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Evaluation of the HENRY approach to support early intervention and prevention of childhood obesity in Lothian, Shetland and Western Isles

Final Report

Prepared for:

NHS Shetland

NHS Lothian

NHS Eileanan Siar Western Isles

Contact: Derek@thelinesbetween.co.uk

EXECUTIVE SUMMARY

Introduction

i. In Scotland, the rates of overweight and obesity for both children and adults are among the highest in the developed world, with the 2019 Scottish Health Survey estimating 30% of children to be at risk of these issues. Scottish Government Early Intervention funding was made available to health boards to support initiatives aimed at addressing these issues.

ii. NHS Lothian, NHS Shetland and NHS Western Isles, in collaboration with partners in their respective health board areas, successfully applied to the fund to provide a recognised training package (HENRY – Health Exercise Nutrition for the Really Young) for frontline staff working with families.

iii. HENRY provide training interventions that equip practitioners to support families in different ways. The HENRY training interventions used in each health board are detailed below:

- HENRY Core training – intended to equip participants with the knowledge, skills, techniques, and confidence to use the HENRY approach to support positive behaviour change for healthy lifestyles. All three health board areas delivered the HENRY core training offer
- HENRY Facilitator training – intended to equip participants with the knowledge and skills to deliver a structured eight-week HENRY family support programme that gives families the knowledge and techniques to make positive lifestyle changes. NHS Shetland and NHS Western Isles have included this training package in their programme of work.

iv. It is worth noting that this programme was delivered during the COVID-19 pandemic with associated restrictions in place. This meant significant changes to how the HENRY training programmes would normally be delivered. The main change saw a shift from a full day of face-to-face delivery to online delivery of two-hour sessions over eight weeks.

Aims of the evaluation

v. NHS Lothian, NHS Shetland and NHS Western Isles commissioned The Lines Between to carry out an evaluation of the HENRY training programme to understand its impact on practitioners' skills, knowledge, confidence and practice. Identifying the learning from the implementation and delivery of the programme was also a requirement.

The recognised need for HENRY

vi. Three key themes emerged from discussions with programme stakeholders regarding the need for the HENRY programme and its alignment with local needs and priorities:

- To complement existing provision and address gaps in support
- To build knowledge, skills and confidence of frontline practitioners to support the families they work with

- To respond to an observed need to tackle obesity with a consistent approach to supporting families.

Delivery in each Health Board area

vii. An overview of the training delivered over the course of the programme is shown below:

NHS Lothian			
Training type	**Number of courses**	**Actual participant numbers**	**Target participant numbers**
Core	12	89	120
NHS Shetland			
Training type	**Number of courses**	**Actual participant numbers**	**Target participant numbers**
Core	2	16	24
Facilitator	2	11	12
Family programme	3	9 (completed)	(N/A)
Western Isles			
Training type	**Number of courses**	**Actual participant numbers**	**Target participant numbers**
Core	3	25	18
Facilitator	1	6	6

viii. It is a credit to each of the project leads that every NHS board performed so strongly against targets that were set before the emergence of the COVID-19 pandemic. They faced disruptions, a delayed start, and dealing with the impact of the changes to delivery resulting from the pandemic.

ix. Further training has been delivered beyond the period of the evaluation, which has boosted participant numbers. Considering these achievements within the wider context, the implementation and delivery of these project have largely been successful.

Participant experience of the HENRY Core and HENRY Facilitator training

x. Overall, feedback about the experience of participation in the HENRY Core and Facilitator training was overwhelmingly positive. Online delivery was well received and did not detract from the participant experience or outcomes. In fact, feedback from participants of the HENRY Core training suggests that online delivery was a key enabler to the application of learning and changes to practice.

xi. The trainer's engaging delivery style and the interactive approach ensured that online delivery did not negatively impact the participant experience. Core training content was found to be accessible and relevant to participant job roles, which points to effective recruitment processes and applicable HENRY training content.

xii. While some participants identified gaps in the facilitator training content, this did not appear to have negatively influenced overall experiences, and survey respondents reported all components of the training to be useful or very useful.

