# Final Report November 2010

## Evaluation of the Live Active health counsellor role

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# Executive Summary

## Background and objectives

Keep Well was developed as an anticipatory care model, focusing on 45 – 64 year olds in areas of greatest need, as part of the wider NHS agenda of tackling health inequalities. The programme focuses on early intervention for those at high risk of coronary heart disease and diabetes, by inviting people in the target population to attend a health check where they are assessed according to a range of factors (clinical and lifestyle) and referred to appropriate services or support to address any issues they may have.

The Live Active Referral Scheme is one service which people can be referred to, where they would benefit from increasing their physical activity levels. Participants receive support in the form of structured consultations with exercise counsellors when they enrol, at six months and twelve months plus telephone support, letter and supported exercise sessions. A dedicated health counsellor service was introduced for Keep Well clients within the Live Active Referral Scheme to provide evidence based interventions around physical activity, weight management and healthy eating. This was based on the Live Active Referral Scheme model, with the addition of weight management and healthy eating elements, greater scope for individualised support according to need, more community based venues and closer links with GP practices. The health counsellor model was introduced into the 5 Keep Well areas in Greater Glasgow & Clyde plus Renfrewshire.

FMR Research Ltd was commissioned to undertake research to:

- explore participants' experiences and the views of Health Counsellor staff of the Live Active Health Counsellor programme;
- explore the impact the Live Active Health Counsellor programme has had on participants' lifestyle behaviours; and
- to provide recommendations for future service delivery.

## Method

The study consisted of a telephone survey with participants of the scheme and a focus group with Health Counsellors. Participants who had attended to varying degrees were invited to take part in the survey by letter, with the choice of opting out of the research at that stage or when telephoned. Interviews were conducted between mid February 2010 and the first week of April 2010. Fifteen interviews were conducted with three different groups: those who did not attend baseline consultation, those who did not attend the six month consultation and those who did not attend the twelve month consultation. Ninety interviews were conducted with those who completed the programme, i.e. attended all consultations. The focus group with all eleven health counsellors was conducted in January 2010.

## Key findings

### THE PARTICIPANT PERSPECTIVE

***First thoughts about the Live Active Health Counsellor programme***

- Nearly half of the sample (45%, 61 respondents) had heard about the programme from their GP and 25% (35 respondents) from their practice nurse.
- GP was also the most common referral route (60%, 81 respondents), followed by practice nurse (27%, 37 respondents).

- Those who were referred for healthy eating were much less likely to recognise that this was the reason for referral to the programme and participants were generally more likely to cite a number of reasons for referral.
- Of those who had attended, 42% (48 respondents) said it had exceeded their expectations and 41% (47 respondents) said it had met them. Just 12 people (10%) felt it did not meet their expectations and 7% (8 respondents) had no expectations.
- Those who said it had exceeded their expectations said this was because they appreciated the encouragement/support/being checked up on (33%, 16 respondents), they enjoyed it [more than expected] (27%, 13 respondents) and 23% (11 respondents) felt the Health Counsellor/instructor was supportive and helpful.
- Reasons given for the programme not meeting expectations included: didn't suit health condition (6 people); not enough contact with Health Counsellor (2 people); timings didn't suit (2 people); and lack of own motivation (2 people). An additional two people gave other reasons (one found it boring and the other didn't like being questioned at the start).

***Experiences***

- Participants were asked if they had been given options for different types of support by the health counsellor. Just over half (54%, 65 respondents) said they had been, 24% (29 respondents) had not and 22% (26 respondents) were unsure.
- When asked how often they received support outwith formal consultations, 24% (28 respondents) received no further support, but 17% (20 respondents) received weekly support, 14% (16 respondents) saw their counsellor regularly at gym/classes and 14% (16 respondents) every quarter.
- The data showed that the more support an individual received, the more likely they were to continue attending the programme.
- More than half of those who received additional support received this by phone (56%, 49 respondents), 41% (36 respondents) were supported at the gym/leisure centre and 15% (13 respondents) at classes.
- The vast majority (88%, 101 respondents) felt this level of support was about right but 12% (14 respondents) felt they didn't receive sufficient support, particularly at the start of the programme.
- When asked to rate the service provided by the Live Active Health Counsellor on a scale of 0 – 10, the mean response was 8.93 out of 10.
- The survey sought to identify the best things about the service and 28% (32 respondents) praised the health counsellor or other staff, 26% (30 respondents) cited the encouragement/motivation provided and 19% (22 respondents) cited getting exercise/becoming healthier/losing weight.
- Nearly two-thirds (63%, 75 respondents) felt there was no room for improvement in the service and 68% (81 respondents) could suggest no changes required. The most common suggestion for improvement was for more tailored exercise or classes.
- The majority (88%, 101 respondents) had noticed benefits to their health as a result of the advice and support given by the health counsellor. The majority of these (82%, 83 respondents) felt fitter, 43% (44 respondents) had lost weight and 73% (74 respondents) felt healthier generally.

***Motivations and barriers***

- The main reasons for people attending the programme in the first place were: a health scare/condition and realising they needed to change (46%, 55 respondents), a desire increase physical activity levels (34%, 42 respondents), a desire to lose weight (35%, 42 respondents), and the nurse/GP/Physio/Cardio suggested it (33%, 39 respondents).
- Half continued to attend as long as they had (51%, 61 respondents) because they enjoyed it, 40% (48 respondents) felt it was making a difference to their health/fitness and 18% (21 respondents) needed the support.

- Of those who did not continue attending, a third (33%, 12 respondents) were unable to do so because of health reasons and 14% (5 respondents) felt it was making no difference to their health.
- Participants were asked whether there were any barriers to taking up the service in the first place and 61% (83 respondents) reported that there were no barriers. The barriers cited were lack of confidence (11%, 15 respondents), other commitments/too busy (8%, 11 respondents) and embarrassment (7%, 10 respondents).
- 46% (46 respondents) also stated that there were no barriers to maintaining attendance but 16% (18 respondents) cited health issues and 10% (11 respondents) lack of time to attend.
- Four out of five respondents (80%, 108 respondents) said that no other support could have been provided to help them to attend/continue to attend the programme, 6% (8 respondents) suggested more/ongoing support (6 of these were completers and 2 did not attend 12m check) and 15% (20 respondents, a mix across the different stages) gave a range of other suggestions.

## THE HEALTH COUNSELLOR PERSPECTIVE

### *Training*

- When asked to rate the training they had received to deal with healthy eating and weight management advice in terms of marks out of ten, the mean score given by counsellors was 6.36 out of 10. The lowest score given was a 5 and the highest was 8.
- Training was rated well, with a good variety of training on offer but there was also feedback on areas for improvement. For example, some felt there was too much detail on some issues (e.g. technical information about diet), but not enough on others and an element of repetition, for example around behaviour change which was covered by several trainers. Those who rated the training less positively considered it to be vague and irrelevant to what they needed to do, as it was not tailored sufficiently to the health counsellor role.
- Counsellors would have liked more guidance on how to structure the healthy eating element of a consultation and detail on how to advise in practice, perhaps with a toolkit, particularly as participants often feel they eat healthily but ensuing discussion reveals that they do not. A more structured approach to the issue would help to manage this. This may help to address the balance between physical activity and other elements of the consultation as physical activity can dominate as it is so structured. Advice on time allocation would also be welcomed. A ‘framework with flexibility’ was suggested as being appropriate so they could address different needs as they arose.
- Counsellors would like training on a regular basis, for example every couple of months, in addition to an opportunity for counsellors to share with each other what they have found to work well in practice. They would also appreciate training around maintaining motivation/re-motivation to help people overcome barriers to changing their lifestyles.
- Advice on dietary improvements where participants do not eat fruit and vegetables would be welcomed.

### *Confidence in delivering healthy eating advice*

- Health counsellors were all recruited to this role, rather than moving over from the discrete physical activity role, and they were asked how they felt about delivering the three distinct elements of advice and support. The confidence of health counsellors to deliver healthy eating advice varied quite substantially. One had a background in nutrition so felt extremely comfortable advising on this and others had found a way of working to suit them, in terms of tackling more sensitive issues in particular.
- Others felt they lacked confidence in raising a number of issues and did not feel able to go into detail on other issues, so kept this input to a minimum.

***The consultation process***

- Health counsellors felt that the vast majority of their input to participants focuses on their physical activity behaviours. This is driven by a number of factors: the structure of the Live Active programme which requires a range of data to be collected systematically; the need for familiarisation with the gym; the limited time available; the lack of advice and structure for the healthy eating element of the consultation; and counsellors' lack of confidence and knowledge to address healthy eating issues.
- This means that there is often just a few minutes to cover healthy eating advice.
- There was consistent criticism of the healthy eating questionnaire, which was considered to be misleading (in terms of whether behaviours are positive or negative) and it was not perceived to be effective in pulling out unhealthy eating patterns.
- There were suggestions on how the questionnaire could be improved, for example by asking who makes the meals, the number of take aways, fizzy drinks, whether they eat breakfast and regular meals, etc. A food diary was also suggested to give them something to discuss and suggest areas for improvement but it was recognised that participants often want the simple and familiar option, a diet sheet.
- Counsellors reported talking through what three things participants would like to change, as this was perceived to be more manageable and to have worked well in previous roles. They give participants some information and ask them to return if they need further assistance, but reported that this rarely happens.
- The healthy eating element was consistently seen as less of a priority for health counsellors than physical activity.
- Counsellors found it difficult to set goals for healthy eating and did not feel that they provided what participants really needed in this regard.
- Counsellors also queried the use of formal diagnostic tools such as the HADS questionnaire just as a measure of progress as participants want to know what the scores mean and they felt a degree of responsibility if the scores give cause for concern.
- The readiness ruler on the front page of the questionnaire was rated highly as a tool to prompt further discussion but they did not think they could use this online, and also reported other questions being missing online. There is apparently scope to record this in the notes.

***Challenges in supporting participants***

- The group considered what challenges there were in supporting participants in general and with healthy eating and weight management issues in particular. One issue was the impact of home and family on an individual and specifically on the way in which they interact with food and activity. The impact of their mother/partner can be significant, whether they prepare the food for the household or have it prepared for them.
- Another key challenge was perceived to be when participants were inappropriate referrals, so did not have the motivation to change their eating or exercise habits.

***Contact levels***

- Counsellors suggested the minimum contact levels or more, depending on participants' needs and requests. For example, by inviting people to come in at 3 months rather than waiting until 6 months or telephoning every so often.
- Participants with mental health issues were perceived by counsellors to need more support than other participants, often one to one support once a fortnight or month. Counsellors reported that seeing participants once a week in the gym was an effective way of encouraging them to stick with the programme.
- Whilst there was a willingness from the counsellors to do as much as they could for individual participants, they were clear that they could only provide additional support to some participants because others drop out of the

programme. It would not be possible to give this level of support to everyone if they continued to engage.

## Conclusions and recommendations

There was variation across the different geographic areas in terms of people's awareness of the programme and referral to it and the impact of Keep Well was evident in terms of the number of practice nurses referring and people aged 45 – 64. It was interesting to note that few participants had been referred to other services, perhaps suggesting that the health counsellor service is perceived to be a 'one stop shop'. However, the way in which the service is described to people would suggest that referrers are not actually aware of the full range of advice on offer. Whilst participants may have been unclear on what they were being referred to, the vast majority had their expectations met or exceeded once they attended. The research has reinforced the importance of support and encouragement to participate from the health counsellors rather than relying on their own motivation. The degree to which this support was provided varied, but counsellors were getting it broadly right, going for the participant driven approach. The majority of respondents felt there was no need to improve the service but there were some suggestions from participants and counsellors.

Participants were very positive about the health counsellor service, with a mean rating of 8.93 out of 10 and the role of staff being praised in making a difference to their participation and enjoyment. Positive impacts on health and behaviours were also reported, with people getting exercise, feeling healthier, losing weight, increasing in confidence and having fun/feeling good about themselves. This improved the longer participants engaged in the programme. The two clear reasons for continuing to attend were because they enjoyed it and they felt it was improving their health and fitness. Few barriers to attendance or continuation of attendance were reported but the sample was biased towards completers. The main reason for non-attendance was health reasons, followed by a feeling that it made no difference to their health but lack of support was also an issue, which is a concern as the biggest barrier was lack of confidence/motivation.

A number of recommendations are offered for consideration, prompted by the research, as follows:

- Communicate better to referrers and those being referred what the health counsellor service entails, with particular reference to what an appropriate referral is, reinforced by closer links between health counsellors and primary care.
- The importance of regular support (at least monthly), particularly early on in a participant's experience is clear and consideration should be given to how this support could be 'front loaded' for participants to address attrition rates and maximise the positive impacts on participants.
- It would be interesting to explore whether the different activities undertaken were driven by participant preference or what was on offer to them. Given the focus of Keep Well is to provide an alternative to more traditional gym experiences, are there opportunities to increase alternative physical activity options here to improve retention?
- There was interest in more tailored exercise or classes specific to conditions/groups of people with similar abilities and consideration should be given to how this could be achieved. Those with specific needs/conditions did not necessarily feel that the service was tailored or that there was a willingness to do so, which suggests a training need around customer care and in providing different options for people.

- Classes are scheduled during the day so those who are working/in full-time education found it very difficult to attend. Consideration should be given to evening or weekend options.
- It may be useful and less repetitious for participants to reconsider what tools are used at consultations, e.g. HADS and alcohol brief interventions, particularly if recently undertaken by a GP/nurse at the Keep Well health check, and to consider how these can be utilised most responsibly.
- A number of suggestions for improved counsellor training were made, for example, greater co-ordination of course content, tailoring the training to the health counsellor role so that it can be readily applied in practice with advice on time management, reconvening following training to discuss changes/improvements in practice to take learning forward in a consistent way, further training on alcohol brief interventions if required and more specialist information on balanced diets/healthy eating for different cultures, preferences or conditions.
- Giving collective thought to the way in which healthy eating advice could be delivered in terms of process and timeframe would be beneficial – the idea of a flexible framework was suggested by counsellors.
- The questionnaire used to direct healthy eating advice would benefit from some improvements to engage participants in a useful dialogue about improving their diet.

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# Terminology

This is an explanation of some of the terminology used in the Live Active Referral Scheme, and in this report.

**Baseline**
Baseline in this context refers to the chronological stage of the Live Active Referral Scheme when participants have their first consultation with the counsellor, after they have been referred onto the scheme. The other chronological stages of the Live Active Referral Scheme are at 6 and 12 months.

Participant exercise details and health related measurements are taken by the counsellor at baseline, 6 and 12 month points and are held in participants' files. These data allow a participant's progress on the Live Active Referral Scheme to be assessed.

**CHCP, Community Health and Care Partnership**
Community Health (and Care) Partnership is the name of the organisations that have been set up across Scotland to provide a wide range of community based health services delivered in homes, health centres, clinics and schools. In Glasgow City Partnerships are also responsible for many local social care services provided by social work staff[1].

**Exercise Counsellor**
A Live Active Referral Scheme staff member who is specifically trained to deliver health behaviour change intervention in relation to physical activity and delivers the Live Active Referral Scheme in a local area.

**FMR**
FMR Research Ltd, the social research firm commissioned to conduct this evaluation.

**GP**
General Practitioner

**HADS**
The hospital anxiety and depression scale (HADS) is a widely used and popular self-report measure designed to detect the presence and severity of mild degrees of mood disorder, anxiety and depression. The participant is asked to answer fourteen questions (7 for anxiety and 7 for depression) relating to their mental attitude. The maximum score possible for Anxiety or Depression on the HADS scale is 21 (totally anxious or depressed), and the lowest score is 0 (totally lacking in anxiety or depression).

- 0-7 Normal
- 8-10 Mild
- 11-15 Moderate
- 16-21 Severe.

HADS is completed at the discretion of the participant; it is not used as a psychological screening tool.

**Keep Well**
Keep Well is a pilot Scottish Executive primary care based approach to enhancing anticipatory care. In Glasgow the Keep Well pilot has funded an additional Live Active

[1] http://www.chps.org.uk/content/default.asp?page=s363.

counsellor. This additional post is based in the same sites as the Live Active exercise counsellor. The aim of the post is to “fast track” participants referred from a Keep Well screening to the Live Active Referral Scheme and to enhance the Live Active Referral Scheme to also include weight management and nutrition as health behaviours being addressed.

**Mean**
The arithmetic average.

**NHSGG&C**
NHS Greater Glasgow and Clyde.

**Participant**
This is the term used by the Live Active Referral Scheme to denote those referred to the Live Active Referral Scheme and participating in it.

**SIMD, Scottish Index of Multiple Deprivation**
The official measure for identifying small area concentrations of multiple deprivation across all of Scotland.[2]

**SPSS**
Originally Statistical Package for the Social Sciences. SPSS is a computer software package designed to accommodate and facilitate the analysis of arrays of numerical data. FMR used SPSS software to analyse the database and survey responses.

**Stage of change**
This is an assessment tool which looks at people and categorises their current behaviour and attitude towards health behaviour change. There are five stages of change:

| | |
|---|---|
| Pre contemplation: | I am not regularly physically active and do not intend to be |
| Contemplation: | I am not regularly physically active but I am thinking about starting in the next 6 months |
| Preparation: | I do some physical activity but not enough to meet the description of regular physical activity |
| Action: | I am regularly physically active but only became so in the last 6 months |
| Maintenance: | I am regularly physically active and have been so for longer than 6 months |

People’s stage of change is a transitory cyclical measure and can go forwards and backwards on the scale. But the observed result is that people are increasingly likely to move closer towards maintenance with every cycle around the stages.

[2] http://www.statistics.gov.uk/StatBase/Product.asp?vlnk=14765&Pos=&ColRank=1&Rank=208.

# 1 Introduction

## 1.1 Background

### 1.1.1 Policy background to Keep Well

The Government White Paper 'Delivering for Health' was announced in October 2005 and outlined a commitment to develop an anticipatory care model as part of the NHS wider agenda of tackling health inequalities. Keep Well (previously known as Prevention 2010) is one example of anticipatory care in practice.

