour change' assist the successful organisation of behaviour change training programmes.

5.3.4.1 Incorporating training into teams' core work

Three interviewees discussed how behaviour change training programmes were incorporated into the core work of certain teams, particularly those providing smoking cessation and weight management services. One interviewee specified that they were planning to include behaviour change training in their contracts for services.

> *"We are looking at it being in everybody's contracts, so where we commission the hospital to deliver services for us then behaviour change training will be part of that and we will expect people to hit certain targets…and it's the same with our own PCT provider services."*

5.3.4.2 Providing training within staff meetings

One interviewee discussed how they had delivered brief behaviour change training programmes during staff meeting to reduce the need to release staff from clinical duties. Participants could then enrol on more in depth training if required.

> *"We are actually delivering an hour brief intervention training session in team meetings, it sort of gives an overview of key messages around healthy eating and physical activity, and gives an overview of the skills you need to do an effective brief intervention and it's not really meant to give them those skills because you can't do that in an hour obviously, but what I will do in that session is help them to identify whether they have got those skills and if they haven't then I sign post them to other training."*

5.3.4.3 Holding face-to-face discussions

One interviewee described how meeting with individuals from different organisations face-to-face helped to recruit participates to the training programmes.

> *"I think in the end that was just down to me going out and speaking to people you know."*

5.3.4.4 Well organised by training and development departments

One interviewee stated that their training programmes had been successful because their training departments effectively organised the sessions.

> *"People knew what they were coming for, so I would like to think that that was the reason for the success, it was a well thought through and followed a line of development really…Well I think we have a training department that does it's job well…because it is advertising the job that is on offer, it coordinates venues, it coordinates people turning up and people pretty much know what they are coming for."*

Issues identified relating to the content of training programmes included the specific techniques and competencies taught within programmes; the interactive elements of the training; basing the training on issues identified as priority areas and ensuring training is not too complicated. These issues were all considered to support the provision of successful behaviour change training programmes.

5.3.4.5 Specific techniques and competencies taught within programmes

Three interviewees stressed the effectiveness of specific techniques and competencies taught within the training programmes. Participants stated that teaching techniques and competencies for overcoming the barriers to behaviour change; considering the responsibilities of clients; reflection and listening were particularly successful.

> *"I think mainly the most successful* [aspect] *seems to be the communication techniques that have been used that link into the behavioural change. We look at things like closed questions and open questions, communication techniques. So they seem quite successful."*

5.3.4.6 Interactive elements of the training

Two of the interviewees specified that the interactive aspects of the training were particularly successful.

> *"Sometimes I can set little group tasks so that might help to explain it. So rather than focussing on behaviour change in relation to the smoking, I might get them to think of their own behaviour, that is probably not in relation to smoking, that they might want to change. So I suppose really the thing is to use lots of different tools and activities, if I have got the time, to make it a little bit more interesting and a bit more interactive."*

5.3.4.7 Basing the training on issues identified as priority areas

One trainer noted that basing the training on an area identified as being a national or local priority was beneficial.

> *"I think alcohol is very high on the agenda at the moment…So I think the smart thing is to offer the training in something that is very much flavour of the month."*

5.3.4.8 Design programmes that are not too complicated

One trainer specified that they deemed it necessary to ensure that the training was not too complicated to reflect the simple nature of delivering brief interventions and brief advice.

> *"So I think trying not to make it too complicated is the key really because for them* [participants] *to be able to use it in the time that I am saying offering a brief intervention or advice can be done in, then obviously that is one of the main areas that I am conscious of."*

5.3.4.9 Matching training to participants' requirements

It was noted by two interviewees that training programmes are more successful if they are matched to participants' needs.

> *"I think some of it is making sure you have matched the right people to the delivery."*

Interviewees discussed a number of issues that they consider to assist the successful delivery of behaviour change training programmes. These included the knowledge and experience of the trainer; adopting a consistent approach to training; delivering the training on-site; adopting an informal approach to training and the ability of the trainer to successfully promote the importance of behaviour change.

5.3.4.10 Experience of the trainer

Five interviewees specified that the experience and knowledge of the trainer were key to the success of the programme/s. In particular, they explained that it was useful if trainers could draw on personal experience of delivering behaviour change training programmes.

> *"I think you need someone here who has experience of actually dealing with patients and people and who has actually done the job, has an understanding because then you bring in experience into the classroom…I was drawing on personal experience."*

5.3.4.11 A consistent approach to training

A consistent approach to training was specifically mentioned by four of the interviewees. For some of the interviewees this included a standardised package that all trainers within the team could use to deliver training. In addition, two interviewees highlighted that their model of behaviour change training included *"Choosing Health Cards"*. One card has been developed for each of the six priority areas specified within the *Choosing Health* white paper (DH, 2004). The cards included background information, key health messages and information about where clients can be referred to. The reverse of the card includes a public health topic relevant tool for working with the client. Other interviewees discussed how trainers within their team or department used the same theoretical model including the transtheoretical stages of change model and the FRAMES Model[4]. One interviewee also stated that the use of the same trainer or trainee enhances consistency.

> *"It is the fact that there is a consistent approach across* [geographical area]*, you are not saying it's the only model or the best model but it's the model that we use."*

5.3.4.12 On-site training

The provision of on-site training (i.e. training delivered at participants' place of work) was considered by two of the interviewees to contribute to the success of the training programmes by removing barriers to participation.

> *"We have got a team of trainers now who can deliver on-site, I think that is the big benefit we have had. If we are saying that a barrier is people getting out to and attending training then having people attending training and delivering on site is a useful way of dealing with that."*

5.3.4.13 Informal approach to training

One of the interviewees specified that adopting an informal approach to training was beneficial.

> *"They* [participants] *like the fact that it's informal, it's usually held in a community centre and I think the fact that lunch is provided helps. We just have a couple of objectives and it's a mixture of group discussion and taught sessions as well. I mean like sometimes I use PowerPoint but the other day it was in the kitchen of a voluntary community centre that's held in a café with a group of volunteers, some of which have mental health issues themselves, and I didn't even do a formal presentation. I just did it as a sit down chat and I went through the programme but did it really informally because that is what works."*

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[4] **F**eedback; **R**esponsibility; **A**dvice; **M**enu; **E**mpathy; **S**elf-Efficacy

5.3.4.14 Successfully promoting the importance of behaviour change interventions

One of the interviewees stressed the importance of the ability of the trainer to successfully promote the importance of behaviour change interventions to participants.

> *"I think there has to be a selling of the behaviour change agenda to encourage people to commit to it and I think that is fundamental to it really and a belief that it works, that it makes a difference!"*

5.3.5   Barriers to the delivery of programmes

The barrier to the delivery of behaviour change training that was discussed most frequently by interviewees was staff being released from their day-to-day duties to participate in the training. Other barriers discussed by interviewees included capacity to deliver; a failure to realise the importance of behaviour change; staff being bombarded with similar training and the need to provide training to a high number of staff.

5.3.5.1 Releasing staff from day-to-day duties

Six of the 11 interviewees stressed the difficulties they experienced in securing the release of staff from their day-to-day duties in order to attend the training. This was considered to be a particular problem for nursing staff.

> *"We have found sometimes if we put training on and 15 people may have booked on but actually they don't all turn up because work pressures have meant that they then can't be released to attend that training."*

5.3.5.2 Lack of capacity to deliver training

Three of the interviewees explained that they had a limited capacity to deliver behaviour change training programmes. One of the interviewees stated that they had to temporarily stop delivering generic behaviour change training because they did not have sufficient numbers of staff to deliver it, as they were not specifically commissioned to do so.

> *"As I say there was general behaviour change training going on up until a couple of months ago… but owing to pressure of work and everything and the fact that we weren't actually commissioned for that, that has stopped and will happen again but once we have got more capacity."*

5.3.5.3 A failure to realise the importance of behaviour change interventions

Three of the interviews described how individuals such as managers and frontline staff did not realise the importance of behaviour change interventions and therefore did not deem it important for them or members of their teams to participate in behaviour change training.

> *"Maybe sometimes people don't see it* [behaviour change training]
> *as necessary for their staff."*

5.3.5.4 Staff bombarded with similar training

Two of the trainers stated that staff were bombarded with similar training opportunities regarding behaviour change. Often these training programmes would be based upon a different public health topic but would include similar information about behaviour change interventions.

> *"I think the trouble with this sort of training is they are getting bombarded with this sort of training at the moment. There is cardiovascular disease training going on, there is obesity training going on, all separate you know to behaviour change training and we are all competing for the same people and that does make it difficult."*

5.3.5.5 Need to provide training to a high number of staff

Interviewees stressed the large scale of the task of training all frontline staff in behaviour change interventions.