Achievement of learning outcomes – HENRY Core training

xiii. The core training is intended to equip practitioners with the knowledge, skills and confidence to support and work with families as part of their day-to-day role and interaction with them. It covers a range of relevant topic areas, including nutrition, healthy weight, lifestyle and parenting.

xiv. Participant survey responses demonstrate positive shifts in measures of different aspects of knowledge, skills, confidence and techniques. Participants were able to describe new knowledge they had gained, skills they had developed, and new techniques and strategies to support sensitive conversations and behaviour change.

xv. Examples of how learning had been applied and what that meant for changes to practice further reinforce the conclusions that intended outcomes have been achieved. High levels of consistency across survey responses and participant interviews provide confidence that the intended outcomes of the core training were met.

Achievement of Learning outcomes - HENRY Facilitator training

xvi. HENRY facilitator training aims to equip people to deliver the structured eight-week HENRY family programme and to feel confident about doing so.

xvii. Survey data demonstrates that the majority of participants gained or developed relevant skills and knowledge to support facilitation of the HENRY family programme. This was reinforced through feedback from those with experience in facilitating a HENRY family programme. A strong indicator of the success of this training is the effective and successful delivery of three family programmes to date.

Changes to practice

xviii. In participant survey responses, all respondents detailed at least one aspect of their practice that they intended to change as a result of the training. During interviews with participants, this was explored further; the most commonly reported ways in which participants have applied their learning and made changes to their practice were reported as:

- Greater use of open questions and empathetic listening during conversations with families
- Supporting families to find their own solutions, rather than creating solutions for the family
- Identifying opportunities to have sensitive conversations about weight and lifestyle when providing other support
- Being more proactive in broaching the subject of nutrition and healthy weight (and other sensitive conversations)

The HENRY family programme

xix. Given that only nine parents from Shetland have completed an eight-week HENRY family programme, the evidence base from this evaluation is not robust enough to make any assessment of effectiveness. However, strong pre-existing evidence of the effectiveness

of the HENRY family programme for participating families in England and Wales does exist and reflects emerging evidence from this evaluation.

xx. The emerging evidence from Shetland participant survey data and interviews indicates that the experiences with the programme are positive, and that parents' knowledge and confidence improves across a range of measures. Positive changes were also reported in relation to diet, levels of physical activity and overall wellbeing. Furthermore, there is strong pre-existing evidence of the effectiveness of the HENRY family programme, from delivery carried out and evaluated in England and Wales.

xxi. Feedback from parents suggests that participation can act as a catalyst for sustainable change, even if those changes are relatively small. Those that have started to apply some of the techniques and tools were able to describe the different ways it has benefitted them, their children or family life overall.

Learning from programme implementation and delivery

xxii. Throughout the implementation and delivery journey, several challenges were faced by project leads, and key factors that supported and enabled delivery were also identified. The main learning themes are set out below.

- **A collaborative approach from the outset -** Before funding bids were prepared, work was undertaken by the programme leads to understand needs at a local level and bring partners and stakeholders into discussions to explore the best way of meeting the identified need. This ensured collective buy-in and support for the programme.
- **Ongoing stakeholder involvement and support** – Partners and stakeholders maintained their engagement and provided valuable input. They had a critical role in the programme's success, supported co-ordination and ensured staff were available for the training.
- **Planning and logistics** – The planning and scheduling of training courses was time and resource-intensive. On reflection, confirming the available training dates across the year would have been more efficient than doing it course by course.
- **Resourcing -** Capacity and availability of resource at key points in implementation and delivery was a significant challenge. While there is no 'one size fits all' solution, careful consideration is needed when planning the resourcing of these projects.
- **Changing the delivery format** – A shift to online delivery over weekly sessions was a key enabler. It mitigated any accessibility challenges, and weekly sessions were reported to make it easier to absorb and apply learning in daily practice.
- **Locality based approach** – In the local authority areas where NHS Lothian focused on a locality approach, a greater degree of traction and buy in was generated. The one area where this approach was not taken had noticeably less momentum.
- **Delivering the HENRY family programme –** NHS Shetland delivered 3 HENRY family programmes. By choosing not to have eligibility criteria, and to promote the value and relevance to all parents instead, led to a broad range of families engaging with the programme. Project leads also observed that careful consideration of programme timings can help to minimise dropout and reduce barriers to access.

- **Maintaining the HENRY family programme -** To build resilience in the model, NHS Shetland required all those participating in the Facilitator training to commit to delivering two to three family programmes per year. This helps ensure sustainability.