The programme aimed to increase the rate of health improvement in 45-64 year olds in areas of greatest need, with a particular focus on early intervention for those at a high risk of coronary heart disease and diabetes. The three-year programme is phased in two waves; wave 1 from 2006-2008 and wave 2 from 2007-2009. In total NHS Greater Glasgow and Clyde had 5 Community Health Partnerships selected for Keep Well. These were: North Glasgow, East Glasgow, South West Glasgow, Inverclyde and West Dunbartonshire.

### 1.1.2 Keep Well background

The Keep Well vision is 'to increase the rate of health improvement in deprived communities by enhancing primary care services to deliver anticipatory care'. Keep Well has done this by:

- identifying and targeting those at particular risk of preventable serious ill-health (including those with undetected chronic disease);
- offering appropriate interventions and services to them; and
- providing monitoring and follow-up.

Individuals in the target population received a letter or a phone call from their GP practice inviting them to attend a Keep Well health check. The health check is essentially a risk assessment carried out by healthcare practitioners to identify intermediate clinical risk factors (such as high cholesterol), lifestyle risk factors (such as smoking) and any other issues that may impact on health (such as unemployment). Based on the assessment, individuals are offered or directed to appropriate services and support. This may include drug therapy, healthy eating advice, physical activity classes, smoking cessation support, alcohol interventions or even benefit advice.

### 1.1.3 Live Active Referral Scheme

The Live Active Referral Scheme is a service for people who are inactive and would benefit from increasing their physical activity. The Scheme may be appropriate for people who:

- are not currently regularly physically active but you are thinking about becoming more active, and feel they require support to make this change;
- are currently doing some activity but feel additional advice and support would help increase their levels of activity; or
- have been advised to become more active, e.g. by their GP or Practice Nurse but don't really know where to start.

Referred participants enrol onto the scheme for a period of 12 months and receive an evidence based one-to-one physical activity counselling service. This is in the form of a structured consultation at the baseline stage, and two further recall consultations at 6 and 12 months. Additional support given to participants throughout the 12 month

scheme includes telephone calls, letters and the option of supported exercise sessions.

### 1.1.4 Health Counsellor Model

In order to achieve the overall aims and objectives of the Keep Well Project, a dedicated health counsellor service was introduced for Keep Well clients within the current Live Active Referral Scheme. NHS Greater Glasgow and Clyde introduced the role of the Health Counsellor to provide evidence based interventions around physical activity, weight management and healthy eating and offer access to a variety of local support programmes and activities in respect to these behaviours. The health counsellor model was based on the evidence base and good practice of the Live Active Referral Scheme but with some key differences/expansions to the Live Active model.

The health counsellor model aims were to:

- provide assistance in supporting people through the behaviour change process addressing nutrition and weight management in addition to physical activity;
- provide an individualised support service which is flexible and determined by the patients' needs and requirements;
- provide a more localised community based service with a range of easily assessable venues as opposed to the Live Active scheme where the service is mainly leisure centre based; and
- establish close links with GP practices.

The health counsellor model was introduced into the 5 Keep Well areas as well as Renfrewshire. A total of 11 counsellors were employed (1 North Glasgow, 1 East Glasgow, 1 South West Glasgow, 2 Inverclyde, 3 West Dunbartonshire and 3 Renfrewshire).

## 1.2 Objectives

The purpose of this research was to:

- explore participants' experiences and the views of Health Counsellor staff of the Live Active Health Counsellor programme;
- explore the impact the Live Active Health Counsellor programme has had on participants' lifestyle behaviours; and
- to provide recommendations for future service delivery.

# 2 Method

This section explains the approach we took in meeting the aims and objectives as outlined in the previous section.

## 2.1 Overview

The study consisted of a telephone survey with participants of the scheme (who had attended to varying degrees) and a focus group with Health Counsellors. The process followed is detailed below.

## 2.2 Survey

### 2.2.1 The process

Following the commissioning meeting, FMR developed the questionnaire for use with programme participants and the topic guide for the focus group in conjunction with the NHSGG&C Health Improvement Team. The questionnaire focussed on the patient experience of the programme, e.g. the level of service received for all aspects of the programme, meeting of expectations benefits noticed, reasons/motivations for continuing with the scheme, options for support given, etc. Those who did not complete the scheme were asked specifically about the barriers they encountered and reasons for this. The interview had a substantial qualitative element, although some quantitative data was also sought for analysis (for example client profile data).

The Health Improvement Team provided data on participants who had taken part in the programme, this included:

- stage of programme reached;
- gender; and
- contact details, including name, address and telephone number.

Using the contact details supplied, letters were sent out introducing FMR, outlining the research and advising people that they might be contacted and asked to take part in the survey. Participants were given the choice of 'opting out' of the research, by telephone to FMR or an NHSGGC named contact. Those who were willing to take part were also asked to specify whether morning, afternoon, evening or weekend interviews suited them best (a form and reply-paid envelope were included to facilitate this). Participants who did not specifically opt out of the survey were contacted and interviews were carried out between mid February and the first week in April 2010.

Participants were invited to take part on the basis of having completed, not completed the programme or been referred at least 6 months prior to the interview time, depending on the stage they had reached. The following terms for the different categories of participants will be used throughout the report.

**Baseline non attender** – refers to a participant who had failed to attend a baseline consultation with the health counsellor. A participant must arrange and attend a baseline consultation within 6 months of the referral date shown on the referral form. Therefore any participant with a referral date between March and May 2009 was chosen – 90 participants who did not attend baseline were invited to take part and 15 interviews were completed.

**6 month non attender** – refers to a participant who had attended a baseline consultation but no further appointments. Participants were chosen on the basis that they had attended a baseline consultation between January and March 2009 – 99

participants who did not attend a 6 month consultation were invited to take part and 15 interviews were completed.

**12 month non attender** – refers to participants who had attended both baseline and 6 month consultations but failed to attend the final 12 month consultation. Participants were chosen on the basis that they had attended a 6 month consultation between October 2008 and March 2009 – 47 participants who did not attend a 12 month consultation were invited to take part and 15 interviews were completed.

**Completer** – refers to participants who attended all consultations. Participants were chosen on the basis that they had attended a 12 month consultation between June 2009 and January 2010 – 181 participants who had completed the programme were invited to take part and 90 interviews were completed.

### 2.2.2 Profile of respondents

**Respondent profile by stage of scheme and reason for referral**

The number of interviews undertaken with respondents at each stage is shown in Table 1 below. The Health Counsellor programme is delivered across three Keep Well areas of Glasgow City and in Inverclyde, Renfrewshire and West Dunbartonshire. Whilst we tried to achieve a spread of interviews across these areas, as shown in Table 2, we were restricted by the number of contacts in some areas, with the three Glasgow Keep Well areas having particularly low numbers of completers, compared to the areas outwith Glasgow City.

**Table 1 Stage of programme reached**

| | No. | % |
|---|---|---|
| Baseline non attender | 15 | 11% |
| 6m non attender | 15 | 11% |
| 12m non attender | 15 | 11% |
| Completer | 90 | 67% |
| Total | 135 | 100% |

**Table 2 Area**

| | All respondents | | Stage reached | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Baseline non attender | | 6m non attender | | 12m non attender | | Completer | |
| | No. | % | No. | % | No. | % | No. | % | No. | % |
| Keep Well East | 14 | 10% | 3 | 20% | 4 | 27% | 5 | 33% | 2 | 2% |
| Keep Well North | 14 | 10% | 2 | 13% | 1 | 7% | 6 | 40% | 5 | 6% |
| Keep Well SW | 14 | 10% | 3 | 20% | 3 | 20% | 1 | 7% | 7 | 8% |
| Inverclyde | 16 | 12% | 1 | 7% | 3 | 20% | 1 | 7% | 11 | 12% |
| Renfrewshire | 38 | 28% | 4 | 27% | 2 | 13% | 1 | 7% | 31 | 34% |
| West Dunbartonshire | 39 | 29% | 2 | 13% | 2 | 13% | 1 | 7% | 34 | 38% |
| Total | 135 | 100% | 15 | 100% | 15 | 100% | 15 | 100% | 90 | 100% |

**Demographic profile of respondents**

Sixty percent of respondents were female (81 respondents) and 40% were male (54 respondents). The tables below show the age profile (two-thirds were aged 45 – 64, the target age for Keep Well), ethnicity (97% were White Scottish) and employment

status (22%, 30 respondents, were not working due to ill health). A third (44 respondents) considered themselves to have a disability.

**Table 3 Age**

| | No. | % |
|---|---|---|
| 16-24 | 1 | 1% |
| 25-34 | 6 | 4% |
| 35-44 | 10 | 7% |
| 45-54 | 45 | 33% |
| 55-64 | 45 | 33% |
| 65+ | 28 | 21% |
| Total | 135 | 100% |

**Table 4 Cultural or ethnic background**

| | No. | % |
|---|---|---|
| White - Scottish | 131 | 97% |
| White - other British | 2 | 1% |
| White - other background | 1 | 1% |
| Chinese | 1 | 1% |
| Total | 135 | 100% |

**Table 5 Employment status**

| | No. | % |
|---|---|---|
| Self-employed | 4 | 3% |
| Full-time employed | 32 | 24% |
| Part-time employed | 14 | 10% |
| In full-time education | 1 | 1% |
| Unemployed and seeking work | 5 | 4% |
| Retired - age | 35 | 26% |
| Retired - medical grounds | 11 | 8% |
| Not working due to ill health | 30 | 22% |
| Other not working and not seeking work | 2 | 1% |
| Volunteer | 1 | 1% |
| Total | 135 | 100% |

**Table 6 Do you have a disability?**

| | No. | % |
|---|---|---|
| Yes | 44 | 33% |
| No | 91 | 67% |
| Total | 135 | 100% |

## 2.3 Focus group with Health Counsellors

All eleven Health Counsellors attended a focus group discussion. Three work in the Glasgow City Council area, three in West Dunbartonshire, three in Renfrewshire and two in Inverclyde. It should be noted that some counsellors were more recent recruits,

for example in post for three months, whilst others had been in post for over two years. This obviously has an impact on the amount and type of training they have received and their experience of implementing their role.

The group was facilitated using a topic guide which allowed flexibility and open-ended responses. Topics covered included:

- training;
- support to transfer from Live Active to Health Counsellor role;
- challenges in supporting participants in general, and with healthy eating and weight management issues in particular;
- ability to meet the needs of people referred for each of the three issues;
- what has worked well – and what not so well; and
- how the service could be improved.

## 2.4 Data analysis and reporting

Qualitative data, from interviews and the focus group were coded and analysed using the lines of enquiry from the topic guide as the coding frame. The quantitative results of the telephone survey were analysed using SPSS. A draft report was offered for comment prior to the final draft being submitted.

# 3 Key findings

This section outlines the key findings from the telephone survey and the focus group. The charts illustrate the full sample of 135 unless otherwise indicated (in the case of missing responses/question not applicable to all). Please note that when comparing results by area that in most instances the Glasgow areas have been combined as the individual numbers were particularly low in these areas. The numbers are low throughout, however, so this must be taken into account when considering percentages in particular.

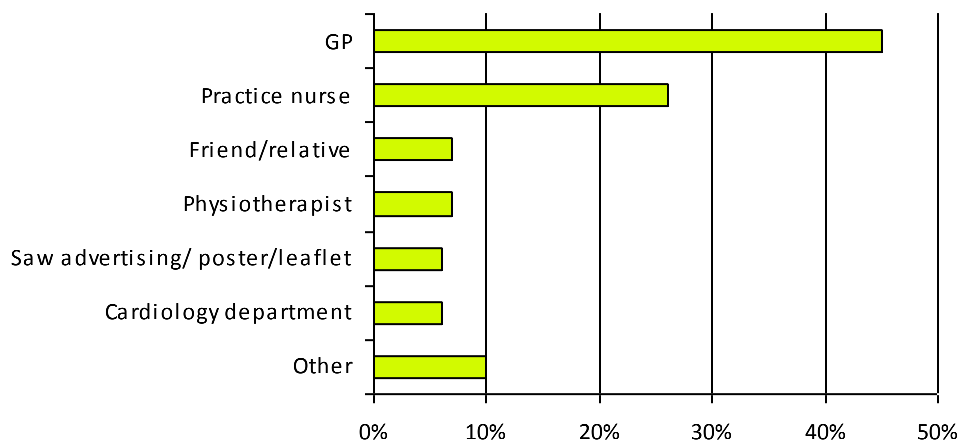
## 3.1 The participants' perspective

### 3.1.1 First thoughts about the Live Active Health Counsellor programme

**Awareness of and referral to the programme**

Almost half the sample (45%, 61 respondents) had heard about the Live Active Health Counsellor programme from their GP and just over a quarter (25%, 35 respondents) from their practice nurse. The full range of responses is detailed below.

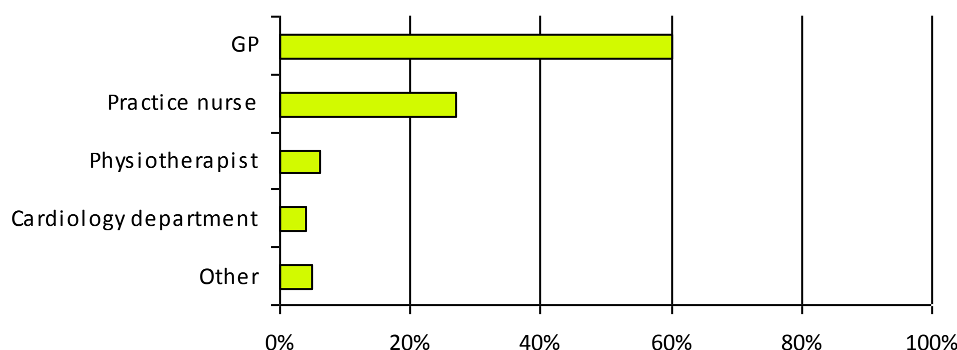
**Figure 1 How did you first hear about the Live Active Health Counsellor programme?**




- Fewer people in West Dunbartonshire had heard about the programme from their GP (26%, 10 respondents) or practice nurse (15%, 6 respondents)
- Respondents in West Dunbartonshire were more likely to have heard of the programme from each of the other sources, for example, of the nine people who heard about the programme from a physiotherapist, eight of them were in West Dunbartonshire.

Similarly, the most common referral route was also via the GP (60%, 81 respondents). Just over a quarter were referred by their practice nurse (27%, 37 respondents), 6% (8 respondents) by their physiotherapist and 4% (6 respondents) by the cardiology department, as can be seen in the figure below.

**Figure 2 And how were you referred?**




- Referrals from a GP were particularly strong in Renfrewshire (68%, 26 respondents).
- Practice nurses were good referrers in Glasgow (43%, 18 respondents), reflecting the strong presence of Keep Well in Glasgow.
- Those in West Dunbartonshire were less likely to be referred by a practice nurse (15%, 6 respondents) but this was the only area where respondents were referred by a physiotherapist (21%, 8 respondents).

Following the interviews, the reasons for referral (physical activity, weight management and/or healthy eating) of those who had been interviewed was determined from the health counsellor records to assist in interpreting the data (Table 7 below). Of the 135 participants interviewed, 79 were referred for physical activity only, 25 for weight management only, 1 for physical activity and weight management, 9 for physical activity and healthy eating, six for all three health behaviours and it was unknown for 15 individuals (those who did not attend a baseline consultation with the health counsellor).

Table 8 below compares the known reasons for referral (this is asked by the health counsellor at the first consultation) and the perceived reasons for referral as given by participants when surveyed. Whilst there is a relatively close match for those who were referred for physical activity (there was sometimes a joint referral for other things), and weight management, those who were referred for healthy eating were much less likely to recognise that this was the reason for referral to the programme (please note that the numbers are small), with most considering their reason for referral to be for physical activity and/or weight management. Participants were generally more likely to cite a number of reasons than the actual reason for referral, as the numbers citing weight management and healthy eating in particular were much higher than the database would suggest.

**Table 7 Referred for… (taken from health counsellor records)**

| | No. | % |
|---|---|---|
| Physical activity only | 79 | 59% |
| Weight management only | 25 | 19% |
| Healthy eating only | 0 | 0% |
| Physical activity and healthy eating | 9 | 7% |
| Physical activity and weight management | 1 | 1% |
| Weight management and healthy eating | 0 | 0% |
| Physical Activity, Weight Management and healthy eating | 6 | 4% |
| Unknown | 15 | 11% |
| Total | 135 | 100% |

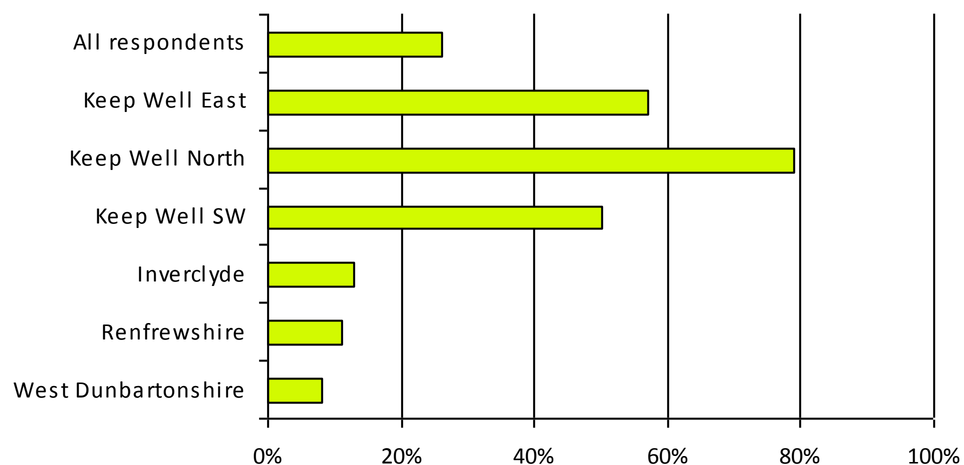
**Table 8 Comparison of database and respondents' perception of reasons for referral (multiple response)**

| | | Referred for (from database) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Total | | Physical activity | | Weight management | | Healthy eating | | Unknown | |
| | | No. | % | No. | % | No. | % | No. | % | No. | % |
| Referred for (from survey) | Physical activity | 119 | 88% | **88** | **93%** | 24 | 75% | 13 | 87% | 13 | 87% |
| | Weight management | 63 | 47% | 32 | 34% | **27** | **84%** | 7 | 47% | 9 | 60% |
| | Healthy eating | 59 | 44% | 30 | 32% | 25 | 78% | **6** | **40%** | 9 | 60% |
| | Unknown | 4 | 3% | 3 | 3% | 1 | 3% | 1 | 7% | 0 | 0% |
| | Total | 135 | 100% | 95 | 100% | 32 | 100% | 15 | 100% | 15 | 100% |

### Keep Well Health Check attendance

Just over a quarter (26%, 35 respondents) reported that they had attended a Keep Well health check, 62% (84 respondents) had not and 12% (16 respondents) did not know. However, it must be noted that this question reflects the respondents' recollections of what they have attended rather than a factual record of Keep Well attendance. For example, whilst attendance was much higher in Glasgow (62%, 26 respondents: 8 were from East, 11 from the North and 7 from the South West), this should have been a 100% response as all Glasgow respondents came to be referred to Live Active via the Keep Well health check. In contrast, just 8% (3 respondents) of respondents from West Dunbartonshire reported that they had attended a Keep Well check and 13% (2 respondents) from Inverclyde. In addition, 11% of respondents from Renfrewshire (4 respondents) reported that they had attended a Keep Well check but Keep Well does not exist in Renfrewshire. Respondents in Glasgow will have attended a Keep Well check but perhaps not realised that this was the case as they were attending the GP for something else, may not have been told or did not recall the term 'Keep Well', whilst those in Renfrewshire may have attended a Well Man or Well Woman check, or something similar, and presumed that this was Keep Well.