> *"It's* [behaviour change training] *only been on a very small size up to now but we have got to look at this industrial scale that everyone is talking about."*

5.3.6 Mandatory programmes

Interviewees were asked about mandatory behaviour change training programmes within their department/organisation. Six interviewees were able to provide some examples of mandatory training programmes that they considered to include aspects of behaviour change. Other themes identified were that behaviour change training programmes were not mandatory; that it would be beneficial to introduce mandatory behaviour change training programmes; and that interviewees had plans to introduce mandatory behaviour change training programmes in the future.

5.3.6.1 Mandatory training considered to include aspects of behaviour change

No examples of mandatory training programmes provided to the general workforce that were explicitly described as behaviour change training programmes could be identified. Those providing specialised services (such as smoking cessation services) would be required to complete some form of behaviour change training. Six interviewees provided examples of mandatory training delivered within their organisation that they considered to include aspects of behaviour change. These training programmes were concerning conflict resolution, negotiation, health action planning and raising awareness of public health messages.

> *"I think like negotiation, conflict resolution is relevant* [to behaviour change training]*."*

5.3.6.2 Plans for programmes to be part of the induction process

No examples were found of organisations that explicitly included behaviour change training as part of an induction process. Two interviewees did however state that they had plans to introduce behaviour change training as part of the inductory processes.

> *"I have just met with training* [representatives from training and development departments] *actually a couple of weeks ago to try and get health improvement generally on their radar but it feels like there is so much in the induction for PCT staff, the real corporate stuff, they feel as though they can't really take on anymore material. They have offered for health improvement to be one of a range of options offered to people and behaviour change will be part of that. So the way I envisaged it was rather than put on a day about mental health, a day on about suicide, have one day about health improvement. Health improvement being everybody's business and within that have a session on behavioural change."*

5.3.7 Assessing the need for programmes

Only two examples were provided of formal assessments of training needs in relation to behaviour change taking place. A reoccurring sub theme within the interviews was that training was determined by national and local strategies, and priorities rather than an assessment of need. In addition, interviewees felt they had identified a need for behaviour change training from observing the success of such training in other organisations.

5.3.7.1 Need for programmes determined by national and local strategies and professional guidance

Four of the interviewees described how decisions about what form of behaviour change training was required were informed by local and national strategies and professional guidance. This included the NICE guidance, smoking cessation guidance and the *Choosing Health* white paper. Interviewees also discussed how local strategies and guidance informed decisions about what training was required including the University of Chester commissioning guidance for behaviour change and local heart and obesity strategies.

> *"Well we sort of use NICE guidance to look at what we need to do. We have also looked at ChaMPs to look at some of the work that they have done."*

5.3.7.2 Formal assessment of need for behaviour change training

Two of the interviewees specified that they conducted some form of assessment of need regarding behaviour change training programmes.

> *"I did a needs assessment or a scoping exercise of our front line staff to ask them what they felt about the Choosing Health report and how they felt about delivering the messages that were asked of them. I was commissioned to do the needs assessment."*

5.3.7.3 Observing how programmes had worked in other organisations

Two of the interviewees stated that they had observed how behaviour change training had successfully been established within other organisations and that this had lead them to believe that it would also be beneficial to provide behaviour change training within their department/organisation.

> *"It's because in a previous existence, I did behaviour change training myself... and I it was a bit of a personal agenda I guess you could say. I recognised the benefits of it and I also recognised how other people value it and I am not in a position to do any training anymore. So we started doing it from within the resource of the general health promotion team."*

5.3.8   Barriers to developing inter-agency programmes

5.3.8.1 A lack of communication between organisations

Two interviewees stated that a lack of communication between organisations acted as a barrier for joint working.

> *"Just communications really, when it comes to setting up courses or getting the information out there it's still a struggle. Just trying to broaden the reach really can be quite difficult sometimes. It always seems to be a problem no matter what you do. That is the main thing I think."*

5.3.8.2 A lack of capacity

One of the interviewees perceived limited capacity and resources to act as a barrier to joint delivery or joint commissioning of behaviour change training programmes.

> *"No I mean there is a willingness over here, I just think there is always a capacity issue. "*

5.3.8.3 A lack of interest

One of the interviewees considered some groups of individuals to be uninterested in behaviour change training because they did not consider behaviour change to be part of their remit.

> *"I think the difficulty we have is there are always going to be some people who won't see it* [behaviour change interventions] *as relevant to them and if we just keep beating the drum at every opportunity, people who want to see the connection will see the connection and open up for training but there is always going to be a segment of people, regardless of what you do, who won't be interested."*

5.3.9   Assisting the development of inter-agency programmes

A number of suggestions were made regarding what assists organisations to work together regarding behaviour change training programmes. These included the

restructuring of Cheshire local authorities, joint training and development departments, a commitment to partnership working and seconding staff from other organisations.

5.3.9.1 Restructuring of Cheshire local authorities

Three interviewees stated that the restructuring of the local authorities in Cheshire, which occurred on the 1st April 2009, would provide an enhanced opportunity for joint working regarding behaviour change training. They considered that it would provide an opportunity for enhanced communication and to establish new agendas. One interviewee discussed plans for a joint health unit between the PCT and local authority.

> *"We have just got a new local authority today, we are hoping to develop a new health unit which will then, very much I think, open up avenues for doing joint working with the local authority. At the moment it's an aspiration but it is something that, certainly conversations have taken place with senior officers of the new Cheshire West and Cheshire local authority and ourselves about developing a unit whereby you would have an officer leading on health and wellbeing from the local authority sitting alongside probably people with health promotion skills from our end. It's just about you know making sense that people working on a similar agenda are actually working much more closely together."*

5.3.9.2 The establishment of joint training and development departments

One of the interviewees discussed the benefits of having a joint training and development department between the PCT and local authority.

> *"I mean they* [local authority staff] *come on our training. The workforce development department is joint PCT and social care, it is an integrated service."*

5.3.9.3 A commitment to partnership working

One of the interviewees perceived their success in including other organisations in the behaviour change training that they delivered to be a result of the commitment from senior staff to partnership working.

> *"We have got a firm commitment to partnership working at the very top of the PCT. My opinion is it is not lip service, it is actually a good partnership…Our Director of Public Health sits in the local authority, actually has an office base within local authority as well as the PCT....* [Senior members of staff] *have done a great deal to drive that* [partnership working] *through and I think it has penetrated."*

5.3.9.4 Seconding staff from other organisations

One interviewee described how she had been seconded from the local authority to the PCT and therefore she had developed positive working relationships with colleagues from local authorities that she could use to develop effective working partnerships.

> *"I think it is partly we have just been fortunate because* [name of colleague] *and I are on a secondment, we actually know a lot of people outside the PCT. So I think that has helped really."*

5.3.10 Outcomes of joint working

Two themes were identified regarding the outcomes of joint working in relation to behaviour change training programmes, namely; opportunities for inter-professional learning and increasing opportunities to deliver health messages.

5.3.10.1 Opportunities for inter-professional learning

Three interviewees stated that the use of trainers from different organisations provides participants with alternative approaches to conducting behaviour change interventions and opportunities for inter-professional learning.

> *"It gives a slightly different handle on things, it just highlights opportunities and just down to something like different approaches."*

5.3.10.2 Increasing opportunities to deliver health messages

Two interviewees stated that providing behaviour change training jointly across different organisations enhances opportunities for delivering health messages.

> *"Well, I suppose getting as many people, as many front-liners as possible, to deliver the key messages to people in* [geographical area]*. We need an army out there really as of people on the ground delivering the messages and if they can do it effectively then that's great."*

5.3.11 Levels of programmes

The most common level of behaviour change training programme identified by the interviewees was basic, followed by intermediate and advanced. Two interviewees stated that they adapted the level of the programme according to the participants.

5.3.11.1 Basic level programmes

Four interviewees stated that the behaviour change training programmes commissioned by or delivered within their organisation were at a basic level.

> *"They* [behaviour change training programmes] *all tend to be the same, I would say they are basic...they are just giving basic skills really."*

5.3.11.2 Intermediate level programmes

Two of the interviewees stated that the training programmes within their organisations were generally of an intermediate level.

> *"In terms of the behavioural change...I think the 'train the trainer' would be more intermediate level, because staff that have been taking part in it will already have awareness and should already be*

taking part in brief advice and interventions. So it is more about the motivational interviewing and how do you actually comfortably engage people, once you have got them in to the service, how do you interview them in the most appropriate way to achieve your shared goal?"

5.3.11.3 Advanced level programmes

Only one interviewee stated that there were advanced behaviour change training programmes being delivered within their organisation. These were completed by those providing specialist services such as smoking cessation and weight management services.