1. Introduction

1.1. This is the final report from the evaluation of the implementation and delivery of the HENRY training programme in three health board areas: NHS Lothian, NHS Shetland and NHS Western Isles.

1.2. The report has nine chapters:

- This chapter provides an overview of the context, the need for a preventive programme to tackle obesity in the early years, and different approaches taken across the three health board areas;
- Chapter two explains the evaluation objectives and methodology and discusses data limitations;
- Chapter three presents progress towards programme targets;
- Chapter four covers experiences of implementation and delivery. This includes foundation stages, engagement with stakeholders, planning and capacity, lessons learned, training delivery, progress with implementing the family programme, working with HENRY and future delivery plans;
- Chapter five explores stakeholder perspectives on HENRY, including fit with local services and priorities, the need to build skills, knowledge and confidence, and a desire to tackle obesity and embed consistent approaches across work with families;
- Chapter six presents findings about the core training – why people attended, accessibility and delivery formats, facilitation approaches, content and resources, learning outcomes, impact on skills, knowledge and confidence, influence on practice and the barriers and enablers to applying learning;
- Chapter seven sets out findings on facilitator training; style and delivery, learning outcomes and other benefits from participation;
- Chapter eight presents parents' experiences of participation in the HENRY eight-week family programme, and the difference it has made; and
- The report ends with conclusions and recommendations for the future.

Context

1.3. In Scotland, the rates of overweight and obesity for both children and adults are among the highest in the developed world, with the 2019 Scottish Health Survey estimating 30% of children to be at risk of these issues.

1.4. The Scottish Government's (SG)'A Healthier Future: Scotland's Diet and Healthy Weight Delivery Plan' (2018) sets out a wide range of actions that support people to eat well and maintain a healthy weight, while reducing diet-related inequalities. Outcome 1 of this plan includes an aim to halve childhood obesity by 2030, with the aspiration that 'children have the best start in life - they eat well and have a healthy weight.'

1.5. Actions to achieve this outcome include upskilling frontline staff, raising their understanding of nutrition and equipping them to support families through conversations around food, nutrition and healthy weight. This aim was further

emphasised and reinforced in the SNP 2021 manifesto, which states '*Improving diet and levels of healthy weight is a public health priority and we will aim to halve childhood obesity by 2030, significantly reducing diet inequalities.'*

1.6. NHS Lothian, NHS Shetland and NHS Western Isles, in collaboration with partners in their respective health board areas, successfully applied for SG Early Intervention funding. The funding is being used to provide a recognised training package – HENRY - for frontline staff that support parents with lifestyle, healthy weight, emotional wellbeing, nutrition and parenting.

Different approaches across the localities

1.7. HENRY offer training interventions that equip practitioners to support families in different ways. The HENRY training interventions explored in this evaluation are:

- Core training –intended to equip participants with the knowledge, skills, techniques, and confidence to use the HENRY approach to support positive behaviour change for healthy lifestyles; and
- Facilitator training – Intended to equip participants with the knowledge and skills to deliver a structured eight-week HENRY family support programme that gives families the knowledge and techniques to make positive lifestyle changes.

1.8. The training focus differs slightly between health board areas. In NHS Lothian, the main priority is to enhance the knowledge, skills and confidence of participants to better equip them to support families with issues around child healthy weight, nutrition, and parenting. Therefore, across NHS Lothian, only the core training is being implemented.

1.9. NHS Shetland and NHS Western Isles adopted a blended approach, which offers both core and facilitator training. This equips practitioners to utilise the HENRY approach in their day-to-day role in supporting families. They will also train practitioners to deliver a formal and structured eight-week programme of support for families.

1.10. While practitioners that attend the HENRY training in NHS Lothian will not be delivering an eight-week family HENRY programme, it is expected that they will be more active in referring to Get Going, an existing family healthy lifestyle programme. Get Going is also an eight-week family programme focused on healthy eating, nutrition, and physical activity with very similar intended outcomes as the HENRY eight-week family programme.