**Figure 3 Did you attend a Keep Well Health Check?**

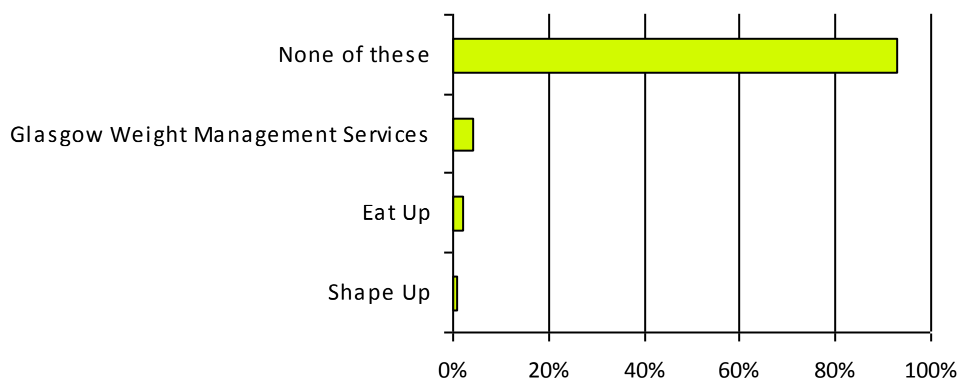



### Referral to other services

We then asked people whether they had been referred to other weight management or healthy eating services such as Glasgow Weight Management Services (GWMS), Eat Up or Shape Up. Very few had (7%, 9 respondents). Five had been referred to GWMS, three to Eat Up and one to Shape Up. An additional five people had been

referred to other health behaviour services and everyone said the number of services they had been referred to was about right.

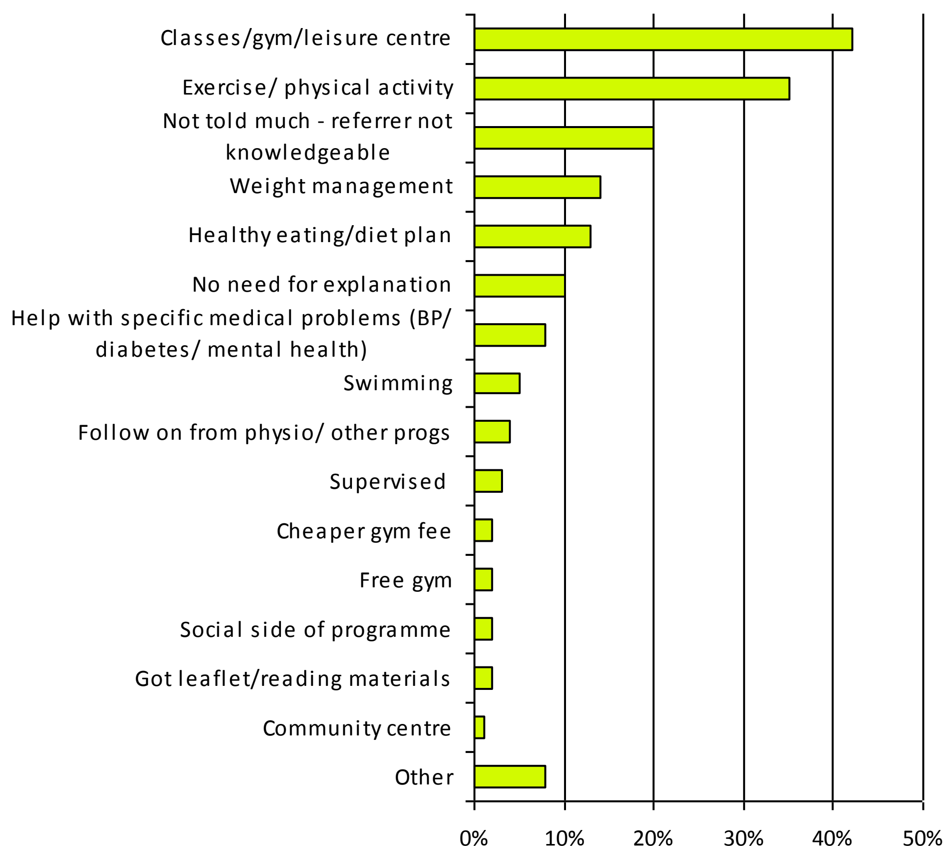
**Figure 4 Have you been referred to any of the following services?**




### Explanation of the Live Active Health Counsellor Service

We asked interviewees how the service was explained to them by the person making the referral. The most frequently cited response was classes/gym/leisure centre (42%, 52 respondents) followed closely by exercise/ physical activity (35%, 44 respondents). A further 20% (25 respondents) said they were not told much/referrer wasn't knowledgeable. This perhaps confirms concerns that the service was strongly associated with going to the gym and other formal exercise opportunities. This is on offer but is not the only form of physical activity suggested or supported by the counsellors, as some people may feel intimidated by the gym/leisure centre environment.

**Figure 5** **How did the person referring you to the Live Active Health Counsellor describe/explain the service to you?**




n=124

Respondents in Glasgow were more likely to report that they were told the service was classes/gym/leisure centre (71%, 25 respondents). This may again reflect the higher proportion of Keep Well referrals and suggests that there is still work to be done in communicating the distinctions of this service to those who may be referring. This may also be because those referrers in Glasgow have had the Live Active Referral Scheme for a number of years and may be less familiar with the different approach of the health counsellor service, whilst the other areas which are newer to the Live Active scheme generally may have had more recent training/communications on the distinctions between the two. The Live Active Scheme previously only operated in Greater Glasgow. However, the expansion of the health board area to include Clyde resulted in the expansion of the Live Active Scheme to Inverclyde, Renfrewshire and all areas of West Dunbartonshire. As a result of the expansion, all GP practices in the new local authority areas received a briefing on the scheme from the Counsellors. Those from Inverclyde and Renfrewshire were more likely to comment that they were not told much (31%, 5 respondents, and 33%, 12 respondents respectively) compared to the other two areas (16%, 6 respondents, in West Dunbartonshire and 6%, 2 respondents, in Glasgow).

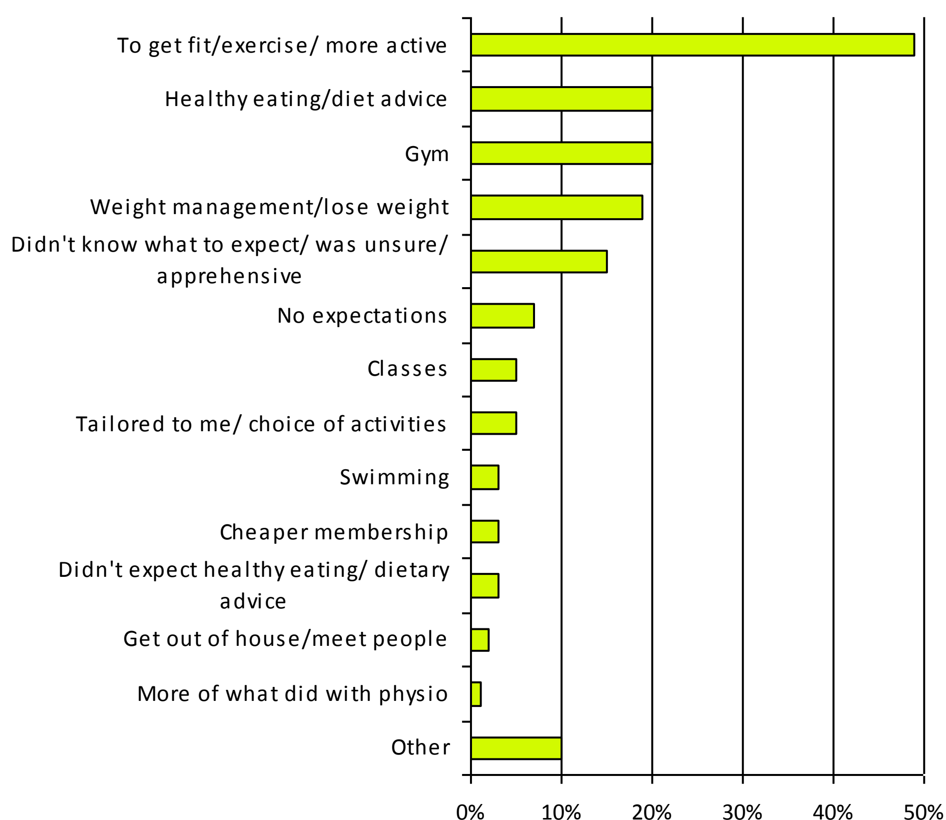
We then asked respondents if they knew how the programme differed from other services like Eat Up. Not surprisingly given so few had been referred to other services, more than half said they did not (53%, 71 respondents), a fifth (20%, 27 respondents) were unsure and more than a quarter stated they had not been referred to any other services (27%, 36 respondents). Just one respondent stated that they knew how the programme differed from other services on offer.

## Expectations of the service prior to attendance

We asked respondents what their expectations of the service were before they attended. Almost half (49%, 66 respondents) expected to get fit/exercise/active, a fifth (20%, 27 respondents) expected to get healthy eating/diet advice and the same number expected the gym. Nineteen percent (25 respondents) expected weight management/to lose weight and 15% (20 respondents) didn't know what to expect/was unsure/apprehensive. Seven percent (9 respondents) had no expectations. The chart below shows the full range of responses.

Nearly a third of those in Glasgow (31%, 13 respondents) expected the gym and 21% (8 respondents) of those in West Dunbartonshire didn't know what to expect/were unsure/apprehensive. Female respondents were also more likely to state that they didn't know what to expect/were unsure/apprehensive (21%, 17 respondents, compared to 6%, 3 males).

**Figure 6 What were your expectations of the service, before you attended?**

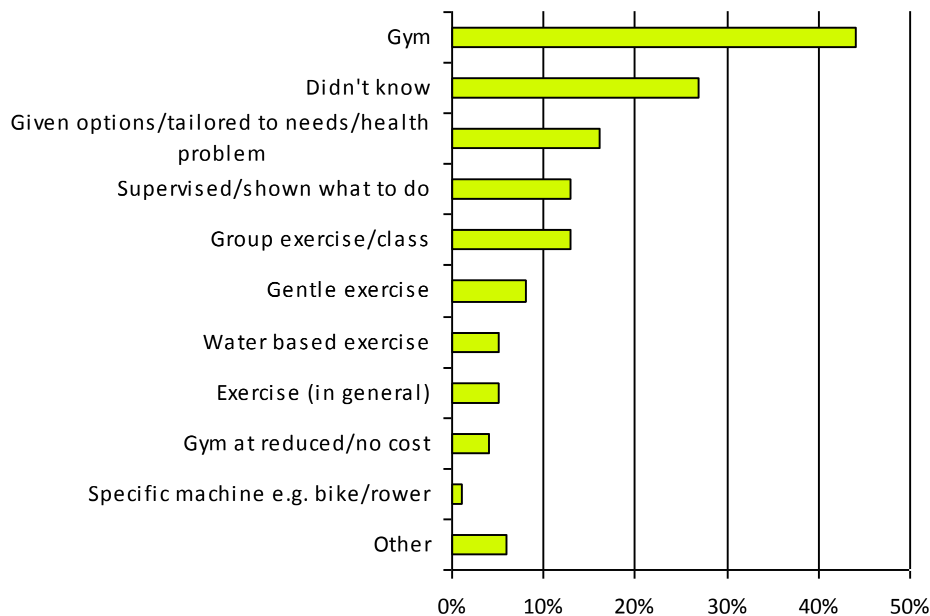



Those who expected to take part in physical activity were asked to be specific about the sorts of things they thought they would do. Forty-four percent (60 respondents) expected the gym, just over a quarter didn't know (27%, 36 respondents), 16% (21 respondents) thought they would be given options/tailored to needs/health problem and 13% thought they would be supervised/shown what to do or would take part in a group exercise/class (18 and 17 respondents respectively). Some other responses were given and these can be seen in the figure below.

Respondents in Glasgow were again more likely to respond 'gym' (57%, 24 respondents), whilst those in Renfrewshire were more likely than other areas to think they would be given options tailored to their needs (24%, 9 respondents), again possibly reinforcing the ways in which the service is communicated in more/less established Live Active areas and those with a high Keep Well quotient. Men were

more likely than women to think they would be given options to suit their needs (24%, 13 respondents) and women were more likely than men to state that they didn't know what to expect (32%, 26 respondents).

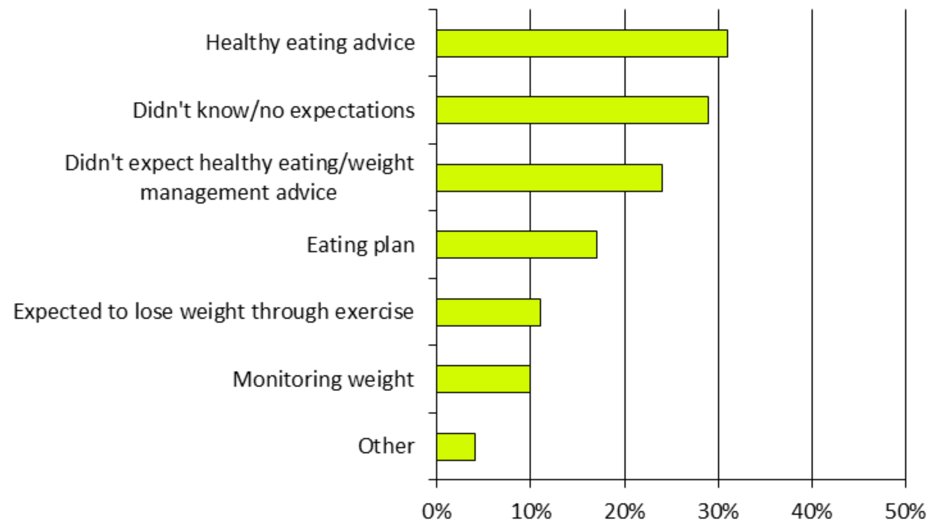
**Figure 7 If physical activity based services, what sort of things did you expect to receive/do (e.g. shown how to use the gym equipment, etc)?**




Participants were also asked what they expected from the healthy eating/weight management aspects of the service. Thirty-one percent (22 respondents) thought they would get healthy eating advice, 29% (21 respondents) didn't know/had no expectations, almost a quarter (24%, 17 respondents) said they didn't expect this sort of advice, 17% (12 respondents) thought they would get an eating plan, 11% (8 respondents) said they expected to lose weight through exercise and 10% (7 respondents) thought their weight would be monitored.

Respondents in Glasgow were more likely than others to expect to lose weight through exercise (21%, 5 respondents), whilst those in Inverclyde and Renfrewshire were less likely to cite healthy eating (0% and 24%, 6 respondents, respectively) and more likely to cite eating plan (25%, 2 respondents, and 24%, 6 respondents respectively) or don't know (75%, 6 respondents in Inverclyde).

**Figure 8** **If healthy eating/weight management, what sort of things did you expect to receive/do (e.g. dietary plan)?**

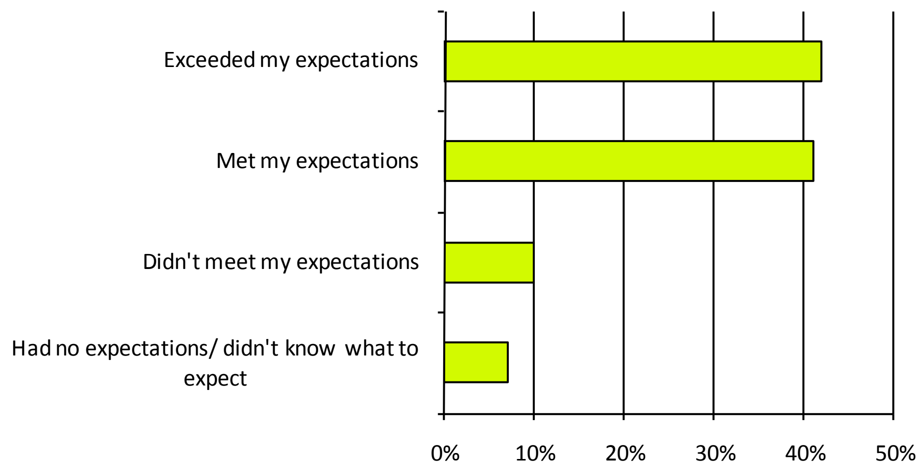



n=72

### Meeting those expectations

The way in which the programme compared to people's expectations once they had attended was also explored. It was encouraging that 42% (48 respondents) of those who attended said it had exceeded their expectations and 41% (47 respondents) said it met them. Only 12 people (10%) felt it did not meet their expectations and 7% (8 respondents) said they had no expectations.