> *"If you take our stop smoking advisors, who are specialists, they have been on the advanced training but that is very small core group."*

5.3.11.4 Level of the programme was adapted to participants

Two of the interviewees stated that they adapted the level of the training programmes according to the participants.

> *"What tends to happen is they* [the behaviour change training programmes] *probably wouldn't be labelled like that but what tends to happen is, if we had lets say a particular group of staff who have requested behaviour change training of some kind, then what we will do is adapt the training to meet the needs of that particular group of people. So it's not necessarily advertised as this is level one, two or three we tend to work with the organisation or the team or whatever to see how much they need, what have they already done? It* [the level] *can potentially vary."*

5.3.12 Modes of delivery for programmes

The majority of the interviewees stated that the behaviour change training programmes took place face-to-face within their department/organisation. A number of interviewees also stated that e-learning packages regarding behaviour change were available.

5.3.12.1 Face-to-face programmes

All of the eleven interviewees stated that the training programmes took place face-to-face. They described the format as a 'classroom style' and there were usually between five and 20 participants in a group. A number of the interviewees stated that participants enjoyed the face-to-face format of the training.

> *"In general it's face-to-face because I think that is what participants enjoy."*

5.3.12.2 E-learning programmes

Five of the interviewees stated that behaviour change e-learning packages were available to their staff. For some, behaviour change was only a small element of the training. Some interviewees reported that the take-up of the e-learning packages was low. However, one interviewee specified that e-learning packages were popular with staff members from the local authority and voluntary sector.

> *"We are looking at extending the e-learning side of things because, although it hasn't been particularly popular within the PCT, people from other organisations have said that they would welcome e-learning."*

5.3.13 Overall approach to programmes across organisations

A number of interviewees discussed the overall approach to behaviour change training across their organisation. Four interviewees stated that there was a lack of awareness of other behaviour change training programmes being delivered across their organisation. Other themes identified were a lack of a coordinated approach; a lack of behaviour change training programmes being delivered; the use of meetings to develop a coordinated approach to training; and the need for a North-West strategy for behaviour change training.

5.3.13.1 A lack of awareness of other programmes being delivered across organisations

Four of the interviewees described how they were unaware of other behaviour change training programmes being delivered across their organisation. Some of the interviewees were unsure of the details of the behaviour change training programmes that were being delivered within their own team.

> *"I would like to see the results of this myself because I am not sure what else is happening really. I don't know what the public health team are doing really, I think the smoking team are but other than that I don't really know what else is happening…that is the unfortunate thing really because no one has got that overview of what everyone else is doing which is a shame really isn't it."*

One interviewee described how staff were aware of the range of behaviour change training programmes being delivered across their organisation. Training programmes used the same theoretical models of behaviour change and efforts were made to ensure that that there was no unnecessary overlap. This was considered to be a result of senior staff members' coordinated approach and the work of the training and development department.

> *"[Senior staff] made sure they led on the training and knew who else was delivering training. So it was just part of the development of the training programme really and the training department had a role in that too because obviously, if they are sending out training PCT wide, you are quite easily alerted to overlap."*

5.3.13.2 Uncoordinated approach to training

One of the interviewees stressed how they considered the approach to behaviour change training to be uncoordinated. They stated that behaviour change training was usually considered separately for each public health topic area rather than considering the provision of generic behaviour change training. Although only one interviewee specifically stated that this was the case, this appeared to be the situation across a number of PCTs.

> *"Barriers are just capacity to actually be more systematic in the commissioning. We don't have a specific lead around workforce development or behaviour change programmes. So that's why it tends to be picked up, you know if we are looking at a specific topic, it tends to get picked up in that way rather than looking at it globally…Its worked okay to date but we are certainly getting to a point where we need to relook at it because obviously there are a core set of skills there that can be used for different topic areas and my belief that instead of expecting people to go on brief intervention training around alcohol and then one on smoking and then one on weight management, there are a core set of skills there that we can give people and then give them specifics around those topic areas in whatever format that might be…I think you have probably gathered from this conversation that we need to have a much more comprehensive approach locally to what behaviour change training programmes we want to see happen and how we are going to commission that and how we are going to make the links between the different topic areas."*

5.3.13.3 A general lack of programmes

Two of the interviewees perceived there to be a lack of behaviour change training programmes being delivered within their organisation.

> *"If I am truthful I don't think there is a lot* [of behaviour change training] *going on."*

5.3.13.4 Meetings held to develop a coordinated approach to programmes

Two of the interviewees described how they had set up meetings in an attempt to develop a more coordinated approach to behaviour change training.

> *"Well one of the things that we are about to do that we have been trying to get to for a little while, we have got a meeting scheduled to look with the PCT more strategically in the way we are approaching training."*

5.3.13.5 Development of a North-West strategy for programmes

One of the interviewees stated that it would be useful if behaviour change training was coordinated across the north-west of England. They stated that the Strategic Health Authority could lead the development of this strategy and that ChaMPs could have a key role in learning development. He suggested that each training and development department within the NHS could deliver the training and that is should

be made available to staff employed by the NHS, local authorities and within the voluntary/community sector.

> *"How do you tackle that agenda? Should we have every education and training organisations within the NHS delivering these* [behaviour change training programmes] *and it doesn't matter whether you work in primary care, you work in a hospital or a third sector organisation, you should be able to access that if you are delivering a health kind of related service and again social care as well."*

5.3.14 Participants of programmes

A large proportion of the interviewees stated that participants of their training programmes included those employed by the NHS. Other groups participating in the training programmes included those employed within the voluntary/community sector; all front line staff; those employed by the local authority and those who requested training. In addition, there was a lack of knowledge about who specifically the training should be aimed at within the local authority and voluntary/community sectors.

5.3.14.1 Participants employed by the NHS

Eight of the 11 interviewees stated that staff employed by the NHS participated in their training. Examples of participants included:
- physiotherapists
- occupational therapists
- cardio-rehabilitation therapists
- stroke therapists
- respiratory therapists
- intermediate care staff
- district nurses
- practice nurses
- general practitioners
- health care assistant
- paediatricians
- community pharmacists
- pharmacy counter staff
- health visitors
- stop smoking advisors
- paramedics
- walk in centre staff
- dental nurses
- receptionists
- midwifes
- community matrons
- mental health support workers

5.3.14.2 Participants employed within the voluntary/community sector

Six of the participants stated that participants of their behaviour change training programmes included those employed by or who volunteered within the voluntary/community sector. A number of interviewees were able to provide examples of these roles. These included:

- wardens
- council for voluntary service staff
- citizens advice bureau workers
- youth workers
- Homestart volunteers
- community housing workers

Some of the interviewees were unable to state the roles of participants who were employed by or volunteered within the voluntary/community sector but were able to provide the names of their organisations. These were:

- Richmond Fellowship (national provider of mental health care with regional offices)
- Victoria Community Care (based in Prescott)
- Personal Social Services (PSS) (works across Merseyside)
- YMCA

5.3.14.3 All front line staff participated in programmes

Seven of the interviewees stated that all front line staff were able to participate in the behaviour change training that their organisation provided or commissioned. Although many interviewees stressed this point, they were not always able to identify what type of roles within the voluntary/community sector or local authority this included.

> *"Our aim is that all front line staff within our sort of NHS organisations, the local authority and we would like to include third sector so they are included if you like, so we can have lots of people providing services."*

5.3.14.4 Participants employed within local authorities

Six of the interviewees stated that individuals employed by local authorities attended their training. They provided the following examples of the roles that this included:

- housing workers
- job centre staff
- Sure Start/Children's Centre staff
- leisure centre staff
- librarians
- social workers
- one stop shop staff
- learning and development officers
- nursery nurses
- youth workers
- home care staff
- children's health promotion workers
- environmental health officers community wardens
- police officers
- fire officers

5.3.14.5 Training provided to those who requested it

Four of the interviewees specified that training was provided to all those who requested it. This was frequently the way in which training was provided to the voluntary/community sector.

> "So we advertise it, we tend to do that more on a request basis so we might get environmental services asking for it or Homestart have it as part of a rolling programme."

5.3.14.6 Lack of knowledge about roles within local authorities and the voluntary/community sector

Despite interviewees stating that they provided training to the voluntary/community sector and local authorities, some interviewees struggled to identify which specific roles should be targeted to receive the training. Two interviewees specifically stated that they lacked this knowledge.

> "Like I say, the voluntary and third sector, I am probably not familiar with, so that might be an area that I am working on but it's the area that is probably the hardest to reach and who probably needs it the most really, when I think about it, you know, it can be a bit frustrating."

5.3.15 Use of the Public Health Skills and Career Framework

Interviewees were asked about their use of the Public Health Skills and Career Framework. Key themes were that it was used internally only, that it was not user friendly and that it was considered to be a tick box exercise.