1.11. While the island health boards aim to broadly cover their geographical areas, NHS Lothian has taken a more focused place-based approach, with support from Education, early learning staff, community projects and the third sector. This targeted communities in the social index of multiple deprivation (SIMD) zones one and two, or where organisations support families at risk of food insecurity. This included:

- **Midlothian: Mayfield** – an area of multiple deprivation
- **West Lothian; Dedridge** - a community regeneration area with data zones in the bottom 20% SIMD
- **East Lothian: Musselburgh, Prestonpans and Tranent** – which has high levels of deprivation with 6 data zones within the 20% most deprived in Scotland

- **City of Edinburgh: Staff within the Discover programme** – an established partnership between council, third sector and health supporting families at risk of food insecurity across the City of Edinburgh

Changes in HENRY delivery

1.12. The COVID 19 pandemic has brought about significant changes for HENRY. Until the introduction of COVID restrictions, HENRY core was delivered in a face-to-face format over two consecutive days, and the facilitator training was over four full day sessions (completing the two days of core training prior to doing a further two days of facilitator training). With the introduction of restrictions, delivery moved online, with training broken down into eight-weekly, two-hour sessions. While the opportunity to run face to face sessions eventually became possible, online delivery also continued.

2. Evaluation purpose and methodology

Aims of the evaluation

2.1. NHS Lothian, NHS Shetland and NHS Western Isles require an evaluation of the HENRY training programme to understand its impact on practitioners' approaches and practice and on the families they support. Identifying and articulating the learning from the implementation and delivery of the programme, to inform decisions for any potential future scale-up and rollout, is also required.

2.2. The evaluation will assess if the objectives of the HENRY training programme have been met, namely:

- Increased knowledge, confidence and skills of participants who engage with families around nutrition and healthy weight;
- Equipping participants to support families to make positive lifestyle changes;
- Training is effective in meeting the needs of participants, and supporting ongoing conversations; and
- Equipping those undertaking the facilitator training to deliver the eight-week structured HENRY family programme.

2.3. Furthermore, the evaluation will also explore and identify outcomes and the difference that practitioner support makes to families, assessing the extent to which:

- Families' experience, and recall, having family-centred conversations around good nutrition and healthy weight as part of the broader holistic support they receive from practitioners; and
- Families attending the eight-week HENRY family programme increase their knowledge and awareness of healthy eating and nutrition, leading to positive choices and behaviour change.

Methodology and data

2.4. Data collection methods and a summary of the fieldwork that has informed this report are presented below.

Discussions with health board area leads and local stakeholders and partners

2.5. The evaluation team maintained regular contact with lead staff in each health board area with responsibility for implementing and managing the HENRY programme. This ensured that the evaluation team remained sighted on the programme's progress in each area, and each was informed of evaluation activity and progress.

2.6. Regular communication with health board area leads was supplemented with two formal discussions that explored the experiences and learning of lead staff during the implementation and delivery of the programme. The first formal discussion took place at the midpoint of the programme, and the final one towards the end.

2.7. Each health board area lead identified stakeholders with an interest or involvement in the HENRY programme. These stakeholders represented organisations that had

supported the implementation of the HENRY programme and managed services where staff were provided with the opportunity to participate in HENRY training.

2.8. Discussions with the identified stakeholders were carried out by the evaluation team, focusing on understanding aspirations for the HENRY programme and exploring where it fits in the current support landscape and why it was needed.

2.9. Fourteen stakeholders (8 NHS Lothian, 5 NHS Shetland, 1 Western Isles) engaged with the evaluation.

Analysis of HENRY survey data

2.10. All core and facilitator training participants are invited to complete an online survey on completion of the training. The surveys explore participants' experiences of the programme, and the extent to which learning outcomes have been achieved. Data collected through these surveys was shared with the evaluation team.

2.11. The findings in this report have been informed by analysis of:

- 101 responses from core training participants (66 NHS Lothian, 20 Western Isles, 15 NHS Shetland); and
- 15 responses from facilitator training participants (11 NHS Shetland, 4 Western Isles).

Discussions with participants

2.12. The evaluation methodology includes discussions with a sample of participants to explore their experiences and outcomes in more depth. These conversations also cover how learning is being applied and the changes to practice any training has led to.

2.13. Discussions with those that have completed the core training took place roughly six-weeks post participation. This timeframe was designed to allow sufficient time after completing the training for learning to be applied and changes to practice implemented. For those participating in the facilitator training, interviews were conducted with participants with experience of delivering a HENRY eight-week family programme.