**Figure 9** **How did the Live Active Health Counsellor programme compare to your expectations once you attended?**



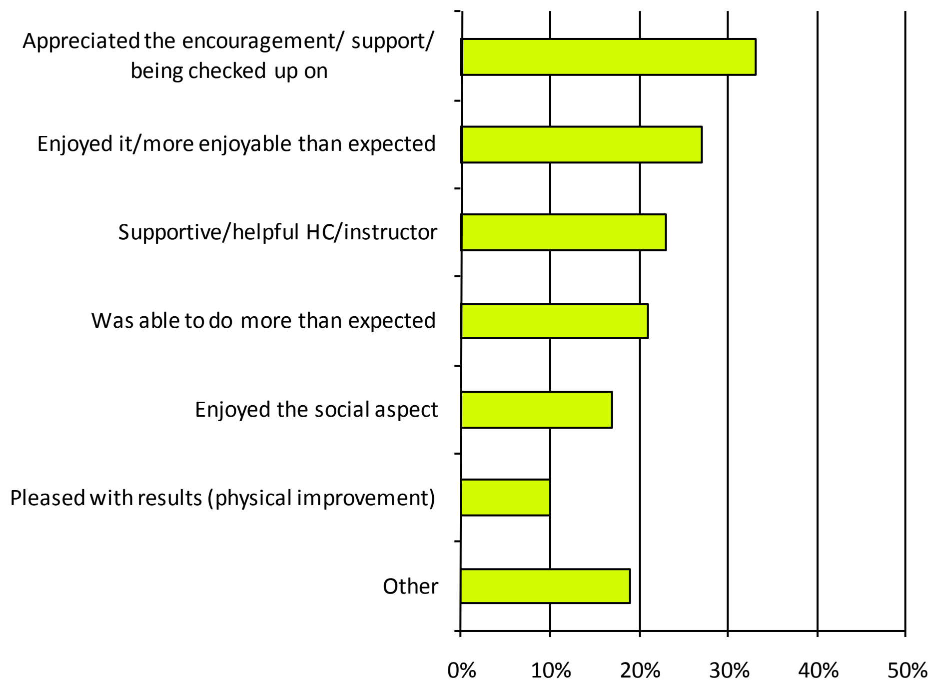

n=115

- Those from West Dunbartonshire were more likely to say the programme exceeded their expectations (57%, 21 respondents, compared to 26%, 9 respondents in Glasgow).
- Women were also more inclined to say the programme had exceeded their expectations (46%, 32 respondents, compared to 31%, 16 male respondents).

- Those aged 55 or over were also more likely to state that it had exceeded their expectations (47%, 32 respondents, compared to 34% of under 55s, 16 respondents), as they enjoyed it more than they expected, particularly the social element.
- As would be expected, the proportion of those who felt it had exceeded their expectations increased as the length of participation on the programme extended (48%, 43 completers, versus 10%, 1 person who did not attend 6 month consultation).

Those who said the programme exceeded their expectations were asked why this was the case. A third (33%, 16 respondents) said they appreciated the encouragement/ support/being checked up on, more than a quarter (27%, 13 respondents) said they enjoyed it/it was more enjoyable than expected, just under a quarter (23%, 11 respondents) gave the reason supportive/helpful Health Counsellor/instructor and around a fifth (21%, 10 respondents) were able to do more than expected. Seventeen percent (8 respondents) enjoyed the social aspect and 10% (5 respondents) were pleased with the results (physical improvement).

**Figure 10 Why do you say that - exceeded expectations?**




n=48

Reasons given for the programme not meeting expectations included: didn't suit health condition (6 people); not enough contact with Health Counsellor (2 people); timings didn't suit (2 people); and lack of own motivation (2 people). An additional two people gave other reasons (one found it boring and the other didn't like being questioned at the start).

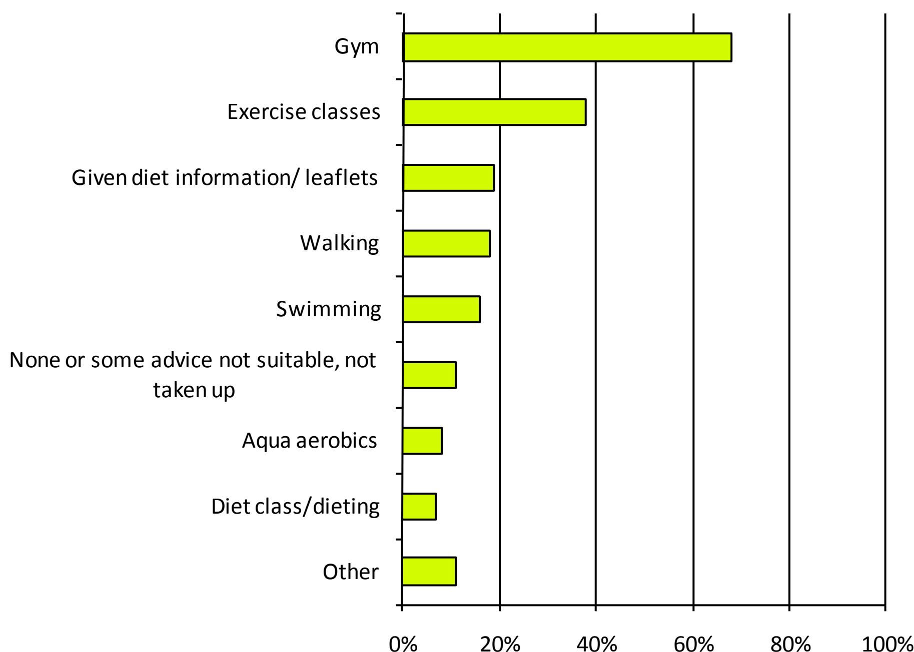
### 3.1.2 Experiences

#### Activities

Section two of the interview explored people's experiences of the programme in more detail. Respondents were asked what activities they got involved in. More than two thirds (68%, 81 respondents) cited the gym, 38% (45 respondents) attended exercise classes, almost a fifth (19%, 23 respondents) were given diet information/leaflets, 18%

(21 respondents) got involved in walking, 16% (19 respondents) went swimming and 11% (13 respondents) said they did not get involved in anything or some of the advice was not suitable. Eight percent (10 respondents) did aqua aerobics, 7% (8 respondents) attended diet class/dieting and 11% (13 respondents) said something else.

**Figure 11 Different activities are on offer to people with this service, what did you get involved in?**




n=120

There were some variations in what people got involved in depending on which area they were in.

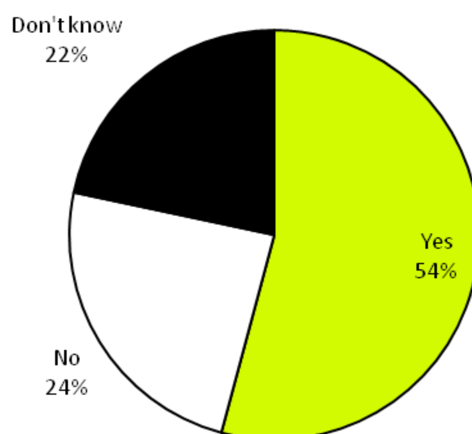
- Those in Glasgow were more likely to have attended the gym (76%, 26 respondents, compared to 40%, 6 respondents, in Inverclyde).
- Respondents in West Dunbartonshire and Inverclyde were more likely to attended exercise classes than other areas (49%, 18 respondents, and 53%, 8 respondents, respectively) but fewer people in West Dunbartonshire received diet information/leaflets (11%, 4 respondents).
- Walking was a more popular activity in Inverclyde (27%, 4 respondents) and Renfrewshire (24%, 8 respondents) than in Glasgow (6%, 2 respondents).
- Six people in West Dunbartonshire attended aqua aerobics but only two from each of the other areas cited this as an activity they got involved in.

### Options for support

Referred participants enrol onto the scheme for a period of 12 months and receive an evidence based one-to-one physical activity counselling service. This is in the form of a structured consultation at the baseline stage, and two further recall consultations at 6 and 12 months. Additional support given to participants throughout the 12 month scheme includes telephone calls, letters and the option of supported exercise sessions. As part of the health counsellor model a more flexible approach was introduced allowing for the participant to receive as much support as they felt necessary and this would be discussed at the preliminary meeting.

Participants were asked if they had been given options for different types of support by the health counsellor. More than half said they had been (54%, 65 respondents), around a quarter had not (24%, 29 respondents) and just over a fifth were unsure (22%, 26 respondents).

**Figure 12 Were you given different options for different types of support by the Health Counsellor?**



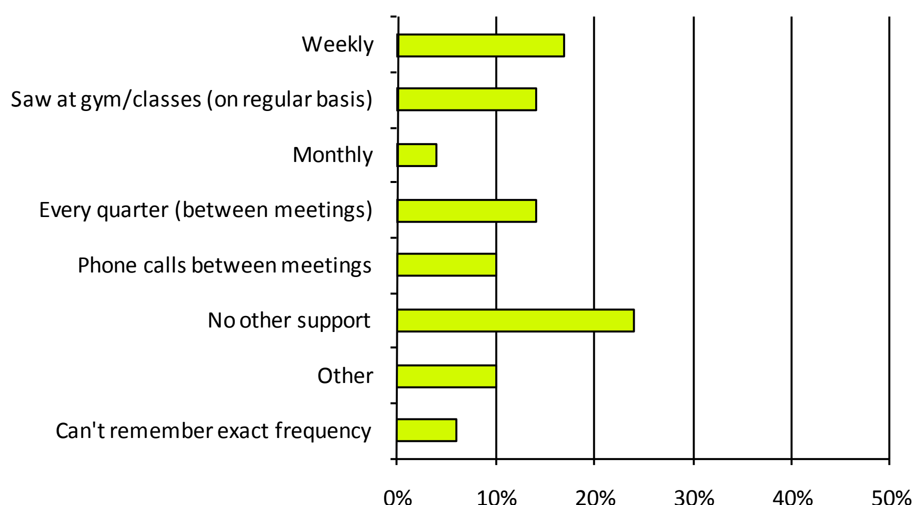

n=120

- Completers were more likely have answered yes to this question than non-completers (59%, 53 completers, compared to 53%, 8 respondents, 12 month non attenders and 27%, 4 respondents, 6 month non attenders).
- Those in West Dunbartonshire were also more likely to say they were given options for different types of support (68%, 25 respondents compared to 41%, 14 respondents, in Renfrewshire).
- Those who were aged under 55 and working/in education were less likely than others to say that they were given different options (47%, 24 respondents, and 48%, 20 respondents, respectively) but more likely to respond don't know (29%, 15 respondents, and 29%, 12 respondents) rather than no (24%, 12 respondents, and 24%, 10 respondents).

### Frequency of support

We asked people how often they received support from their Live Active Health Counsellor, outwith the more formal consultations. A quarter stated that they received no other support (24%, 28 respondents). However, 17% (20 respondents) received weekly support, 14% (16 respondents) saw their counsellor regularly at gym/classes and the same number said every quarter (between consultations). Ten percent (11 respondents) received phone calls between consultations, 4% (5 respondents) got monthly support, 6% (7 respondents) couldn't remember and 10% (12 respondents) said something else ('other', primarily whenever needed or that it varied).

**Figure 13 How often did you receive support from the Live Active Health Counsellor?**




n=115

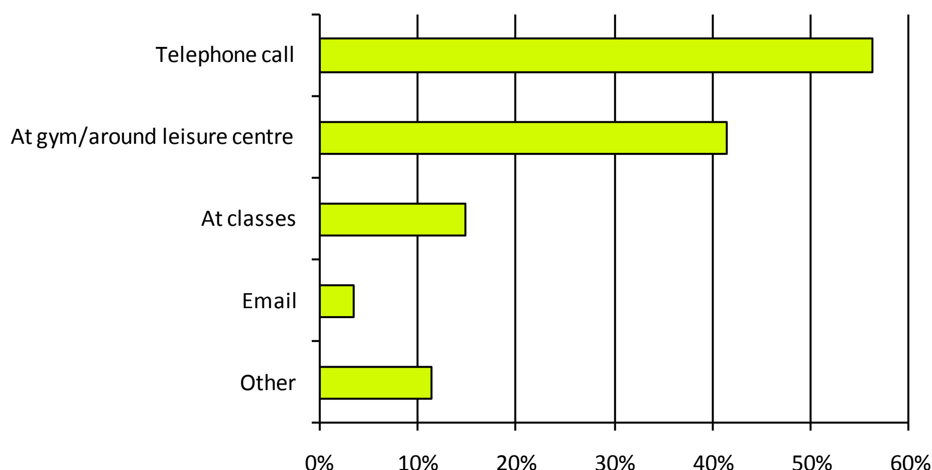
When grouping the data and looking at those who had consultations only, those who had support less often than monthly and those who had it at least monthly, it is clear that the more support an individual received the more likely they were to continue attending the programme.

- Seventeen percent (15 respondents) of completers stated they had no support outwith the meetings.
- However, 40% (6 respondents) of 12 month non attenders and 70% (7 respondents) of 6 month non attenders said they only had consultations.
- No-one who did not attend the 6 month stage had support at least monthly in addition to consultations and just 33% (5 respondents) of those who did not attend 12 month had at least monthly support, in contrast to 49% (44 respondents) of those who completed the programme.
- Those in West Dunbartonshire received the most support outwith consultations.
- Respondents in the Glasgow area were more likely to have had consultations only (47%, 14 respondents, compared to 11%, 4 respondents, in West Dunbartonshire).
- More than half of respondents in West Dunbartonshire (57%, 21 respondents) received support at least monthly compared to 27% (8 respondents) in Glasgow.
- Male respondents were more likely to receive at least monthly support (51%, 25 respondents) compared to women (36%, 24 respondents).
- Those who were working/in education were much less likely to receive at least monthly support (21%, 8 respondents) than those of other employment status.

**Type of support**

Those who received additional support were asked which form this took. This question was not mutually exclusive and people may have cited more than one kind of support. More than half received support by phone (56%, 49 respondents), 41% (36 respondents) were supported at the gym/leisure centre, 15% (13 respondents) cited at classes and 3% (3 respondents) received support by email. Eleven percent (10 respondents) mentioned other kinds of support.

**Figure 14 What kind of support did you receive?**




n=87

We then asked whether this support was too much, about right or not enough. The vast majority (88%, 101 respondents) felt it was about right and 12% (14 respondents) felt they didn't get enough support (the reasons for this are included separately with the data tables, but they generally would have liked more regular contact/support, particularly at the start of the programme). As would be expected, given the findings noted above, those who were more likely to state that they did not receive sufficient support were:

- less likely to have completed the programme (40%, 4 did not attend 6 month; 27%, 4 did not attend 12 month);
- based in Glasgow (20%, 6 respondents) or Inverclyde (27%, 4 respondents)
- female (15%, 10 respondents);
- aged under 55 (19%, 9 respondents); and
- working/in education (21%, 8 respondents).

## Rating of the service provided

Interviewees were asked to rate the service provided by the Live Active Health Counsellor on a scale of 0-10 where zero was low and ten was high. The mean response was a very positive 8.93 out of 10. The table below shows how this varied by different sub groups. The mean score increased as respondents attended the programme for longer, from 8.10 from participants who did not attend 6 month to 9.10 for completers. However, even those who did not complete gave a positive score. Respondents in Glasgow gave slightly lower scores (8.45 compared to 9.24 in Renfrewshire). Mean scores were consistent with the responses to previous questions, as men gave higher ratings than women (9.04 compared to 8.85), those aged 55 and over were more positive than those aged under 55 (9.00 compared to 8.83) and those who were working were less positive than those who were not (8.50 compared to 9.02 for those not working and 9.36 for retired people).

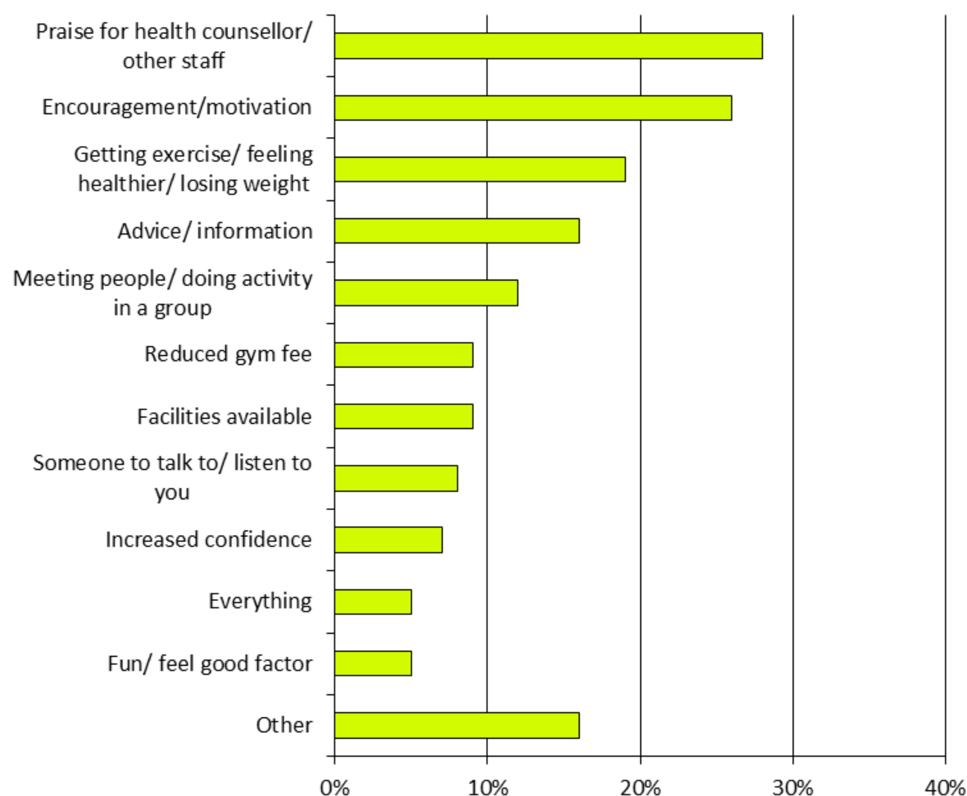
**Table 9 How would you rate the service overall?**

| Total | Stage reached | | | Area | | | | Gender | | Age | | Employment status | | | Do you consider yourself to have a disability? | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mean | Did not attend 6m | Did not attend 12m | Completer | Glasgow | West Dun | I'clyde | Renf | Male | Female | under 55 | 55 or over | Working/ education | Other non working | Retired age | Yes | No |
| 8.93 | 8.10 | 8.47 | 9.10 | 8.45 | 9.01 | 9.04 | 9.24 | 9.04 | 8.85 | 8.83 | 9.00 | 8.50 | 9.02 | 9.36 | 8.92 | 8.94 |

## Best things about the service

Participants were asked what the best things about the service were. More than a quarter (28%, 32 respondents) praised the health counsellor or other staff and a similar proportion said the encouragement/motivation was the best thing about the service (26%, 30 respondents). One in five (19%, 22 respondents) cited getting exercise/becoming healthier/losing weight and 16% (19 respondents) cited the advice/information provided. Other things were offered by interviewees and these can be seen in the chart below.