5.3.15.1 Public Health Skills and Career Framework used internally

The majority of the interviewees stated that they did not use the Public Health Skills and Career Framework as a tool to assess staff competencies in order to determine training requirements. Three of the interviewees specified that they used the Public Health Skills and Careers Framework internally as part of staff members' professional development.

> "In terms of my own staff…I sort of use it as part of the PDR [Professional Development and Review] process."

5.3.15.2 The Public Health Skills and Career Framework is not user friendly

One of the interviewees stated that they did not use the Public Health Skills and Career Framework with the wider public health workforce because it was not deemed appropriate nor user friendly.

> "The framework isn't easy and if you are trying to work with the wider public health force and maybe colleagues in local authority or community and voluntary sector, they do not see that framework as user friendly and applicable to them. So there is a conscious effort not to use, we decided that we wouldn't use it."

5.3.16 Types of programmes

Examples were provided of generic behaviour change training programmes as well as training programmes that focused upon smoking cessation, alcohol, weight management and illegal substances. Examples of training programmes that may incorporate some elements of behaviour change theory or practice without explicitly being identified as behaviour change training programmes were also highlighted. There may well be other behaviour change training programmes being delivered within or commissioned that interviewees were not aware of.

5.3.16.1 Generic programmes

Three interviewees described generic behaviour change training programmes that were delivered within their organisations. However, one of these interviewees stated that the training had temporality ceased due to lack of capacity.

> *"As I say there was general behaviour change training going on up until a couple of months ago, so that was based on the helping people change core model but owing to pressure of work and everything and the fact that we weren't actually commissioned for that, that has stopped. It will happen again but once we have got more capacity."*

5.3.16.2 Smoking cessation programmes

Three interviewees specified that behaviour change training in relation to smoking cessation was being delivered within their organisations.

> *"We do some specific behaviour change training around smoking."*

5.3.16.3 Alcohol programmes

Two of the interviewees specified that behaviour change training programmes regarding alcohol were provided.

> *"We do within our team provide some specific behaviour change training around alcohol."*

5.3.16.4 Weight management programmes

Three interviewees identified their organisation as delivering or commissioning weight management behaviour change training programmes.

> *"The community weight management team conducts training but it is not as formalised and is ad hoc."*

5.3.16.5 Illegal substances programmes

One interviewee stated that their organisation provided behaviour change training programmes in relation to illegal substances.

> *"…the drugs and alcohol brief interventions, those types of things, what we did up until this year is we have commissioned an organisation from Liverpool called Health Wise…now that's actually*

finished this year and the only reason we have stopped using them is, we were actually really pleased with the work they did, was because our own drug action team have now got a programme up and running and have given us access to that."

5.3.16.6 Programmes that included an element of behaviour change

Two of the interviewees stated that they provided training that had not formally been described as behaviour change training but that included elements of behaviour change theory or practice.

"It's one of those things that isn't sort of prescription[ly] *mentioned but it sort of underlies a lot of the principles in terms of, there is elements in there around the management of performance and coaching skills and various other things and that all gets interwoven with behaviour change really in terms of positive ways of encouraging your staff as a manager."*

5.3.17 How programmes link into training and development plans

Six of the interviewees stated that their organisations' training plans incorporated behaviour change but others did not. Other themes identified were difficulties experienced with training and development departments; competing against clinical priorities and the development of a public health training plan.

5.3.17.1 Organisations' training plans incorporate behaviour change

Six of the interviewees stated that their organisations' training plan included behaviour change training. However, when questioned further, they were often referring to the inclusion of behaviour change training within the training and development prospectus which lists available training programmes rather than any detailed structured plans. Many of the interviewees may have been unaware of the details of the organisations' training and development plans.

"Yes it's [behaviour change training] *in the prospectus because there is a section, you know, health promotion training."*

5.3.17.2 Difficulties with training and development departments

Two of the interviewees stated that they experienced difficulties in working with the training and development departments. They had attempted to work with the training and development department to ensure adequate public health training within their organisation. One of the interviewees had worked with the department to ensure that that training met their requirements.

"We are trying to influence training…I have just met with training [representatives from the training and development department] *actually a couple of weeks ago to try and get health improvement generally on their radar."*

5.3.17.3 Competing against clinical priorities

One of the interviewees considered it to be difficult to develop behaviour change training within their organisation because of the prioritisation of clinical training.

> *"Ha ha. I have tried to understand it* [the organisation's training plan]. *It is very difficult when you are competing against clinical priorities. Most of the money goes to clinical. Clinical is more sexy isn't it."*

5.3.17.4 Development of a public heath training plan

One of the interviewees explained that they were developing a specific training plan for public health which would incorporate behaviour change training programmes.

> *"I am developing a work plan which is around building public health capability and capacity which is a working document which is going to be reviewed at a steering group."*

5.3.18 Using evidence and guidance to inform programmes

Interviewees were asked whether the training programmes were based upon the evidence and followed guidance. One identified sub-theme identified was that trainers were not specifically required to work in accordance with guidance. Another sub-theme was that it was specified that training programmes should work towards guidance but evidence was not required.

5.3.18.1 Not specified that trainers should work in accordance with guidance

Seven of the interviewees stated that evidence of working towards relevant guidelines was not requested.

> *"No it was not specified but should have been I suppose."*

5.3.18.2 It was specified that guidance should be followed but evidence was not required

Two of the interviewees stated that documentation such as contracts and service level agreements specified that trainers should follow guidance; however they were not requested to provide evidence that they adhered to the relevant guidance.

> *"I think that we have written into our service specifications with our provider unit that that needs to happen but I haven't actually seen documented evidence."*

5.3.18.3 Programmes were evidence based

Two of the interviewees stated that their programmes were based on evidence of effectiveness. One stated that their programme adhered to the guidance written by the University of Chester regarding commissioning behaviour change programmes (Powell & Thurston, 2008).

"I have to say that all the training that I deliver already adhered to that book that was produced, the one produced by the University of Chester. So I was quite happy with that really. I thought 'oh you know great, everything that I should be doing I am doing.'"

5.3.19 Monitoring and evaluation of programmes

The majority of interviewees used questionnaires to evaluate their programmes. Other themes identified were the use of monitoring data; programmes being regularly reviewed and a lack of quality measures or standards for behaviour change training programmes.

5.3.19.1 Questionnaires

Nine of the interviewees used questionnaires as a tool for evaluating programmes. These were usually distributed at the end of the programme and trainers provided a summary of the evaluations to the heads of their department or their training and development department. Interviewees stated that the evaluation forms were used to obtain simple information and that evaluation forms revealed that participants enjoyed the training and found it useful.

"Yes everyone [programme] *is evaluated with a questionnaire, it is quite straight forward it is not an in depth one because if you make the evaluations too complicated or long-winded people tend to leave it."*

5.3.19.2 Monitoring data

Six of the interviewees provided information about how they collected monitoring data regarding their training programmes. Participants of one of the training programmes were required to submit data concerning the number of individuals they signposted to services and where they signposted individuals to. One of the interviewees also stated that smoking 'quit rates' were collected which provided some indication of whether the smoking cessation training programmes were successful. Monitoring data was also collected concerning 'train the trainer' programmes. Participants were required to submit the attendance sheets for the training programmes they went on to deliver after completing the training and the amount of resources they collected from a centralised resource to enable them to deliver the training.

"We require this as part of 'train the trainers'. If we were training them we required them to get materials from a central source, so we could keep a track of where they were training. So they needed to say where the training was, the number of people etc."

5.3.19.3 Programmes were regularly reviewed

One of the interviewees specified that they regularly reviewed the training programmes.

"The actual delivery is monitored on a regular basis and reviewed on a regular basis, so hopefully what is being delivered is good and uniform across the patch because it is being monitored. So we don't

just deliver something and keep delivering it, it is reviewed on a regular basis."

5.3.19.4 A lack of tools to measure the quality of programmes

Two of the interviewees stated that it would be beneficial if there was some form of measurement tool to assess the quality of behaviour change training programmes. There was a concern that anyone could establish themselves as a trainer without being assessed on the quality of their programmes.

> *"There are loads of companies who will give you nice little attendance slips, you know, you have attended a two course training on…but it means didily squat in terms of quality and content...what is quality of what, what are you bench marking it against? The people might just like the trainers and think it was good but actually it might be crap so you know yes we do evaluate it and seldom have got poor evaluation but I wouldn't be convinced of that as selling point…The only way I think you can improve behaviour training is if there was a standard, if we had something to benchmark against, if there was a quality standard it would take a lot it would take something like that to convince me that a training programme was robust, whether it was peer accreditation, peer approval, Chester Uni[versity] accreditation, JMU [Liverpool John Moores University] accreditation. I think it would need to go through some process that it was any good."*

5.3.20 Assessing the quality of the trainers

A set of sub themes were identified regarding how the quality of the trainers were assessed. Sub themes identified included examining the trainers' curriculum vitae (CV); trainers' professional development reviews; commissioners participating in the training themselves; the use of *ad hoc* checks to assess trainers; using trainers that have been recommended by other organisations; providing updates for trainers and facilitating a network to support trainers.