**Figure 15 What were the best things about the service?**



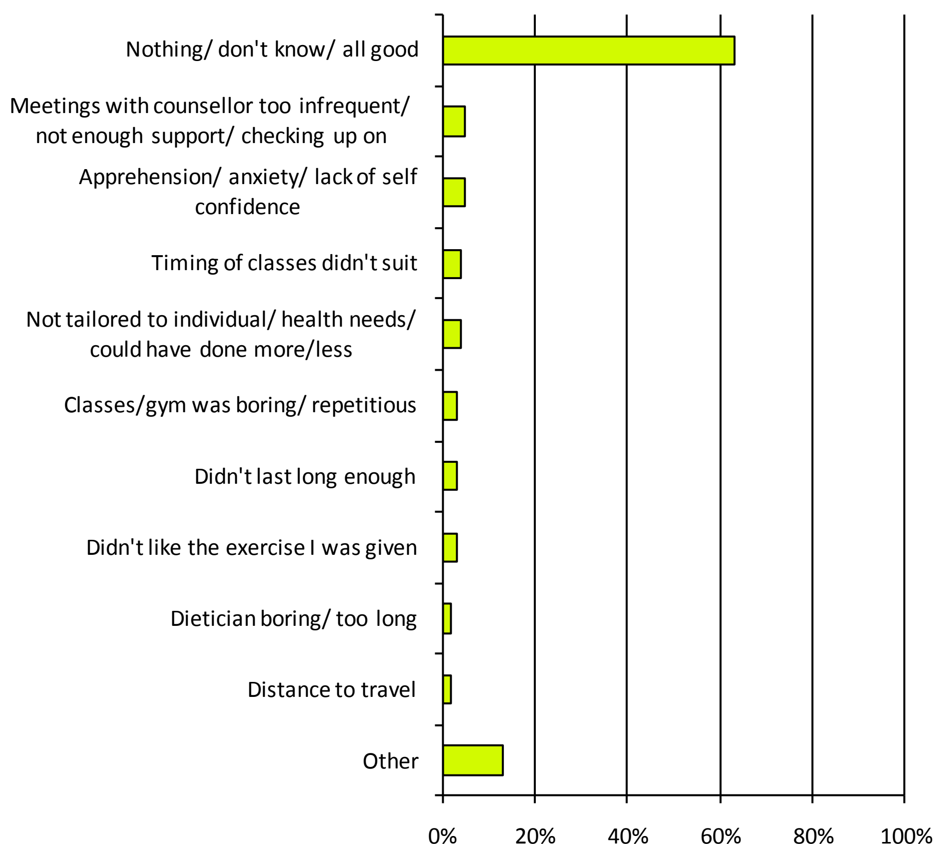

n=116

- Respondents in Glasgow were less likely to praise the staff they came into contact with than the other areas (16%, 5 respondents) or cited encouragement/motivation as the best thing about the service (19%, 6 respondents) but were more likely than other areas to cite the facilities available (19%, 6 respondents).
- Whilst the numbers were low, female respondents were more likely than men to rate the advice/information given (21%, 14 respondents, compared to 10%, 5 respondents) and meeting people/doing things in a group (16%, 11 respondents, compared to 6%, 3 respondents).
- Those aged under 55 were more likely to give praise for staff (33%, 16 respondents, compared to 24%, 16 respondents aged 55+) and cite the reduced gym fee (21%, 10 respondents, compared to 1%, 1 respondent).

## Areas for improvement in the service

Participants were then asked where there might be room for improvement. The majority (63%, 75 respondents) said nothing/don't know/all good, which is extremely encouraging. The full range of suggestions is illustrated below.

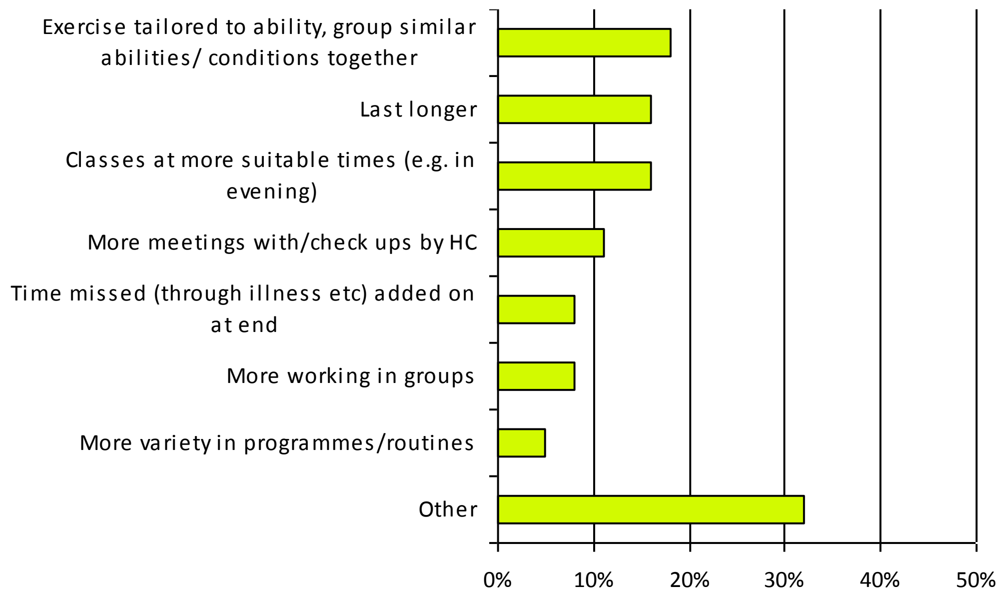
**Figure 16 What were the not so good things?**




n=120

Respondents were then specifically asked if there was anything they would change about the programme. Two-thirds of respondents (68%, 81 respondents) could suggest no changes or were happy with the service. Suggestions were mainly centred around improvements in the exercise regime, with changes to the programme itself (such as the programme lasting longer, more contact with the health counsellor, or the addition of time missed through illness added on at the end) being less common. Of those who suggested improvements, the most common suggestion was for more tailored exercise or classes, for example by grouping people of similar abilities or conditions together. Five of the six respondents who wished to see classes at more suitable times, for example in the evening, were in employment or education and so less able to attend during the day. The full range of responses is shown in the figure below.

**Figure 17 What, if anything, about the service provided by the Live Active health counsellor would you change?**

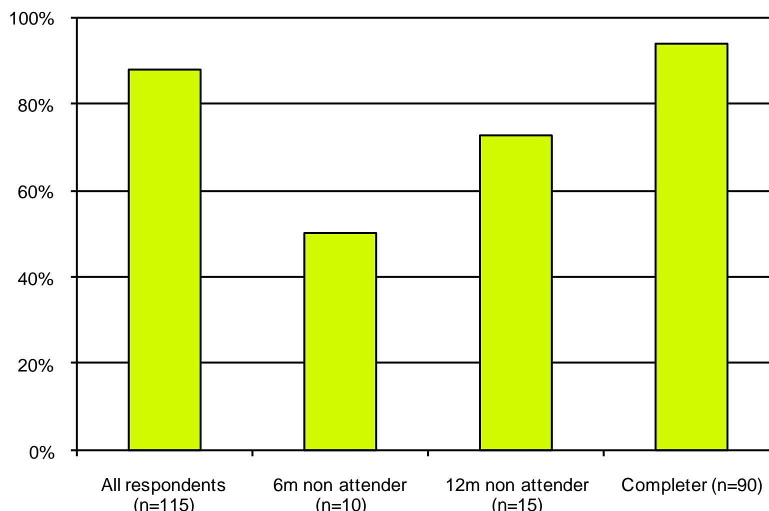



n=38

### Benefits to health

We asked whether people had noticed any benefits to their health as a result of the advice and support given by the health counsellor and 88% (101 respondents) said they had, 12% (14 respondents) had not. As would perhaps be expected, the longer an individual was with the programme the more likely they were to have seen a difference to their health: 94% (85 respondents) of those who completed answered yes to this question compared to 73% (11 respondents) of 12 month non attenders and 50% (5 respondents) of 6 month non attenders.

**Figure 18 Have you noticed any benefits to your health?**




Respondents who had noticed benefits to their health were first of all asked unprompted what these were and were then prompted with a pre-coded set of responses. The chart below shows the unprompted responses as well as the total number of responses after prompting (so prompted and unprompted combined). Responses with an asterisk were not prompted. The top three unprompted responses

were feeling fitter (39%, 39 respondents), losing weight (33%, 33 respondents) and feeling happier/less depressed/improved mental health (23%, 23 respondents). When combined with the prompted responses the top three were also feeling fitter (82%, 83 respondents) and losing weight (43%, 44 respondents) but the third most frequently cited was feeling healthier generally (73%, 74 respondents). The full range of responses can be seen below.

**Figure 19 If so, what would you say the benefits have been?**

* indicates those issues which were not prompted as they were coded from other responses on completion of the survey
n=101

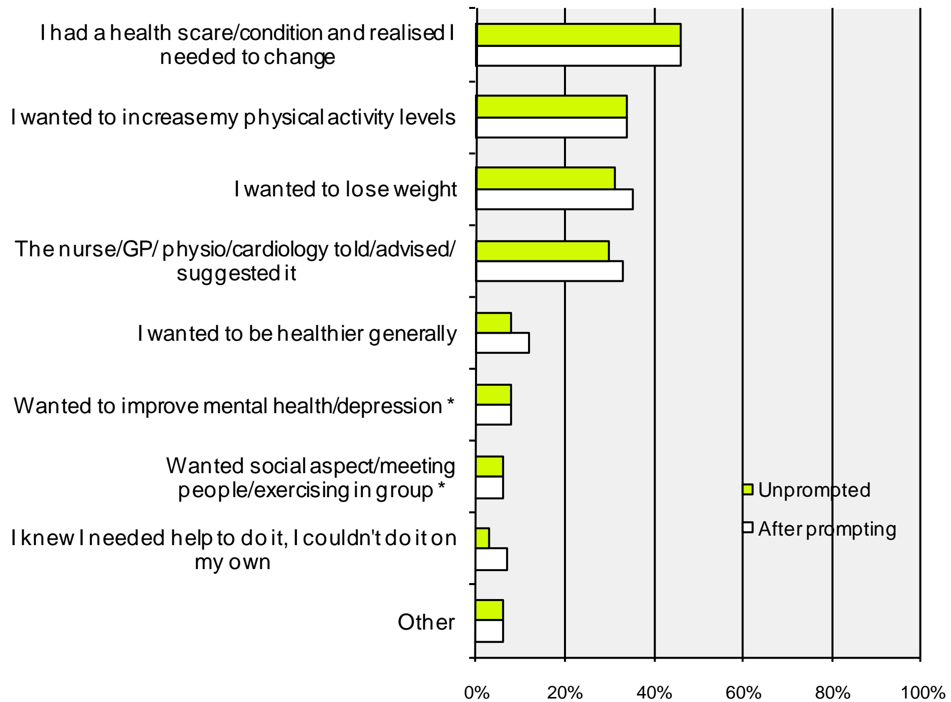
### 3.1.3 Motivations and barriers

**Reasons for attending**

The final section of the interview looked at motivations and barriers. Participants were asked why they attended the Live Active Health Counsellor in the first place; firstly unprompted and then prompted with a list of possible responses. As with the previous chart the one below shows both the unprompted response and the unprompted and prompted combined. There is little difference between the two types of response with a desire to lose weight, the nurse/GP/physio/cardiology told/advised/ suggested it, a wish to be healthier generally and needing help as unable to do it on own increasing

only slightly.  Forty six percent (55 respondents) said they attended because of a health scare/condition, 34% (41 respondents increasing to 42 when prompted) wanted to increase physical activity levels, 31% (37 respondents increasing to 35%, 42 respondents when prompted) wanted to lose weight and 30% (36 respondents increasing to 33%, 39 respondents when prompted) attended because the nurse/GP/physio/cardiology told/advised/suggested it.  As might be expected with the presence of Keep Well, this last point was particularly common in Glasgow (47%, 16 respondents).  Additional motivations are illustrated below.

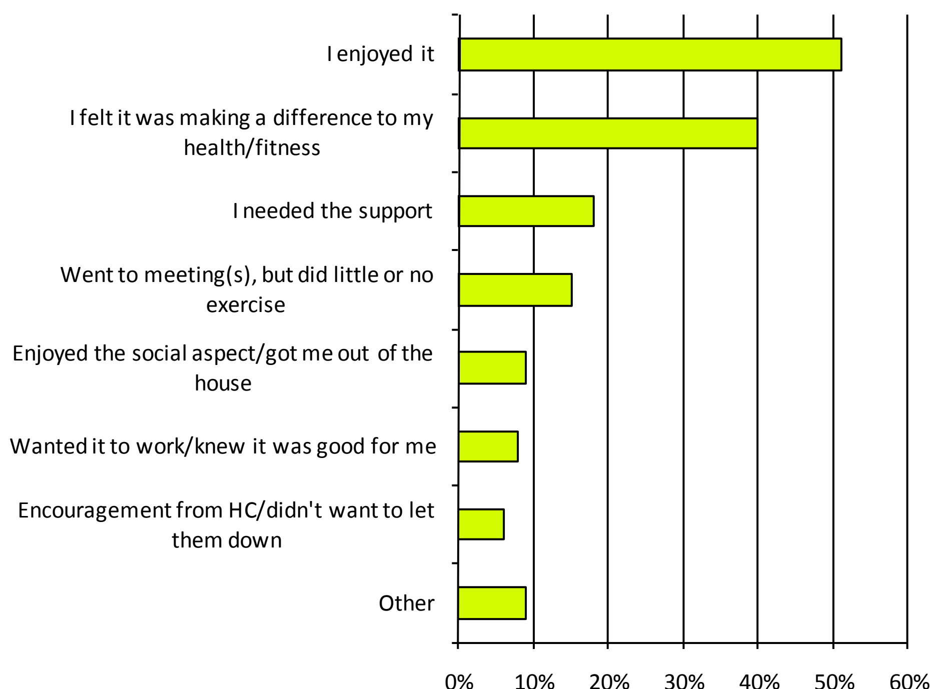
**Figure 20   Why did you attend the programme in the first place?**




* indicates those issues which were not prompted as they were coded from other responses on completion of the survey
n=120

If appropriate, we asked people what made them continue attending as long as they did.  Again this was prompted and unprompted but there was little difference therefore the chart below shows the combined answers only.  Just over half (51%, 61 respondents) said they enjoyed it, 40% (48 respondents) felt it was making a difference to their health/fitness, 18% (21 respondents) needed the support and 15% (18 respondents) pointed out that although they went to consultations they did little or no exercise, although it should be noted that twelve of these were 6 month non attenders, two were 12 month non attenders and just four were completers.  The full range of responses is shown in the chart below.

**Figure 21 What made you continue to attend as long as you did?**



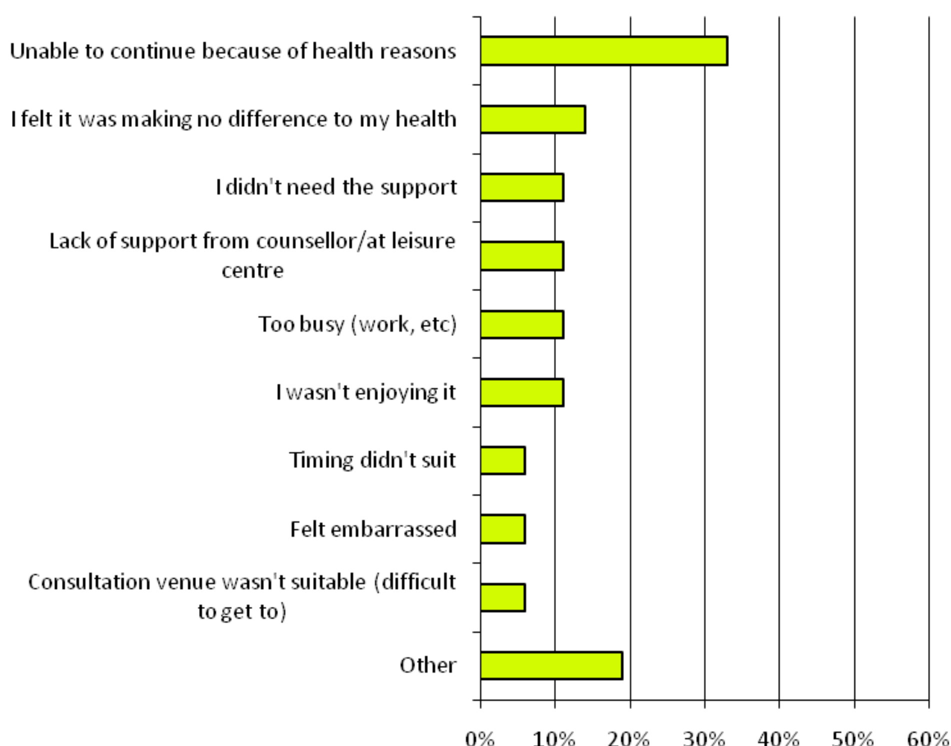

n=120

- Those who completed the programme were more likely to say that they enjoyed it (60%, 54 respondents, compared to 13%, 2 did not attend 6 month and 33%, 5 did not attend 12 month) and that they felt it was making a difference to their health and fitness (49%, 44 respondents, compared to 0% did not attend 6 month and 27%, 4 did not attend 12 month).
- Those who completed were also the only ones to say that they needed the support (23%, 21 respondents).
- Respondents in Renfrewshire (62%, 21 respondents) and Inverclyde (53%, 8 respondents) were more likely to say that they enjoyed it.
- More than half (57%, 21 respondents) from West Dunbartonshire felt it was making a difference to their health/fitness compared to just 18% (6 respondents) from Glasgow.
- Fewer people in Glasgow also said they needed the support (3%, 1 respondent compared to 27%, 10 respondents, in West Dunbartonshire and 24%, 8 respondents, in Renfrewshire).
- Half of those (9 out of 18) who said they went to consultations but did little or no exercise were in the Glasgow area (26%, 9 respondents) and this was also an issue in Inverclyde (27%, 4 respondents)
- Those aged 55 or over and retired on account of age were more likely to say they continued to attend as long as they did because they enjoyed it (61%, 42 respondents aged 55 and over compared to 37%, 19 respondents, aged 55 and under; and 85%, 28 retired respondents compared to 40%, 18 other non working respondents and 36%, 15 respondents working/in education).
- As one would perhaps expect, these groups were also more likely to say they enjoyed the social aspect/got me out of the house (14%, 10 respondents aged 55 and over, compared to 2%, 1 respondent aged 55 and under; and 24%, 8 retired respondents, compared to 2%, 1 other non working respondent and 5%, 2 respondents working/in education).

## Reasons for non-attendance

We asked those who had stopped attending why this was the case, as well as six completers who said they had not continued to exercise despite attending a 12 month consultation (and so were effectively non-adherers to the programme). A third (33%, 12 respondents) were unable to continue because of health reasons, 14% (5 respondents) felt it was making no difference to their health and 11% (4 respondents) gave each of the following responses: they didn't need the support, they received a lack of support from counsellor/leisure centre, they were too busy (work, etc.) or weren't enjoying it. Six percent (2 respondents) said the timing didn't suit, they felt embarrassed or the consultation venue wasn't suitable (difficult to get to). The numbers are too low to analyse this question by sub-group.

**Figure 22 Why did you stop attending?**




n=36

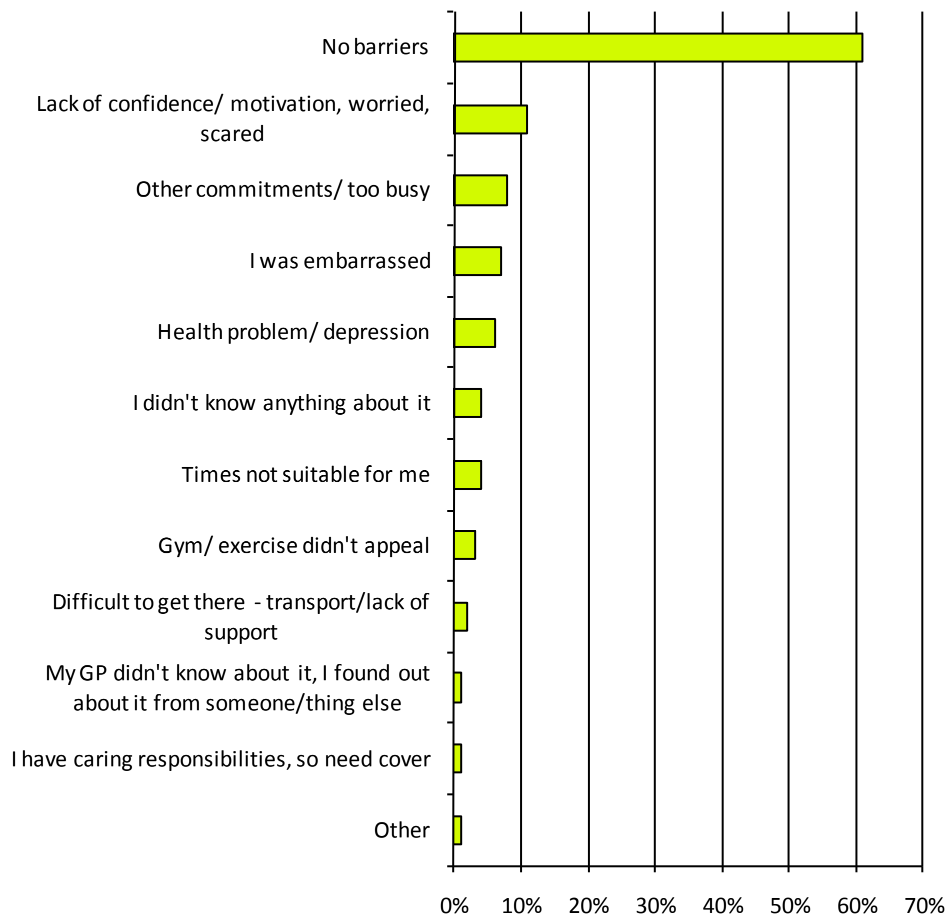
## Barriers to take up

Participants were asked whether there were any barriers to taking up the Health Counsellor Service in the first place. It was positive that the most frequently cited response was that there were no barriers (61%, 83 respondents). The top 3 'real' barriers were lack of confidence/motivation, worried, scared (11%, 15 respondents), other commitments/too busy (8%, 11 respondents) and embarrassment (7%, 10 respondents). The full range of responses given is in the chart below.

Those who completed the programme were more likely to state that they had no barriers (68%, 61 respondents) but this dropped to 53% (8 respondents) for those who did not attend 6 month and 20% (3 respondents) for those who did not attend baseline. Therefore those who did not progress with the programme were most likely to identify barriers to taking part, as would be expected. Three-quarters of those who did not attend the 12 months consultation stated that there were no barriers, however.

Those who did not attend baseline were most likely to cite barriers (80%, 12 respondents), with the highest number citing other commitments/too busy (47%, 7 respondents). Participants in Glasgow were also more likely to cite barriers (45%, 19 respondents), with other commitments being the biggest concern here too (19%, 8 respondents). Female respondents (43%, 35 respondents), those aged under 55 (53%, 33 respondents) and those in employment or education (47%, 24 respondents) were also more likely to cite barriers, with a wide spread of barriers cited.

**Figure 23 Barriers to taking up the health counsellor service in the first place?**




### Barriers to maintaining attendance

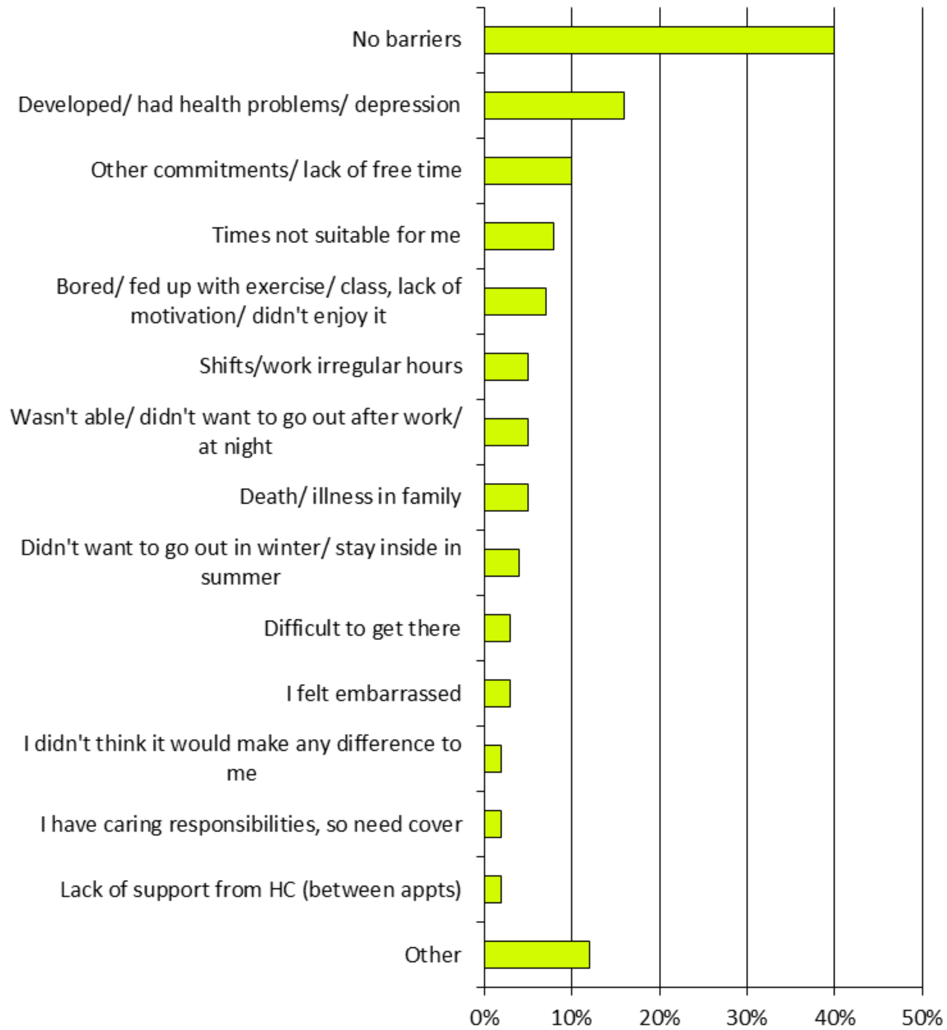
We then wanted to establish whether there were any barriers to maintaining attendance once interviewees had started the programme. Forty percent (46 respondents) said there were no barriers, 16% (18 respondents) developed/had health problems/depression, and 10% (11 respondents) had other commitments/lack of free time. Many more reasons were given by fewer than 10 people all of which are illustrated below. Again, barriers were more likely to be cited by those who did not complete the programme (90%, 9 respondents who did not attend 6 months and 80%, 12 respondents who did not attend 12 months, compared to 53%, 48 completers).

Those who were more likely to cite barriers were:

- participants in Glasgow (68%, 21 respondents) and Inverclyde (71%, 10 respondents);
- female respondents (65%, 43 respondents);
- those aged under 55 (67%, 32 respondents);

- those who were in employment/education (62%, 24 respondents) or not working but of working age (74%, 22 respondents); and
- those who considered themselves to have a disability (77%, 31 respondents).

**Figure 24 Barriers to keeping up attendance once started?**

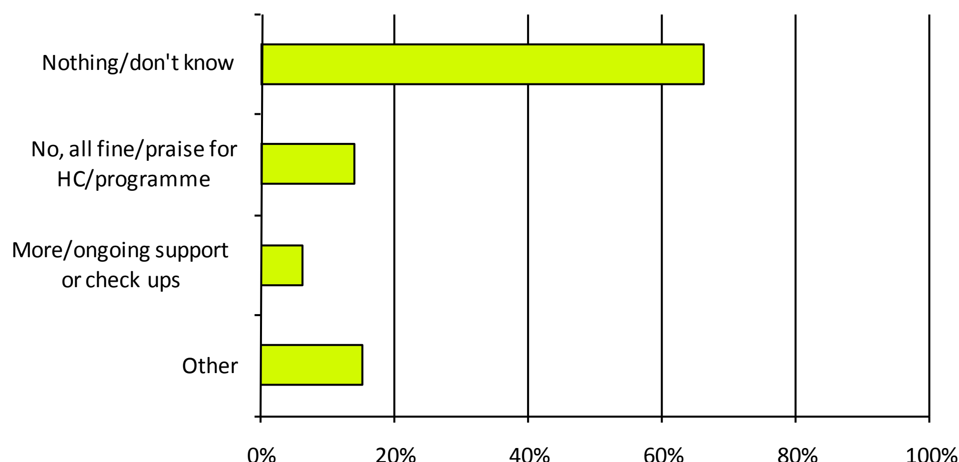



n=115

### Additional support required

The final question asked whether any support could have been provided to help people to attend or continue to attend the programme. Two-thirds (66%, 89 respondents) said there was nothing/don't know and a further 14% (19 respondents) said no, all was fine and/or praised the Health Counsellor and/or programme. Six percent (8 respondents) suggested more/ongoing support or check-ups and a further 15% (20 respondents) gave another response (full details of which can be found with the data tables). Most of these were one-offs but there were a few which related to being part of a small group of similar individuals, which would have helped.

**Figure 25 Anything else that could have helped you to attend?**




## 3.2 The health counsellor perspective

A focus group was convened with the eleven health counsellors (three counsellors work in the Glasgow City Council area, three in West Dunbartonshire, three in Renfrewshire and two in Inverclyde). It should be noted that some counsellors were more recent recruits, for example in post for three months, whilst others had been in post for over two years. This obviously has an impact on the amount and type of training they have received and their experience of implementing their role.

The discussion covered a wide range of issues relating to the training they had received to perform their role, the way things worked in practice and areas for improvement. Each of these is discussed more fully below.

### 3.2.1 Training

**Rating of training received**

The counsellors were asked to rate the training they had received to deal with healthy eating and weight management advice in terms of marks out of ten and to comment on the reasons for their rating. The mean score given was 6.36 out of 10, with the lowest score given as 5 (three gave this score) out of 10 and the highest score an 8 (one gave this score).

Those who gave a higher score felt that training had been good, with a good variety of training which fitted what they needed to do in their role, but there was also some useful feedback from counsellors in terms of potential improvements. Some counsellors felt that there was too much detail on some issues but not enough on others (for example perhaps more ‘technical’ information on diet than they would feel comfortable talking about after brief training, some of which was more interesting than others), with an element of repetition on topics such as behaviour change as this was covered by several trainers. Where more explicit information on conditions such as diabetes might have been helpful as participants sometimes seeks advice, and interesting on a personal level, counsellors were clear that they should not provide specific advice on this.

Eat Up training was rated as being well structured and useful to implement and the motivational interview training was also rated very highly as it was seen to help break down the barriers when a participant doesn’t want to talk.

Those who scored the training lowest felt that it was *"vague, there was no point me being there"* and *"bitty, not relevant"*. There was a view that the training was not sufficiently tailored to the health counsellor role to help them apply the training delivered. It is fair to say that the training programme evolved over time and would have been driven by when training needs were identified, who could provide training and when. Training was also delivered by different people so there was not necessarily as cohesive an approach as might have been liked, for example with some issues being covered more than once.

**Areas for improvement**

Counsellors would have liked to have had guidance on whether they should have a separate consultation on healthy eating or tack it on to the end of a physical activity discussion, indeed more guidance on how to structure the healthy eating element generally would be welcomed. Counsellors felt that more detail on how to apply the information learned, with more demonstrations on how to put it into practice (for example how the dieticians would do a consultation), would be helpful. It was also suggested that a toolkit to take away and use with clients would have been more useful. Trainers talked about a variety of tools, for example healthy plates, but the counsellors were not given these and, whilst some tried to make them up/source these themselves, it was not perceived to be the same as something 'official'. Also, materials for participants to take away to use at home would have been welcomed. The FSA Eat Well booklets were given as an example of a useful leaflet to give to participants. These can be ordered and most counsellors reported accessing these for participants. Having more time to spend going through booklets such as these was suggested as being more helpful rather than focusing on the questionnaire.

There was a fair amount of discussion around having more structured approaches to delivering the healthy eating aspects of the programme in particular, for example having a booklet to work through to ensure all aspects are covered. There was a concern that whilst many people think they eat healthily and know a lot about nutrition, the ensuing discussion then illuminates that they don't, so having a systematic format to go through would facilitate going through the facts even if people felt they knew them. Some counsellors use the British Heart Foundation materials to go through with people as this allows them to discuss things with people which the questionnaire does not. There was recognition that each health counsellor is probably doing this element of the consultation in different ways as they have different experience and it can be difficult if not from a nutrition background.

Training was criticised for not being specific enough to the counsellor role, so there could be a struggle to apply it to what they did in reality. Tailoring the training specifically was therefore seen to be extremely beneficial. This was particularly perceived to be an issue as the physical activity training is so structured that it automatically dominates the consultation and it can be difficult to bring other issues into the consultation to the same degree, particularly as counsellors are not specialists in healthy eating. There was a sense that, for some, the information provided through the training was useful but they found it difficult to apply in practice during a consultation as it wasn't anchored in the Live Active consultation. For example, there was a concern that clients could go *"off on a tangent"* on a discussion around healthy eating but the counsellors would not know how long to give certain issues or keep things on track in the way that they would with the physical activity element of the consultation. The general Live Active counsellor role was perceived to be very structured but the health counsellor role was not, as so many other issues may need to be taken into account. The fact that the physical activity section of the consultation is so structured also meant that other issues were usually *"tacked on at the end of the consultation"* and they often ran out of time to address them fully. Counsellors reported that the majority of participants said they wished to address physical activity and healthy eating as they wanted to lose weight, regardless of the reason for referral, but with most people the focus of the consultation was on physical activity. Training

on managing the time allocation for consultations with more than one emphasis would therefore be appreciated.