5.3.20.1 Examining the trainers' curriculum vitae

Six of the interviewees stated that they assessed the quality of trainers by examining their CV. In particular, they considered their qualifications, experience and their knowledge of training as well as issues relating to behaviour change.

> *"With the contract we tend to ask for CV type evidence, we don't tend to check copies of certificates or any great detail."*

5.3.20.2 Trainers' professional development reviews

Four of the interviewees stated that the quality of the trainers would be assessed during trainers' professional development reviews. Professional development reviews would only be used when training was delivered internally.

> *"I think that will be done through their one-to-one with their personal development contact with their own line manager."*

5.3.20.3 Commissioners participating in the training themselves

Two of the interviewees specified that those who commissioned the training would also participate in the training as part of the assessment process.

> *"We do actually sit in and monitor delivery ourselves, so we will actually participate in events, so we can get a feel for if someone who has got the relevant expertise. If it is quite a specialist area, we will get someone to sit in and feedback to us so. Those tend to be the ways of sort of quality assuring really."*

5.3.20.4 *Ad hoc* checks on trainers

Two of the interviewees stated that they would conduct *ad hoc* checks on those delivering the training.

> *"We just used to threaten,…in the nicest possible sense, that there would be randomised checks."*

5.3.20.5 Using trainers that have been recommended by other organisations

One of the interviewees specified that they would use trainers that had been recommended by other organisations and colleagues.

> *"We rely on recommendation from other organisations and neighbouring authorities in terms of people they have found* [to be] *effective."*

5.3.20.6 Ensuring trainers' knowledge was up to date

Two of the interviewees, who were trainers themselves, stressed that they made efforts to ensure that they remained updated regarding developments in behaviour change practice.

> *"I have attended the midfield institute; I have attended two one day seminars which are MA level. So I try to keep myself up to date really, my own knowledge base."*

5.3.20.7 Facilitating a network for trainers

Two of the interviewees specified that they have developed networks for trainers that have participated in the 'train the trainer' programmes to provide further support and opportunities for development.

> *"We keep them updated on new developments, new print runs for the cards, additional cards, any new information, if NICE guidance changed. It's that kind of forum and also for them to speak to each other and offer support about what they find difficult and what they need more of."*

5.3.21 Assessing the impact of programmes on participants

There were two sub-themes relating to assessing the impact of the training upon participants. These included contacting trainers to 'follow-up' on their progress and conducting pre and post assessments of knowledge.

5.3.21.1 Follow-up procedures

Four of the interviewees specified that they had developed strategies to 'follow-up' participants. This would involve contacting those who had completed the training at three months or six months after the training had ended to establish to what extent they were adopting the approaches they had learned. This was conducted via a questionnaire and/or over the telephone.

> "What we are doing is a three month follow-up and a six month follow-up because what we are interested in is has it made a difference? So are they actually using some of the skills that they have used on the course and put them into practice and follow them up in six months."

5.3.21.2 Conducting pre and post assessments of knowledge and attitude

One of the interviewees described how they tested participants' knowledge and attitudes pre and post training, as a measure of the training programmes' effectiveness.

> "We are giving people pre and post and then at the end of it we assess where people are up to…one of the people from the suicide training which I am using as an example because I have got it in front of me. 'People who say they want to end their lives don't mean it'…and we ask people to say if they think that is that true or not and sometimes people think it is just attention seeking because it is a huge myth. So at the being of it they might say, 'no they don't mean it' and at the end of it they might say they have changed their attitude."

6   Discussion

Initial discussions held with the advisory group proved useful in the development of a working definition of behaviour change training. Through these discussions it became clear that those working within local authorities and the voluntary/community sector may not use the terms brief intervention, brief advice or motivational interviewing. Although these staff may not always use these terms, they may well be using aspects of behaviour change interventions in their day-to-day work and include elements of behaviour change within training programmes. As a result training programmes that include aspects of behaviour change may be more difficult to identify within local authorities and the voluntary/community sector.

The process of completing the research provided a valuable insight into the approach taken to behaviour change training across Cheshire and Merseyside. Difficulties were experienced when attempting to identify those who delivered behaviour change training programmes within local authorities. When the contact details of individuals thought to deliver behaviour change training programmes within local authorities

were provided, these were often the contact details of NHS employees. This may be indicative of a lack of behaviour change training programmes being delivered by local authority staff and/or that behaviour change training is less explicit within local authorities than in the NHS due to differences in terminology. Attempts were also made to identify the most appropriate individuals to provide an overview of behaviour change training programmes within the NHS and local authorities through their participation in interviews. Only one interview was conducted with a representative from a local authority due to difficulties in identifying appropriate individuals. This further suggests a lack of awareness of behaviour change training within local authorities in Cheshire and Merseyside.

A total of 61 training programmes were identified via the mapping exercise. Despite providing a definition of behaviour change training programmes, some of the programmes identified did not actually meet this definition. This illustrates the challenges involved in identifying behaviour change training programmes. The topics that the majority of behaviour change training programmes identified in the mapping exercise focused upon were those prioritised within the *Choosing Health* white paper (DH, 2004). The greatest number of trainers delivered training regarding smoking cessation, alcohol or weight management (all 9 trainers). There were four trainers who delivered mental health and wellbeing training and four who provided sexual health training (both = 4 trainers). There were however other topics that training focused on including home safety, illegal drugs and infectious disease. Within the literature, the four most advocated behaviour change interventions are brief advice, brief intervention, motivational interviewing and social marketing (Powell & Thurston, 2008). Out of these four methods/approaches, most providers delivered training on brief interventions (17 trainers), followed by motivational interviewing (15 trainers), brief advice (14 trainers) and social marketing (3 trainers). There were however other competencies taught in programmes.

Evidence suggests that training should teach participants how to assess readiness to change (Powell & Thurston, 2008). In accordance with the evidence, a large proportion of the behaviour change training programmes included developing knowledge and skills in dealing with clients' ambivalence and resistance to change (17 trainers). The evidence further indicates that training programmes that enhance skills in developing rapport and facilitating discussion with clients are likely to be more effective (Powell & Thurston, 2008). In accordance with this, a high number of the programmes included the competencies of discussing healthy lifestyle issues with clients (19 trainers), and listening to and understanding clients' concerns regarding behaviour change (17 trainers) in their programmes.

The evidence further suggests that an understanding of the theories that underpin behaviour change interventions can enhance the likelihood that participants will go on to adopt the approaches taught (Powell & Thurston, 2008). The majority of the behaviour change training programmes identified included some explanation of the theories of behaviour change. The most frequently cited model included in programmes was the transtheoretical stages of change model (15 trainers, 71%). This is the most commonly adopted model of behaviour change (Powell & Thurston, 2008). The model has however been widely criticised. It has been described as a *"security blanket for researchers and clinicians"* which is *"not founded on evidence and arguably been damaging to progress"* (West, 2005, p.1038). Key criticisms include: the lack of consideration to the complexities of behaviour; the use of algorithms for determining stage of change which have not been validated; and the tendency to focus upon stage progression which may not be associated with behaviour change (Adams & White, 2004). It is unknown whether or not trainers discussed these criticisms of the model with participants.

NICE guidance (2007) does not promote the use of any one particular model of behaviour change because of a lack of consistency in research findings. It recommends that training should focus upon key competencies and skills rather than specific models. NICE (2007) suggests a number of competencies that training programmes should aim to address. One of these was developing knowledge and skills in designing, implementing and evaluating interventions and programmes (NICE, 2007). Only six of the trainers specified that they aimed to develop this competency within their training programmes. However, this competency may only be appropriate for more advanced programmes. Thirteen of the trainers identified that they worked towards the competencies of understanding the psychological, social and economic and cultural determinants of health, and working in partnership with members of the target populations and those with local knowledge.

Only four trainers stated that they used the Public Health Skills and Career Framework to help determine the learning outcomes for their behaviour change training programmes. Three trainers stated that they delivered behaviour change training programmes as part of an induction process. Furthermore, three trainers stated that they delivered behaviour change training programmes that were mandatory. The majority of the trainers stated that the training programmes they delivered would usually be described as basic training (17 trainers).