When asked what should be done differently in terms of training in future, it was suggested that keeping the flow of training going, for example every couple of months, would be helpful. An opportunity for counsellors to share with each other what they have found to work well in practice would also be appreciated. For example, tips that they could share for ways in which to address the issues participants present to them, or barriers to taking a course of action forward, would be helpful and mean that participants were getting more co-ordinated and effective advice in the most efficient way, i.e. without each counsellor having to address each challenge afresh. The training provided by Liz Cornwallis was rated very positively – this entailed two days training and they were then told to go away and write down how they had used what they had learned and came back on a third day to discuss. A similar approach with other topics would be helpful, e.g. healthy eating. Training around maintaining motivation and re-motivation, as this can be harder, was also suggested as being helpful. For example, techniques to help people overcome their barriers to changing their lifestyles.

Counsellors found it particularly challenging to recommend dietary improvements if the participant did not eat fruit and vegetables, as can sometimes be the case. Advice or assistance on alternative ways to approach this would be appreciated.

Counsellors reported having asked for more training at their employee development review but they had received no feedback on that at the time of the group. Training on more specialised client groups had also been requested.

The project co-ordinator was perceived to have provided support or training when this had been sought.

The training on alcohol brief interventions was discussed, as this was an issue that some counsellors did not feel comfortable raising. Alcohol brief intervention training was provided to West Dunbartonshire counsellors, funded by the local CHP, but this is not part of the standard health counsellor model. West Dunbartonshire counsellors felt that it could be very difficult as to raise as participants could react inappropriately, they may not feel comfortable talking about alcohol consumption and this might then inhibit their relationship with the participant. Whilst one had made several referrals and another came from the perspective of the number of calories in alcohol and tackling weight gain rather than criticising them for drinking too much, others (including those based in other areas) felt they would be uncomfortable raising this issue with clients. If this is to be required of all counsellors in future, then further training on how to raise it, specific to the health counsellor role, would be required, although not all would welcome this.

Counsellors felt that GPs and nurses, who would have recently seen the participant, have greater expertise in getting into the issues around why they drink, etc., and links to other services so it is more appropriate for them to address this issue. Similarly, if GPs and nurses have recently asked about alcohol consumption *"it feels like we're getting onto them more if we ask again"*. The majority view was that the health counsellor role could advise on the recommendations and suggest that heavy drinkers reduce consumption, perhaps linking the number of calories to units and how long it takes to burn these off given the reason for people's referral to them, but most counsellors didn't feel that it was appropriate for them to do much else. It was also suggested that the type of client would also have a bearing on how comfortable they felt in raising issues like this.

That said, the trainers who provided training on alcohol and smoking were seen to be much more proactive in the way in which they provided ongoing support, calling at 3, 6 and 12 month points after the training.

### 3.2.2 Confidence in delivering healthy eating advice

Health counsellors were asked how they felt about delivering the health counsellor role, looking at weight management and healthy eating in addition to physical activity. The counsellors had been recruited to that role rather than moving over from the discrete physical activity role and felt comfortable delivering the role now, although there was a view that the physical activity role is the primary function, which takes the majority of their time and the weight management/healthy eating function take a secondary role.

The confidence of health counsellors to deliver healthy eating advice varied quite substantially. One counsellor had a background in nutrition so felt extremely comfortable advising on this. Others had found a way of working to suit them, in terms of tackling some of the more sensitive issues and getting their points across without offence.

However, some felt they lacked confidence in raising a number of issues and did not feel able to go into much detail on others so kept this input to a minimum. For example, one counsellor responded:

> *"With the healthy eating you're on your own. I'm more inclined to refer on to other routes rather than tackle it myself. The information from training is useful but I'm not confident to deliver this myself."*

Different cultures and the impact this can have on what people can/cannot eat and the increased diversity of ingredients presented other challenges for counsellors who did not all feel confident in advising on what a balanced diet would entail in this context, feeling that more specialist advice was required*: "recommending meat and two veg. doesn't carry to other cultures – more specific information would help".*

Counsellors noted that they meet as a group every quarter to talk about things but felt that the meetings are too structured to really have an opportunity to discuss things that would help them do what they do better, so they email each other instead if they have queries that they want to check with others. Some share offices so that helps to test what other people think of challenges/problems.

It was also suggested that counsellors could shadow other health counsellors to help share practice rather than shadowing Live Active counsellors, which wasn't found to be particularly helpful.

### 3.2.3 The consultation process

It was clear that the vast majority of participants have most input from health counsellors around their physical activity behaviour. This was perceived to be driven by a number of factors, as follows:

- by the structures of the Live Active programme, which require a range of different data to be collected with a very systematic approach;
- by the nature of the physical activity element, which entails familiarisation with the gym, etc.;
- the limited time available (the usual consultation time is 1 hour and, although 1.5 hours can be utilised for a dual referral this is not always known from the referral form, and so not scheduled, and the counsellors did feel that this is too long for people to take things in fully);
- the lack of advice and structure for the healthy eating element of the consultation; and
- the counsellors' lack of confidence and knowledge to address healthy eating issues.

This often resulted in having just five minutes or so to cover healthy eating advice. Whilst every counsellor was perceived to address the healthy eating element of their role differently, there was consistent criticism of the healthy eating questionnaire they are meant to use. It was suggested that the questionnaire was only used for a minority of participants as it provides scores which can be very misleading (in terms of whether behaviours tested are positive or negative) and it was not perceived to be at all effective in terms of pulling out unhealthy eating patterns, in order to stimulate discussion of how these could be improved.

Counsellors would like to see the questionnaire improved. Questions such as who makes the meals in the home, the number of take aways they eat, fizzy drinks, whether they eat breakfast and regular meals, etc., are all much more useful for counsellors to then pull out areas for change/improvement. It was also suggested that keeping a food diary for x number of days may be helpful and/or noting what participants have eaten in the last 24 hours, the number of portions of oily fish, etc., as they could then discuss the issues and give pointers for improvement.

If the questionnaire gives examples, there was a request that they be useful examples. Counsellors queried the use of the butter/spread questions on the questionnaire as participants all say 'medium' and queried what that means, it can't be true that everyone takes the same amount, this will vary for different individuals. Alternatively, just questions to ask rather than a full questionnaire may be more helpful to open the discussion. If scores aren't needed, counsellors could then pick and choose as required as they need tools to use with people and find a way in to talk about difficult things.

It was noted that healthy food can still be quite calorific so participants need to think about that too if they want to lose weight. It was appreciated that it can be difficult for people to eat a balanced diet and it can be a problem if people are on a budget or live alone and can't cook. It was suggested that *"there are probably a lot more problems around healthy eating than physical activity*". The training was perceived to have covered the healthy plate, salt content, etc., but failed to cover the real barriers that people come in with, for example they can't cook. Participants often want the simple and familiar option – a diet sheet.

Talking through what three things participants would like to change was perceived to be more manageable, as this has been used well in previous roles, and keeps things nice and simple for them to take away and remember: *"I'd rather spend the five minutes on something I know is more useful."* The health counsellors usually gave some information and asked participants to return if they needed more assistance or information, but reported that people rarely did so. The healthy eating element was consistently seen as less of a priority than the physical activity element of the programme, as the quotes below illustrate:

> *"I ask them if they know what a healthy diet is and if they say yes, I leave it at that as I'm not that confident about it."*
>
> *"If they're making a lifestyle change about their exercise too, it's too hard to do two at the same time."*

Counsellors also felt that it was difficult to set goals for healthy eating (the boxes aren't laid out well on the form for this) and that they didn't feel that they could or did provide the help that participants really needed.

Counsellors did query the use of formal diagnostic tools such as HADS[3] questionnaire just as a measure of progress as it is a diagnostic tool and participants want to know

[3] The hospital anxiety and depression scale (HADS) is a widely used and popular self-report measure designed to detect the presence and severity of mild degrees of mood disorder, anxiety and depression.

what the scores mean. There is also a degree of responsibility to do something if the scores give cause for concern, particularly if they get worse rather than better at six months.

The readiness ruler[4] on the front page of the questionnaire was considered to be a good tool as it helps counsellors to prompt ‘why do you say it’s that high/low’, etc., but this is not on the web database so if not using the paper version then counsellors did not think they could use it (although there is apparently scope to report it in the notes). Counsellors pointed out that there were quite a few other questions missing on the web version of the database.

### 3.2.4 Challenges in supporting participants

The group considered what challenges there were in supporting participants in general and with healthy eating and weight management issues in particular. One issue which was raised was the impact that home and family has on an individual and specifically on the way they interact with food and activity. For example, the impact of their mother and their partner can be significant, particularly if the participant is not the person who prepares the meals in the household – they can be very dependent on others and there is perhaps a need for educating/influencing the actions of other household members on this issue. Counsellors have to be careful not to criticise the person who does the shopping/cooking within the household either as this can be counter-productive. If the participant is a mother, she has to cook things for her partner/family so this can present different problems. The danger is that all family members are over-weight. However, counsellors felt that children are better educated on healthy eating now, so can have a role to play in educating their parents.

Another big challenge is when participants shouldn’t be on the scheme, i.e. inappropriate referrals. The referral form asks if clients are willing to change their eating habits – but in reality it is clear that the practice nurse told them to come and they know nothing about the programme. The counsellors feel that many don’t have the motivation to change and the nurse just tells them they need to lose weight. Some participants are told they will get into the gym for free or not told what the programme is about so counsellors perceived that there continued to be inappropriate referrals coming through.

### 3.2.5 Contact levels

The minimum contact level, after the baseline consultation, was the same as the Live Active Scheme, i.e. 1 month contact, the 3 month letter then consultations at 6 months and 12 months. The counsellors suggest these and more depending on participants’ needs and requests, for example invite them to come to see them at 3 months rather than waiting until 6 months, or telephone every so often depending on what they have agreed.

Those participants with mental health issues were perceived by counsellors to need more support than other participants, generally one to one support around once a fortnight/month. However, if counsellors see participants once a week in the gym this is better as they are more likely to stick with the programme.

Whilst there was a willingness from the counsellors to do as much as they could for participants, they were clear that they couldn’t do everything that they needed to do if they increased the amount of contact for all participants and all were to stay in the programme for the full duration – they can only do what they do because some people drop out. Some counsellors reported that they make sure that they are visible in the

[4] There are two scales on the front of the counsellors’ lifestyle referral questionnaire, from 0 – 10 for importance and confidence. Participants are asked to mark how important it is to them to make changes in each of the areas they have been referred for (physical activity, health eating and weight management) and how confident they are in making those changes.

gym regularly so that people can speak to them if they want, as their view was that it is more beneficial to see participants whilst they are exercising rather than calling them in for appointments, and it is a waste of time if they do not then attend the appointment.

### 3.2.6 Concluding comments

To conclude, health counsellors considered it to be important to cover healthy eating and weight management alongside physical activity but counsellors did not feel that they were able, or necessarily the most appropriate people, to give participants all that they needed in this regard. It has a value as it joins things up for participants, they see that they need to change their lifestyles in different ways and it is more of a 'one stop shop' for them than having to attend a number of different services.

Whilst there was a desire for more structure, there was recognition that the approach to healthy eating couldn't be too structured. The final suggestion was that a *"framework with flexibility"* for consultations would be more appropriate for the type of referrals that they have, addressing different needs and issues, rather than the very structured approach to physical activity which currently exists. Making the questions more valid was key for others to ensure that they illuminate the issues people need to address. They were clear that the questionnaire/tool should not be about validation, but give them a way in to the constructive discussion of sensitive issues with participants.

# 4 Conclusions & recommendations

This section outlines our conclusions from the primary research undertaken and offers recommendations for consideration. The original aims of the research were to:

- explore participants' experiences and the views of Health Counsellor staff of the Live Active Health Counsellor programme;
- explore the impact the Live Active Health Counsellor programme has had on participants' lifestyle behaviours; and
- to provide recommendations for future service delivery.

Section 4.1 therefore draws conclusions to meet the first two aims and section 4.2 makes recommendations, meeting the third aim of the study.

## 4.1 Conclusions

### 4.1.1 Views and experiences of the programme

There was variation across the different geographic areas in terms of people's awareness of the programme and referral to it as, for example, there are obviously one or more physiotherapists in West Dunbartonshire actively promoting the programme to patients. Having referrers who have bought into the concept of programmes such as this, and who make appropriate referrals, can make a significant difference to its success. The impact of Keep Well, particularly in Glasgow, was also evident in terms of the number of referrals from practice nurses and of people aged 45 – 64 and this was confirmed by respondents who had attended Keep Well health checks. Our research around Keep Well in South West Glasgow may suggest that Keep Well is perhaps also one of the reasons for the lower completion rates in Glasgow, as people are often referred to more than one service (so this may not be their priority and their other health issues may present barriers to participation), they may be told that this is what they need to do rather than being self-motivated to attend and the fact that they are from 0-15% SIMD areas may mean that they have greater barriers to participation and adopting/maintaining a healthier lifestyle (as, for example, healthier foods can be more expensive, particularly if an individual does not have cooking skills).

It was interesting to note that few participants had been referred to other services, suggesting that the health counsellor service was perhaps perceived to be a 'one stop shop' for referrers as they dealt with the inter-related issues of physical activity, healthy eating and weight management. However, the way in which the service was explained to participants – as the 'gym', with little detail – suggests that referrers are not actually aware of the full range of advice on offer from health counsellors or at least fail to communicate that to the people they refer. This was particularly the case in Glasgow where the Live Active Referral Scheme has been established for longer so referrers may have been confused around the differences between the Live Active Referral Scheme and the Live Active health counsellor programme or communications may not have been so strong to potential referrers in recent years, unlike those areas which have adopted the scheme more recently.

Whilst participants may have been unclear on what they were being referred to and what they could expect from the service, this low expectation base meant that the vast majority of those interviewed had their expectations met or exceeded once they attended. It must be remembered that this is biased towards those who completed the programme, however, and it would be expected that those who completed the

programme got something positive from it. That said, the research has reinforced the importance of support and encouragement to participate from the health counsellors, or just being *"checked up on"* and not having to rely solely on their own motivation. The fact that some participants could do more than they expected to, could see a physical improvement and enjoyed the social aspects of the programme are also selling points which could be reinforced to encourage greater attendance rates in future. The options for support are driven largely by health counsellors and their workloads, although over half of participants felt that they had been given a say in this. The frequency of support is a very individual factor and the expressed health counsellor approach that support should be participant driven is a helpful one. That said, the amount of support received had an impact on likelihood of continuing to attend the programme and the stated level of support did vary by area, with Glasgow being less likely to provide additional support outwith consultations than other areas.

Nearly two-thirds of participants did not feel there was a need to improve the service provided, but there were some suggestions for improvement from both participants and health counsellors themselves. For example, counsellors made a range of suggestions for improving training, guidance around healthy eating in particular and the tools provided to ensure a consistent quality of service. There is a confidence issue around delivering healthy eating advice and some reluctance to provide any substantive service in this regard.

Health counsellors have a very structured approach to the physical activity element of their role but much more flexibility to the healthy eating element and this was a challenge for some. This was 'outside the comfort zone' of some health counsellors with any input being kept to a minimum as they were not confident in delivering appropriate advice (and some did not feel it was their role to do so). The fact that the physical activity element was so structured, and took nearly an hour to implement, made it easier for counsellors to de-prioritise the healthy eating element of the consultation. A more structured approach and appropriate tools to use with participants/give to participants would be appreciated.

### 4.1.2 Impact on lifestyle behaviours

Participants were very positive about the health counsellor service, with a mean rating of 8.93 awarded out of 10 and praise given for staff and the encouragement/motivation received. Positive impacts on health and behaviours were also reported, with people getting exercise, feeling healthier, losing weight, increasing in confidence and having fun/feeling good about themselves. The reduced gym fee also made a difference to some participants (which would mean that they might be able to attend more frequently or at all, depending on their economic situation).

The vast majority of respondents reported improvements to their health as a result of the advice and support provided to them by the health counsellor, with people feeling fitter, losing weight, feeling happier and healthier generally. This clearly improved the longer participants engaged in the programme. The reason for attending varied from realising that they needed to change their lifestyles to someone else telling them that they needed to do so but the two clear reasons for continuing to attend was that they enjoyed it and they felt it was making a difference to their health and fitness. Interestingly, those who completed the programme were the only ones to admit that they needed the support provided in order to make the changes they needed to make to their lifestyles. There was a sense that participants in Glasgow were 'told' to attend, did not generally adopt the programme wholeheartedly, and were not supported well beyond consultations. Early and regular support clearly made a difference to participants in other areas, however. Glasgow participants' involvement in activities was consequently lower than in other areas and their enjoyment from participation and the impact on their health was less marked than in other areas.

The majority of respondents considered there to be no barriers to attendance or continued attendance, but this was a sample biased towards completers and issues

were more prevalent for those who did not complete. The main reason for non-attendance was health reasons, followed by feeling that it made no difference to their health but lack of support was also an issue (as was feeling that they did not need any) which is a concern as the biggest barrier was lack of confidence/motivation and some people felt embarrassed.

## 4.2 Recommendations

This has been an interesting project which will hopefully add to the body of knowledge developed from the Live Active programme generally and other health promotion work. The following recommendations are provided for future service delivery, based on the primary research undertaken during the course of this study.

- Communications to referrers and those being referred about the health counsellor service and what it entails should be considered afresh, particularly in areas which have a more established Live Active Referral Scheme in operation. Clarification around who should be referred to Live Active Counsellors and who should be referred to the Health Counsellors may also be helpful in this regard, as there is a sense that this is unclear for both referrers and participants. This could be reinforced by closer links between Health Counsellors and primary care to ensure the aims and objectives of the programme are understood and clear. This will help to address inappropriate referrals, thus making more effective use of counsellors' resources; hopefully increase attendance by reducing uncertainty/apprehension from a lack of clarity about the service on offer; and potentially increase the uptake of advice on more than one of the three inter-related services on offer. Now that the health counsellor approach has been in place for two years, there is scope to make use of case studies to illustrate the successful outcomes for participants. This would help to reinforce the role of the service and options open to participants to engage in different activities, to hone the appropriateness of referrals and 'sell' participation to those who may benefit from the service.