Almost half of the trainers stated that they delivered the training programmes when requested (10 trainers) and the highest number of trainers stated that their training programmes usually lasted between one and four hours (8 trainers). The highest proportion of trainers stated that they held the programmes in the morning (17 trainers), with only six trainers stating that they usually held their training programmes at lunchtime. It has been suggested that it is useful if programmes are delivered at lunchtime to facilitate the involvement of participants with demanding work roles (Rollnick et al., 1999). The greatest number of trainers stated that they usually held the programmes in NHS or local authority premises (both = 9 trainers).

Training programmes with over 20 participants can restrict discussion, which is considered to be a crucial part of effective programmes (Rollnick et al., 1999). In accordance with the evidence, the majority of the trainers specified that their training programmes enrolled less than 20 participants. There is some evidence to suggest that follow-up support provided over the telephone is particularly cost effective (Powell & Thurston, 2008). Ten of the trainers specified that they provided such support. However, it is not known whether these arrangements were formalised.

Trainers also provided detail regarding the participants of their programmes. The greatest number of trainers stated the participants including those employed within the NHS (19 trainers). This was followed by the local authority and voluntary/community sectors (both = 16 trainers) and the private sector (6 trainers). The majority of trainers stated that their programmes were aimed at frontline staff (19 trainers) and only one trainer stated their programmes was aimed at commissioners. The trainers stated that their training programmes were aimed at a wide range of roles, the majority of which were roles within the NHS. The role targeted by the greatest number of trainers was nurses (16 trainers). The majority of the trainers stated that they made attempts to tailor programmes to participants' level of knowledge (15 trainers). However, only five of the trainers stated that they usually assess participants' knowledge in advance of the training programme. Training programmes were usually advertised, these occurred through a wide variety of formats including prospectuses, newsletters, email lists and the organisation's intranet.

When discussing what they thought assisted the commissioning of behaviour change training programmes, six interviewees described the availability of guidance. Seven of the interviewees highlighted how informal the commissioning process for behaviour change training programmes was. Frequently, the behaviour change training programmes were not put out for tender or expressions of interest but decisions were made to use specific trainers or organisations because they had been recommended by other organisations; previous working relationships had already been established and/or commissioners had seen the effectiveness of the training programmes within other organisations. Behaviour change training programmes were often provided as part of wider commissioned services such as smoking cessation and weight management services, rather than being commissioned separately.

The experience of the trainer was considered by five of the interviewees to be of particular importance as it was considered necessary for trainers to draw upon their own personal experience of delivering behaviour change interventions. Furthermore, four of the interviewees deemed it useful for training programmes to be consistent. This incorporated the use of standardised packages; the use of tools such as reminder cards or a theoretical model such as the transtheoretical stages of change model (Prochaska & DiClemente, 1983).

A reoccurring challenge was securing the release of staff to attend the training, particularly nursing staff. This was considered to be a barrier to delivering training by eight of the 11 interviewees. Three interviewees explained that they had a limited capacity to deliver behaviour change training programmes. One of the interviewees stated that they had to temporarily cease one of their courses because they were not specifically commissioned to deliver behaviour change training. There was a concern amongst three of the interviewees that some managers and frontline staff did not consider the issue of behaviour change to be particularly important. No examples of mandatory training provided to the general workforce that was explicitly described as behaviour change could be identified. However, specialist staff such as those providing smoking cessation services would be required to attend behaviour change training programmes. Furthermore, there were no examples of training programmes that were explicitly described as behaviour change training programmes provided as part of the induction process. However, two interviewees did describe plans to include an element of behaviour change practice in future induction procedures.

Four of the interviewees stated that the behaviour change training needs were determined by local and national priorities and strategies. Only two of the interviewees stated that an assessment of need specifically in relation to behaviour change had been conducted. The restructuring of Cheshire local authorities was considered by three of the interviewees to provide an opportunity to enhance joined-up working in relation to behaviour change because general discussions were being held in relation to joined-up working. One of these interviewees highlighted plans for a joint health unit to be established between the local authority and PCT. Additionally, it was considered by three of the interviewees to be useful if training programmes were delivered by individuals from a number of organisations to increase opportunities for inter-professional and inter-agency learning. The majority of the training programmes were considered to be of a basic level and were delivered face-to-face. There were however, a number of e-learning packages regarding behaviour chance delivered by trainers.

Four of the interviewees specifically stated that they did not have a good knowledge of the behaviour change training programmes being delivered across their

organisation. However, one interviewee did have such knowledge and considered this to be important to ensure a consistent approach and prevent overlap.

The majority of the interviewees stated that they did not use the Public Health Skills and Career Framework (Public Health Resource Unit & Skills for Health, 2008) as a tool to assess staff competencies in order to determine training requirements. However, three of the interviewees specified that they used the Public Health Skills and Careers Framework internally as part of their professional development. Six of the interviewees stated that their organisations' training plan included behaviour change training. However, they were often referring to the inclusion of behaviour change training within the training and development prospectus rather than any detailed plans.

Seven of the interviewees stated that evidence regarding working towards NICE guidelines was not requested, although this was often assumed. Nine of the interviewees used evaluation forms which were distributed to participants at the end of programmes. There was no evidence provided of detailed evaluations which aimed to objectively assess learning and long term behaviour change in the eventual recipients of the interventions. Six of the trainers collected some form of monitoring data which was considered to provide some indication of the effectiveness of behaviour change training programmes but in general this was simplistic. As much of the training was conducted internally, trainers' CVs and their professional development reviews were used as a measurement of trainers' appropriateness for delivering the training. Four of the interviewees provided some form of follow-up to the training programme at three and/or six months. This included the completion of questionnaires and/or discussions over the telephone.

7   Conclusion

A total of 61 training programmes were identified via the mapping exercise. Overall, the majority of the training programmes identified within the mapping exercise appeared to be in accordance with many aspects of the evidence base. They were largely focused around priority areas identified within the *Choosing Health* white paper (DH, 2004); many of them included vital skills concerning developing knowledge and skills in dealing with clients' ambivalence to change; and developing rapport and facilitating discussion with clients. The majority also included an explanation of the theoretical underpinnings of behaviour change training to some extent. The most frequently included theory was the transtheoretical stages of change model, which has been widely criticised. It is not clear whether trainers made participants aware of this critique. Furthermore, over half of the trainers stated that the training programmes aimed to address the NICE competencies of understanding the psychological, social, economic and cultural determinants of health and working in partnership with members of the target population and those with local knowledge. However, only a limited number aimed to develop knowledge and skills in designing, implementing and evaluating interventions and programmes. However these competencies may only be applicable to advanced programmes.

NICE (2007) have stated that there is a lack of strategic approach to behaviour change across government, the NHS and other organisations and conclude that approaches to behaviour change are often uncoordinated. The interviews conducted for this research suggest that this lack of a strategic approach may also be applicable to behaviour change training programmes across some areas of Cheshire and Merseyside. In the main, behaviour change training programmes were being delivered as part of specialised services (such as smoking cessation and weight

management) and therefore generic behaviour change requirements were not always being considered. This was characterised by a lack of knowledge of other behaviour change training programmes being delivered across PCTs and a lack of assessment of training needs in relation to behaviour change. Although there was an apparent lack of coordination of services, which resulted in some overlap and a potential lack of consistency, it does not necessarily mean that training programmes being delivered were of a poor standard. Indeed, the majority appeared to be delivered in accordance with the evidence base. Furthermore, there were some examples where a coordinated approach to behaviour change training was adopted. This included assessing the needs of staff in relation to behaviour change training; a consistent approach and preventing overlap in training delivery. There were also examples of providers taking the initiative to deliver behaviour change training without being commissioned to do so.

8   Recommendations

8.1   Top tips for commissioners of behaviour change training

8.1.1   Assess training needs regarding behaviour change

Conducting training needs assessments can identify gaps in knowledge and skills, and therefore determine the most appropriate form of training package to provide. All staff with roles that have the potential to change health related knowledge, attitudes and behaviour should be included in the assessment. Where possible this should include roles within the NHS, local authority and community/voluntary sector. Efforts should be made to identify the specific roles within these organisations that should participate in the training needs assessment. The Public Health Skills and Career Framework should be used where possible, to identify training requirements in relation to behaviour change.

8.1.2   Develop joint strategies for behaviour change training between the NHS, local authorities and voluntary/community sector

Choosing Health states improving health is everyone's responsibility. It is important that a consistent approach to behaviour change training is adopted across organisations. This helps ensure consistent messages are delivered to the public and all appropriate opportunities to positively influence health-related attitudes, knowledge and behaviour are used effectively.

8.1.3   Commission generic behaviour change training programmes whenever possible

Generic behaviour change training programmes develop knowledge and skills that can be applied to a wide range of public health topics including alcohol, smoking, obesity, sexual health, and mental health and well-being. There is an opportunity to increase efficiency by providing generic behaviour change training to larger numbers of staff rather than several packages that focus on specific public health topics. Training should be provided at a range of levels and could incorporate different delivery methods (including face-to-face and e-learning). Consideration should also be given to whether the training is mandatory, forms part of induction processes or contributes to continued professional development.

8.1.4 Conduct robust evaluations of behaviour change training programmes

Robust evaluation is crucial for determining the effectiveness of the training programme. This should include identifying and assessing:

- the processes involved in delivering the training
- the outcomes of the training on the professional behaviour of recipients

More advanced evaluations should include an assessment of health outcomes in clients receiving interventions from trainees.

8.2 Top tips for providers of behaviour change training

8.2.1 Promote the benefits of behaviour change training programmes to managers, commissioners and front line staff

Behaviour change interventions are an important means of reducing the risk of illness and early death. They have the potential to reduce the numbers of people who smoke; cut obesity, and improve diet and nutrition; increase levels of exercise; reduce alcohol consumption; improve sexual health; and promote mental health and well-being. For training programmes to be a success, they need to be commissioned and supported by managers.

8.2.2 Develop inter-professional and inter-agency learning regarding behaviour change

Inter-professional and inter-agency learning helps to create an effective public health workforce. It facilitates participants' understanding of other roles and encourages the development of effective collaborative working patterns. It is therefore useful if a number of trainers can contribute to the delivery of sessions.

8.2.3 Consider carefully the theoretical content of behaviour change training programmes

Evidence suggests that an understanding of the theories that underpin behaviour change interventions can enhance the likelihood participants will go on to use the approaches taught. The evidence does not support the use of one particular model or theory but promotes a focus upon the development of skills and competencies. For example, the effectiveness of one popular model, the transtheoretical stages of change model, has been widely debated.

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10 Appendices

10.1 Best practice checklist for behaviour change training programmes

This checklist was developed from the guidelines for best practice produced by Powell and Thurston (2008) and from the findings of this research. It is relevant for training regarding one-to-one behaviour change interventions i.e. brief advice, brief interventions and motivational interviewing. The following points should be incorporated into behaviour change training programmes where appropriate. The checklist can be used prior to commissioning to determine whether a proposed training programme is likely to deliver quality, or after a training programme to evaluate against best practice.

A behaviour change training programme should include clear information about:

1. The evidence base for the behaviour change methods/approaches discussed in the training.

2. Different theories of behaviour change such as the transtheoretical stages of change model; the health belief model; social cognitive learning theory and/or diffusions of innovation theory, as appropriate. This should include a critique of the theories discussed. However, the main focus should be on the development of the skills and competencies rather than the theories of behaviour change.

3. How specific assessment tools can be used to indicate individuals' readiness to change and demonstrations on the use of these tools, as appropriate. They should also provide participants with an opportunity to practise using appropriate assessment tools, to be tested in their ability to use the tools effectively and to receive feedback on competency and skill development.

4. Encouraging client-directed conversations; dealing with clients' adverse reactions; managing clients' concern and distress; and adopting reflective listening skills as appropriate. Training programmes should also include dedicated time for demonstrations and to practise these skills; an opportunity to assess abilities in relation to these skills, and feedback on competency and skill development.

5. Tailoring information to different client groups such as the elderly; young people; those with mental health issues; families, those with disabilities; those from black and minority ethnic groups; foreign nationals; and, where appropriate, other groups with specific needs. This may include specific information on cultural issues, sensitivities, and health and social inequalities. In addition, training programmes should provide the opportunity for participants to practise tailoring this knowledge through role-play and be given feedback to facilitate improvement in effectiveness.

6. The public health topic(s) addressed by the training, including smoking; obesity; diet and nutrition; exercise; alcohol consumption; sexual health or about health in general, as appropriate.

Providers of behaviour change training programmes should:

7. Understand the context of participants' work; be a respected colleague; have a rapport with the participants; and have practical experience delivering effective behaviour change interventions.

8. Take account of participants' professional roles and their relationship with clients, conducting an assessment of participants' knowledge in advance and tailoring the programme accordingly. In addition, trainers should draw on real cases, design exercises to address common challenges and, where possible, use recordings or transcripts from relevant settings.

9. Use a workshop style of training and provide opportunities for reflection and discussion, and to practise new skills and observe colleagues in action. Trainers should facilitate activities that are task-orientated and, where possible, provide opportunities for feedback to the whole group for wider discussion.

10. Provide opportunities for ongoing on-site consultation from a trainer or peer, as appropriate.

11. Provide the opportunity for role-play where turns are taken to play the client and staff member, encourage the exploration of mistakes in a safe environment, and receive feedback on their techniques and skills development.

12. Offer continuous support and verbal feedback during the training session/s and wherever feasible include a number of booster sessions to provide feedback and follow-up support.

10.2 Questionnaire

The mapping of behaviour change training programmes delivered across Cheshire and Merseyside: Questionnaire for trainers

This questionnaire refers to the behaviour change training programmes that **you deliver**. If you have any queries or questions about any aspects of the questionnaire, please contact Katrina Stredder (k.j.stredder@ljmu.ac.uk or 0151 231 8096). Your contact details are requested in case we require any further information.

Name of the organisation you are employed by:

Which of the following best describes your organisation?

NHS ☐   Private ☐

Local authority ☐   Voluntary/Community ☐

Other (Please state in box below) ☐

Your name & address:

Your email:

Your telephone number:

Please list the behaviour change training programmes that <u>you</u> deliver.

Please place a cross in the box below to confirm that you are involved in delivering behaviour change training programmes

Please place a cross (**x**) in the box to indicate your response or responses.

The behaviour change training programmes

1a. Do you deliver behaviour change training programmes that are topic specific?

Yes ☐   No ☐

1b. If yes, which of the following topics do they focus upon? (Please mark all that apply)

Smoking cessation ☐   Healthy weight ☐
                                     (obesity/exercise/nutrition)
Alcohol ☐   Sexual health ☐
Illegal drugs ☐   Mental health/wellbeing ☐
Food safety ☐   Infectious diseases ☐
Home Safety ☐   Fall prevention ☐
Other (please state in box below) ☐

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2. Do the behaviour change training programmes that you deliver include any of the following? (Please mark all that apply)

Motivational interviewing ☐
Brief advice ☐
Brief intervention ☐
Cognitive Behavioural Therapy ☐
Client centred conversations ☐
Eliciting behavioural change talk ☐

Reviewing lifestyle messages ☐
Listening to and understanding clients' concerns regarding changing behaviour ☐
Signposting clients to appropriate services ☐
Raising clients' awareness of risky behaviours ☐
Teaching/coaching clients ☐
Goal setting ☐
Social marketing ☐
Reflective listening skills ☐
Understanding the influences on clients' behaviour ☐
Understanding clients' perceptions of risk ☐
Dealing with clients' ambivalence and resistance to change ☐
Effectively exchanging information with clients ☐
Discussing healthy lifestyle issues with clients ☐
Encouraging clients to take responsibility for their behaviour ☐
Other methods/approaches (please list in box below) ☐

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│   │
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│   │
│   │
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3. Are any of the following theories included within the behaviour change training programmes that you deliver? (Please mark all that apply)

The Transtheoretical Stage of Change Model ☐
The Health Belief Model ☐
Social Cognitive Learning Theory ☐
Diffusions of Innovations Theory ☐
Theory of Reasoned Action ☐
Unsure ☐
No ☐
Other (Please list in the box below) ☐

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4. Do the behaviour change training programmes that you deliver attempt to develop the following competencies? (Please mark all that apply)

Identify and assess evidence on behaviour change ☐
Understand the evidence on the psychological, social, economic and cultural determinants of behaviour ☐
Interpret relevant data on local or national needs and characteristics ☐
Design, implement and evaluate interventions and programmes ☐
Work in partnership with members of the target population(s) and those with local knowledge ☐

5. Please list the intended learning outcomes of the behaviour change training programmes that you deliver.

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6a. Do you currently utilise the Public Health Skills and Career Framework to help you determine the learning outcomes for the behaviour change training programmes you deliver?

Yes ☐ No ☐ Unsure ☐

6b. If yes, please explain how.

☐

7. Do you deliver behaviour change training programmes as part of an induction process? (Please mark one option)

Yes ☐ No ☐

8a. Are any of the behaviour change training programmes that you deliver mandatory? (Please mark one option)

Yes ☐ No ☐

8b. If yes, please state which ones are mandatory in the box below.