- This research, as with other research around the Live Active Referral Scheme, reinforces the importance of support, particularly early on in a participant's experience of the programme, both from health counsellors and other participants, for example in a group setting. Consideration should be given to the way in which support could be 'front loaded' for participants, with their active agreement, in order to address attrition rates and maximise the positive impacts on participants. This doesn't need to be a formal appointment; moreover informal opportunities to ask questions and to know that someone is interested in their progress could make a substantial difference. The research would suggest that it needs to be at least monthly in order to make a positive impact and the research would suggest that more effort needs to be made to support women, those aged under 55, particularly those in employment or education and Glasgow residents. It would be useful to consider if the reasons for Glasgow's poorer completion rates were due to the 'Keep Well factors' outlined in the conclusions or if there is anything which Glasgow counsellors can learn from the way in which the programme works in other areas.

- It would be interesting to explore whether the different activities undertaken were driven by participant preference or what was on offer to them. For example, was the emphasis on the gym in Glasgow due to people rating these facilities, and wishing cheaper access, rather than exercise classes or walking which were more popular elsewhere? Given that Keep Well and the health counsellor approach was meant to provide an alternative to 'traditional' gym fitness options, which can be very intimidating for some people, are there opportunities to increase alternative physical activity options here and improve retention?

- There was interest in more tailored exercise or classes specific to conditions, or grouping people of similar abilities together and consideration should be given to this. Those participants who did have more specific health needs did not necessarily feel that the service was tailored to meet those needs, or that there was a willingness to do so. This attitude needs to change and suggests there is a training issue to be addressed in terms of both customer care and physical activity/healthy eating options for specific target groups, for example people who are wheelchair dependent, with different degenerative conditions, etc.

- Those who are working or in full-time education found it very difficult to attend exercise classes, etc., as these are scheduled during the day. Consideration should be given to providing evening or weekend options, when it suits people rather than perhaps to suit those who deliver it. This has obvious implications for the terms and conditions of health counsellors but could start with one evening class per week to test the approach.

- It may be useful and less repetitious for participants to reconsider what tools are used at the consultations, for example HADS and alcohol brief interventions. Given that these may have recently been undertaken by the GP/nurse, is there a need to repeat this during the live active consultation? If diagnostic tools are being used and scores generated, consideration should be given to what is done with these and to act as responsibly as possible.

- The training provided to health counsellors could be improved in a range of different ways. For example:

  - greater co-ordination of course content to reduce duplication on such issues as behaviour change although some work around motivation/ remotivation to change and barriers to changing lifestyles would be helpful;
  - tailoring the training to the health counsellor role to help counsellors to apply their learning in practice in addition to advising on managing time within consultations, as the physical activity element is so structured and can otherwise dominate the consultation;
  - delivering training then tasking counsellors with noting how they apply this and any challenges experienced before reconvening to discuss how to take forward the learning in a cohesive and consistent way across the service;
  - if alcohol brief interventions are required to continue in West Dunbartonshire or to be introduced in other areas, (further) training on this is required, both in terms of why this is appropriate and the way in which to raise this sensitive subject; and
  - providing more specialist information on balanced diets/healthy eating for different cultures and health conditions, or dietary preferences such as those who do not like fruit and vegetables so that advice can be provided.

- Giving collective thought to the way in which healthy eating advice could and should be delivered in terms of process and timeframe would be beneficial – the ‘flexible framework’ raised by the health counsellors. At present, it is anticipated that the quality and amount of advice and information provided on this may vary quite substantially. Shadowing those who are confident and knowledgeable in this area may also help in building confidence to respond to this agenda. Ensuring there are regular opportunities for health counsellors to learn from each other, talk through challenges they are facing, share learning and good practice would be helpful to improve the consistency of the quality of the service provided most effectively.

- The questionnaire used to direct healthy eating advice needs work to make it fit for purpose as a route in to engage participants in a useful dialogue about improving their diet. Asking more relevant questions than is currently the case to gain a sense of what people eat/drink and how they do so is recommended. This may not need to be a questionnaire per se but a mix and match set of questions to be used as appropriate. This could also look at ways in which to engage other family members to ensure that the participant has the support at home to make the changes to their lifestyle that they wish to, with the added benefit of impacting positively on the health of other family members.

# Appendices

Appendix 1 The questionnaire
Appendix 2 The topic guide

# Appendix 1 Questionnaire

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**Contract No:** **3117**
**Contract Name:** **Health Counsellor Evaluation**
**Type of survey** **Telephone Survey**

**Introduction**

**READ OUT**
"Good morning/afternoon/evening, my name is _______________ from FMR Research. I am undertaking a survey on behalf of NHS Greater Glasgow and Clyde on the Live Active Health Counsellor scheme. Could you please spare 10-15 minutes to give me your views? All your answers will be in strict confidence."

**COLLECT RESPONDENT DETAILS:**
**EXPLAIN THAT THERE IS A ONE IN TEN CHANCE THAT A SUPERVISOR MAY PHONE TO CONFIRM THE ACCURACY OF THE INTERVIEW.**

| | |
|---|---|
| **Respondent Name** | |
| **Address** | |
| **Full Post Code this must be given** | |
| **Telephone Number** | |
| **Area** | **Keep Well East 1**<br>**Keep Well North 2**<br>**Keep Well South West 3**<br>**Inverclyde 4**<br>**Renfrewshire 5**<br>**West Dunbartonshire 6** |
| **Completer?** | **Completer 1 Non-completer 2** |
| **Non-completers, dropped out…** | **Before attending a baseline appointment 1**<br>**Attended baseline but not 6 months appt 2**<br>**Attended baseline/6 months but not 12 months appt 3** |
| **Referred for…** | **Healthy eating intervention only 1**<br>**Weight management and healthy eating intervention 2**<br>**Weight management, healthy eating and physical activity interventions 3**<br>**Physical activity only 4** |

**CLOSE INTERVIEW BY READING OUT STATEMENT:**

"Thank you very much for your help. Can I assure you once again that the information you have given will be treated as absolutely confidential and will only be used for the purposes of evaluation of the health counsellor role."

**INTERVIEWER DECLARATION:**
I declare that this interview was carried out according to instructions, within the Market Research Society's Code of Conduct, and that the respondent was not previously known to me.

| | |
|---|---|
| Interviewer Name | |
| Signature | |
| Date | |

CO. NUMBER SC141767

## Section 1: First thoughts about the Live Active Health Counsellor programme

**1a. How did you first hear about the Live Active Health Counsellor programme?**
**1b. And how were you referred?**

| | First heard | Referred |
|---|---|---|
| GP | 1 | 1 |
| Practice nurse | 2 | 2 |
| Physiotherapist | 3 | 3 |
| Friend/relative | 4 | -- |
| Saw advertising/posters/leaflets | 5 | -- |
| Cardiology department | 6 | 4 |
| Other (please state below) | 7 | 5 |
| | | |

**2. Did you attend a Keep Well Health Check?**

| | |
|---|---|
| Yes | 1 |
| No | 2 |
| Don't know | 3 |

**3a. Have you been referred to any of the following services?**

| | |
|---|---|
| Eat Up | 1 |
| Shape Up | 2 |
| Glasgow Weight Management Service | 3 |
| None of these | 4 |

**3b. Have you been referred to any other services? If so, how many?**

_______

**4a. Did you feel the number of services you were referred to was:**

| | |
|---|---|
| Too many | 1 |
| About right | 2 |
| Too few | 3 |

**4b. Why do you say that?**

**PROBE IF TOO MANY, DID IT MEAN THEY WERE LESS LIKELY TO ATTEND THE LIVE ACTIVE HEALTH COUNSELLOR PROGRAMME?**

_______________________________________________

_______________________________________________

_______________________________________________

**5.** **How did the person referring you to the Live Active Health Counsellor describe/explain the service to you?**

**PROBE WHETHER IT WAS REFERRED TO AS 'THE GYM', EVEN THOUGH SOME THINGS ARE IN COMMUNITY VENUES…**

______________________________________________________________

______________________________________________________________

______________________________________________________________

**6.** **Did you know how the Live Active Health Counsellor programme differed from other services on offer, like Eat Up?**

| | |
|---|---|
| Yes | 1 |
| No | 2 |
| Not sure | 3 |

**7.** **What were your expectations of the service, before you attended?**

**PROBE IF THEY EXPECTED ONLY PHYSICAL ACTIVITY BASED SERVICES, OR DID THEY WANT/NEED HEALTHY EATING/WEIGHT MANAGEMENT.**

______________________________________________________________

______________________________________________________________

**7a** **If physical activity based services, what sort of things did you expect to receive/do (e.g. shown how to use the gym equipment, etc)?**

______________________________________________________________

______________________________________________________________

**7b** **If healthy eating/weight management, what sort of things did you expect to receive/do (e.g. dietary plan)?**

______________________________________________________________

______________________________________________________________

***8*** ***Can I just check how many times you had a meeting with your Live Active Health Counsellor?***

| | |
|---|---|
| *None, I didn't start the programme* | *1* |
| *One* | *2* |
| *Two* | *3* |
| *Three* | *4* |
| *Other, please specify* | *5* |
| | |

***INTERVIEWER: FROM THE DATABASE, CHECK WHETHER THIS AGREES WITH THE DATABASE. IF NOT, PROBE WHETHER THEY STARTED THE PROGRAMME AND IF SO, WHICH APPOINTMENTS THEY HAVE ATTENDED, ETC.***

***BASELINE NON ATTENDERS GO TO Q23***

***ASK ALL ATTENDERS (BASELINE, 6 MONTHS OR 12 MONTHS)***

***Over what period of time did these meetings take place?***

---

**9a And how did the Live Active Health Counsellor programme compare to your expectations once you attended?**

| Exceeded my expectations | 1 |
|---|---|
| Met my expectations | 2 |
| Didn't meet my expectations | 3 |
| I didn't attend | 4 |

**9b. Why do you say that?**

## Section 2: Your experiences

**10. Different activities are on offer to people with this service, can you tell me what you got involved in?**

**11. Were you given different options for different types of support, by the health counsellor?**

| Yes | 1 |
|---|---|
| No | 2 |
| Can't remember | 3 |

**12a. How often did you receive support from the Live Active health counsellor?**

| Weekly | 1 |
|---|---|
| Monthly | 2 |
| Every quarter | 3 |
| Other, please specify | 4 |

**12b. And what kind of support did you receive, e.g. telephone calls, face to face meetings, etc.?**

**12c. Was this the right amount of support for you?**

| Too much | 1 |
|---|---|
| About right | 2 |
| Not enough | 3 |

**12d. Why do you say that?**

________________________________________________

________________________________________________

**13. How would you rate the service provided by the Live Active health counsellor, overall? Please give them a 'mark out of 10', where 0 is low and 10 is high.**

_____

**14. What were the best things about the service?**

________________________________________________

________________________________________________

________________________________________________

**15. And what were the not so good things?**

________________________________________________

________________________________________________

________________________________________________

**16. What, if anything, about the service provided by the Live Active health counsellor would you change?**

________________________________________________

________________________________________________

________________________________________________

**17. Have you noticed any benefits to your health from the advice and support given by the health counsellor?**

| Yes | 1 |
|---|---|
| No | 2 |

**18. If so, what would you say the benefits have been? Unprompted**

| | Unprompted | Prompted |
|---|---|---|
| Feeling fitter | 1 | 1 |
| Feeling healthier generally | 2 | 2 |
| Feeling happier | 3 | 3 |
| Going out more | 4 | 4 |
| Losing weight | 5 | 5 |
| Eating more healthily | 6 | 6 |
| Helping my family be more healthy too | 7 | 7 |
| Other, please say what | 8 | 8 |
| | | |

**19. If not, why do you think that is? Unprompted**

| | Unprompted | Prompted |
|---|---|---|
| Haven't followed the advice | 1 | 1 |
| Don't agree with what they have said | 2 | 2 |
| Don't want to change how I live | 3 | 3 |
| Other, please say what | 4 | 4 |
| | | |

## Section 3: Motivations and barriers

**20. Why did you attend the Live Active health counsellor in the first place?**

| | Unprompted | Prompted |
|---|---|---|
| The nurse told me to | 1 | 1 |
| I wanted to lose weight | 2 | 2 |
| I wanted to be healthier generally | 3 | 3 |
| I knew I needed help to do it, I couldn't do it on my own | 4 | 4 |
| I had a health scare and realised I needed to change | 5 | 5 |
| I wanted to increase my physical activity levels | 6 | 6 |
| Other, please say what | 7 | 7 |
| | | |

**21. And what made you continue to attend as long as you did (if appropriate)?**

| | Unprompted | Prompted |
|---|---|---|
| I felt it was making a difference to my health | 1 | 1 |
| I enjoyed it | 2 | 2 |
| I needed the support | 3 | 3 |
| Other, please say what | 4 | 4 |
| | | |

22. **Why did you stop attending?**

| | Unprompted | Prompted |
|---|---|---|
| I felt it was making no difference to my health | 1 | 1 |
| I wasn't enjoying it | 2 | 2 |
| I didn't need the support | 3 | 3 |
| Timing didn't suit | 4 | 4 |
| Felt embarrassed | 5 | 5 |
| Consultation venue wasn't suitable (difficult to get to) | 6 | 6 |
| Unable to continue due to health reasons | 7 | 7 |
| Other, please say what | 8 | 8 |
| | | |

**ASK ALL**

23. **Did you feel that there were any barriers to taking up the health counsellor service in the first place? If so, what were they?**

| | Unprompted | Prompted |
|---|---|---|
| I didn't know anything about it | 1 | 1 |
| My GP didn't know about it, I found out about it from someone/thing else | 2 | 2 |
| I was embarrassed | 3 | 3 |
| Not wanting to face up to the fact that I had a problem | 4 | 4 |
| Difficult to get there - transport | 5 | 5 |
| Times not suitable for me | 6 | 6 |
| I have caring responsibilities, so need cover | 7 | 7 |
| Other, please say what | 8 | 8 |
| | | |
| No barriers | 9 | 9 |

**BASELINE NON ATTENDERS GO TO Q25**

24. **Were there any barriers to keeping up attendance once you had started? If so, what were they?**

| | Unprompted | Prompted |
|---|---|---|
| Difficult to get there | 1 | 1 |
| Shifts/work irregular hours | 2 | 2 |
| I didn't think it would make any difference to me | 3 | 3 |
| I didn't like the counsellor | 4 | 4 |
| I felt embarrassed | 5 | 5 |
| Times not suitable for me | 6 | 6 |
| I have caring responsibilities, so need cover | 7 | 7 |
| Other, please say what | 8 | 8 |
| | | |
| No barriers | 9 | 9 |

**25.** **Is there anything (support) that could have been provided to help you (continue) to attend?**

______________________________________________________________________

______________________________________________________________________

**26.** **Any other comments or suggestions for ways in which the service could be improved?**

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

## Section 4: About you

**27.** **Gender**

| | |
|---|---|
| Male | 1 |
| Female | 2 |

**28.** **Into which of these age bands do you fall?**

| | |
|---|---|
| 16-24 | 1 |
| 25-34 | 2 |
| 35-44 | 3 |
| 45-54 | 4 |
| 55-64 | 5 |
| 65+ | 6 |

**29.** **How would you describe your cultural or ethnic background?**

| | |
|---|---|
| White – Scottish | 1 |
| White – Irish | 2 |
| White – other British | 3 |
| White – other background | 4 |
| Mixed background | 5 |
| Chinese | 6 |
| Indian | 7 |
| Pakistani | 8 |
| Bangladeshi | 9 |
| Other Asian | 10 |
| Black Caribbean | 11 |
| Black African | 12 |
| Other Black | 13 |
| Other (please specify) | 14 |

**30. Employment status**

| | |
|---|---|
| Self-employed | 1 |
| Full-time employed (30 hours per week or more) | 2 |
| Part-time employed (up to 30 hours per week) | 3 |
| In full-time education | 4 |
| In training programme/Government training programme | 5 |
| Unemployed and seeking work | 6 |
| Retired – age | 7 |
| Retired – medical grounds | 8 |
| Not working due to ill health | 9 |
| Full time carer | 10 |
| Other not working and not seeking work | 11 |

**31. Do you consider yourself to have a disability?**

| | |
|---|---|
| Yes | 1 |
| No | 2 |

# Appendix 2 Topic guide

## 3117: Evaluation of the Live Active Health Counsellor Role

## TOPIC GUIDE

*Background and introductions.*

**Training**

1. How would you rate the training you received to deal with healthy eating and weight management advice? Marks out of 10? Note overall score and probe if different training topics/trainers were better/worse (check which ones against list provided by Chris).

2. What was good about the training?

3. And how could it have been improved?

4. If we were doing this again, should it be done differently? If so, how? For example, all the training delivered at the start, different content, more of a training package rather than individual themes?

5. Would you suggest any changes to course materials? Did you use the web yourselves to answer questions people had/provide advice the training hadn't answered? If not, why not?

6. How confident did you feel to deliver the healthy eating service after the training? And now you have been doing it for a while?

7. Is there any further training you think you would benefit from? What about ongoing support to help you continue and develop your role? What on the job support have you received? How could this be improved?

**Expanding the role**

8. How do you feel about delivering the health counsellor role, looking at weight management, healthy eating and physical activity?

9. How do you rate the support you were given to transfer from Live Active to Health Counsellor role? What could have been improved?

10. What challenges do you face in supporting participants in general, and with healthy eating and weight management issues in particular?

11. Do you feel you are able to meet the needs of people referred for each of the three issues? If not, what could be done to help?

12. How do you cover both physical activity and healthy eating in practice? Do you cover it in two sessions or just one? How do you split them – evenly or more emphasis on one than the other? Which element do you cover first? How comfortable do you feel in practice covering both issues? Is there enough time within a 1 hour consultation to cover both?

13. There is a readiness ruler on the front page of the questionnaire to direct the consultation, have you used it? Why is that? What do you like/dislike about it?

14. It is up to you and the participants to agree how much contact is required. How has this worked in practice – what is the average amount of contact? Most? Least? Is this driven by you or the client? Did this give you any issues around capacity?

**And finally…**

15. Overall, what has worked well? And not so well?

16. Should it continue? Has it made a difference to participants? How could it be improved?

17. Any other comments?

**Thank and close**

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