☐

9. At what levels are the behaviour change training programmes that you deliver? (Please mark all that apply)

Basic (equivalent to college or high school) ☐
Intermediate (equivalent to university under-graduate) ☐
Advanced (equivalent to university post-graduate) ☐

10. How regularly do you deliver behaviour change training programmes? (E.g. daily, weekly, monthly, yearly, 'one off', when requested)

☐

11. How long do the behaviour change training programmes you deliver usually last for in total? (E.g. 4 hours, 5 days)

☐

12. At what time of day are the behaviour change training programmes you deliver usually held? (Please tick all that apply)

Morning ☐ Afternoon ☐
Lunchtime ☐ Evening ☐

13. Where are the training sessions usually held?

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Participants

14. Which type of organisations are the participants of the behaviour change training programmes that you deliver drawn from? (Please tick all that apply)

NHS ☐   Local authority ☐

Private sector ☐   Voluntary/Community sector ☐

Other (Please state in box below) ☐

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15a. Which of the following groups are the behaviour change training programmes that you deliver aimed at? (Please mark all that apply)

Managers ☐   Administrative staff ☐

Commissioners ☐   Frontline staff ☐

15b. Which of the following groups are the behaviour change training programmes that you deliver aimed at? (Please mark all that apply)

General Practitioners ☐   Nurses ☐

Residential Home Workers ☐   Pharmacists ☐

Youth Workers ☐   Health Visitors ☐

Social Workers ☐   Teachers ☐

School Counsellors ☐   Dentists ☐

Dieticians ☐   Pest Controllers ☐

Dog Wardens ☐   Health Improvement Officers ☐

Environmental Health Officers ☐   Beauty Therapists ☐

Community Wardens ☐   Others (Please state in box below) ☐

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16. On average, approximately how many participants take part in each behaviour change training programme that you deliver? (Please mark one option)

1-5 ☐   21-25 ☐

6-10 ☐   26-30 ☐

11-15 ☐   31-35 ☐

16-20 ☐   35 + ☐

17a. Are attempts usually made to tailor training to participants' level of knowledge? (Please mark one option)

Yes ☐   No ☐

17b. If yes, please explain how.

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18a. Do you usually assess learners' knowledge in advance of the training programmes? (Please mark one option)

Yes ☐   No ☐

18b. If yes, please explain how this information is used to inform the content of the training programmes?

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19a. Are the occupations of participants usually taken into account when designing the training programmes? (Please mark one option)

Yes ☐   No ☐

19b. If yes, please explain how.

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20a. Do you usually advertise the training programmes? (Please mark one option)

Yes ☐   No ☐

20b. If yes, please explain how and where.

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Knowledge and skills of trainers

21. On average, how many trainers facilitate each training programme? (Please mark one option)

1 - 3 ☐
4 - 6 ☐
7+ ☐

22. Please provide the name, job title, organisation and email address of all those involved in delivering behaviour change training programmes within your department (this is to prevent duplication of responses)

Trainer 1	
Name:	
Job title:	
Organisation:	
Email address:	

Trainer 2	
Name:	
Job title:	
Organisation:	
Email address:	

Trainer 3	
Name:	
Job title:	
Organisation:	
Email address:	

Trainer 4	
Name:	
Job title:	
Organisation:	
Email address:	

Trainer 5	
Name:	
Job title:	
Organisation:	
Email address:	

Please continue on separate sheet if necessary.

23. What qualifications do you possess which assist you in delivering behaviour change training programmes?

24. What additional skills do you possess which assist you in delivering behaviour change training programmes?

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25. What additional knowledge do you possess which assist you in delivering behaviour change training programmes?

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Follow-up support

26a. Do you or one of the other trainers usually provide follow-up support after the training programmes have finished? (Please mark one option)

Yes ☐   No ☐

26b. If yes, what form does this follow-up support take?
(Please tick all that apply)

Telephone ☐   Face-to-face ☐
Email ☐   Other (Please state in box below) ☐

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27. At which of the following time periods is the follow-up support usually provided? (Please mark one option)

As and when required ☐
At structured intervals (Please state how often this occurs) ☐

28. For how long afterwards is the follow-up support usually offered?

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29. Do you use any of the following approaches for follow-up support? (Please tick all that apply)

Outreach visits ☐   On-site consultation from trainer ☐

Peer consultation ☐   Other (Please state in box below) ☐

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Evaluation

30. Are the behaviour change training programmes that you deliver usually evaluated?

Yes ☐   No ☐

31. Are the evaluations usually conducted…?

Internally ☐   Externally ☐

32. Which of the following methods are utilised to evaluate the behaviour change training programmes? (Please tick all that apply)

Questionnaires ☐   Individual interviews ☐

Focus groups ☐   Other (Please state in box below) ☐

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33a. Do you usually use the evaluations to inform future training programmes?

Yes ☐   No ☐

33b. If yes, please explain how?

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Trainers' perspectives

34. What three aspects of the behaviour change training programmes you deliver make them particularly successful?

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1.


2.


3.
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35. What three aspects of the behaviour change training programmes you deliver would you like to improve?

1.

2.

3.

Providing further information

We would be very grateful if you could provide documentation regarding the behaviour change training programmes you deliver such as materials distributed, training manuals, training schedules and evaluation reports. This may be sent electronically or through the post. Please list any documentation you have been able to enclose.

Please return this **questionnaire** and any **documents provided** by **17:00 on Wednesday 18th March** to (k.j.stredder@ljmu.ac.uk) or if you would prefer you may return the questionnaire in the free post envelope provided or by post to…

Katrina Stredder
Centre for Public Health
Liverpool John Moores University
Kingsway House
5th Floor
Hatton Garden
Liverpool
L3 2AJ

0151 231 8096

Many thanks for your time.

10.3 Interview guide

- Go through information sheet
- Go through consent form
- Go through explanation of behaviour change training programmes
- Explain that there may well be questions that participants are unable to answer

Participant's organisation: …………………………………………….
Participant's department:…………………………………………….
Participant's role:…………………………………………………….

Background

1. Please could you briefly outline your role

Commissioning process

2. What is the process for commissioning behaviour change training programmes in your department/organisation?
3. Which trainers/organisations do you use to deliver behaviour change training programmes in your department/organisation?
4. Are behaviour change training programmes commissioned from within your department/organisation?
5. Are you able to commission behaviour change training programmes locally?
6. Why/Why not?
7. How do you decide what sort of behaviour change training programmes your department/organisation needs?
8. To what extent do you use the Public Health Skills and Career Framework to assess staff competencies in order to determine training requirements?
9. Are there any barriers to commissioning behaviour change training programmes within your department/organisation?
10. If yes what are they?
11. What assists you to commission behaviour change training programmes within your department/organisation?
12. How are behaviour change training programmes recommissioned within your department/organisation?

Behaviour change training programmes

13. Are you aware of training being conducted within your department/organisation regarding behaviour change?
14. What topic specific training programmes are being conducted in your department/organisation?
15. What training programmes regarding a particular method/approach are being conducted?
16. How are the behaviour change training programmes being delivered in your department/organisation (e.g. face-to-face/distance learning)?
17. Are you aware whether behaviour change training programmes are conducted as part of any induction processes within your organisation?
18. Are any behaviour change training programmes mandatory within your organisation?

19. Are behaviour change training programmes provided at a range of levels (e.g. basic, intermediate, advanced) within your organisation?
20. Does your organisation have a formal training plan?
21. How do behaviour change training programmes fit in to this training plan?

Participants

22. Who is targeted to receive behaviour change training programmes within your organisation?
23. Do you work with other departments/organisations to commission behaviour change training programmes?
24. If so which ones?
25. Do you work with other departments/organisations to deliver behaviour change training programmes?
26. What are particularly successful aspects of this joint working?
27. How could this joint working be improved?
28. How are behaviour change training programmes advertised or how do they find out about them?
29. Are individuals nominated to attend or do they have to apply?
30. To what extent do you feel that your advertising and recruitment process results in those who actually need to, actually receiving the behaviour change training programmes?

Knowledge and skills of trainers

31. What mechanisms are in place to ensure those who actually deliver the behaviour change training programmes are appropriately trained themselves?
32. Do training providers have to supply evidence of competence or accreditation by appropriate bodies?
33. Do providers have to supply evidence of working in accordance with NICE guidelines?
34. How do you quality assure the training that takes place?

Follow-up support

35. Are there any processes in place to assess whether learners are putting their new found knowledge and skills into practice after completing a behaviour change training programme?

Evaluation

36. Are mechanisms in place to evaluate behaviour change training programmes in your organisation?
37. If so please explain what these are?

Perspectives

38. What aspects of behaviour change training programmes in your department/organisation do you think are particularly successful?
39. What aspects of behaviour change training programmes in your department/organisation do you think require improvements?
40. Is there anything else you would like to add about behaviour change training programmes in your organisation?
41. Could you identify any other individuals within LA or NHS that could provide an overview of behaviour change training within their department.