2.14. Over the duration of the evaluation interviews were conducted with:

- 25 core training participants (17 NHS Lothian, 4 NHS Shetland, 4 Western Isles)
- Six facilitator training participants (NHS Shetland only)

Discussions with parents

2.15. Only three HENRY family programmes were delivered during the evaluation period, and all in NHS Shetland. In each programme three families completed; all were invited to participate in a discussion with a member of the evaluation team. Four parent participants accepted the invitation, with representation from each of the programmes delivered.

Data limitations

2.16. The following limitations in data should be noted when considering the findings of this evaluation report.

2.17. Only nine families have participated in and completed an eight-week HENRY family programme. Of those, eight completed the HENRY baseline and post completion survey, and four took part in an interview with a member of the evaluation team. This dilutes the robustness of the evidence relating to experience and outcomes.

2.18. Aligned to the above, the evaluation planned to engage with parents who were supported by participants who completed the core training, to explore the extent to which the application of the HENRY approach was having a positive impact. Although core training participants who participated in evaluation interviews were receptive to supporting recruitment of parents for the evaluation, this did not lead to parents engaging with the evaluation. Therefore, we can only present the anecdotal evidence and observations provided by practitioners during interviews.

2.19. The evaluation intended to conduct interviews with 51 core training participants from across the three health board areas. All participants were offered the opportunity to participate, but only half (25) accepted. Similarly with participants of the facilitator training, the evaluation aimed to interview 10 staff who had delivered a HENRY eight-week family programme. However, only six facilitators in NHS Shetland had experience of delivery by the end of the evaluation period. All six participated in an interview

2.20. While the target number of interviews has not been reached, we do not believe that this presents a significant limitation to the findings. The high level of consistency in findings from respondents across each health board area, and from both the survey and interviews provides confidence in the robustness of findings on participant experiences and outcomes.

3. Delivery overview and progress against targets

3.1. The table below outlines the approach and training targets for each health board area:

Delivery Component	NHS Lothian	NHS Shetland	NHS Western Isles
Parts of the HENRY package being utilised	HENRY Core training only	HENRY Core and Facilitator training	HENRY Core and Facilitator training
Target number of participants	120	Core – 24 Facilitator – 12	Core – 18 Facilitator – 6
Practitioner roles	Range of practitioners across the Early Years setting	**Core** – Health Visitors, Health Care Assistants (maternity), Play Workers, Oral Health Staff, Social Care workers (children and families), Practitioners and manager from private childcare settings **Facilitator** – Play Worker, Family Support Worker, Trainee Health Visitor, Integrated Midwife and Health Improvement Practitioners	**Core** – staff from Dietetics, health promotion, health visiting and early years **Facilitator** – healthy weight practitioners, health promotion staff and early years staff
Type of family support/ interventions delivered	HENRY Core approach with option to refer into existing healthy eating, nutrition and physical activity programme	HENRY Core approach and eight-week family programme (online and face-to-face)	HENRY Core approach and eight-week family programme (online)

Delivery progress

3.2. An overview of the training delivered over the course of the programme is shown below:

NHS Lothian		
Training type	Number of courses	Actual number of participants
Core	12	Edinburgh - 20 West Lothian -38 Midlothian - 24 East Lothian - 7 **Total - 89**
NHS Shetland		
Training type	Number of courses	Number of participants
Core	2	16
Facilitator	2	11
Family programme	3	9 (completed)
Western Isles		
Training type	Number of courses	Number of participants
Core	3	25
Facilitator	1	6

3.3. As the figures above demonstrate, NHS Western Isles exceeded their target for the number of participants trained in the Core training and met the target for the facilitator training. NHS Shetland are only one below their target for facilitators trained, but the delivery of one fewer core training programme than planned means that they have not met their initial target. However, further core training is planned for 2022 and this will see them meet that target. NHS Lothian are close to meeting their ambitious target, and like NHS Shetland, further core training planned for early in 2022 will see them meet, or get very close to it.

3.4. That every NHS board has performed so strongly against targets that were set before the emergence of the COVID-19 pandemic is a credit to each of the project leads. They have faced disruptions, a delayed start, and dealing with the impact that a shift from a 2-day delivery model to an eight week and eight session delivery model has on planning and implementing such a project.

4. Programme implementation and delivery

4.1. In this chapter, we discuss the experiences of staff leading the implementation and delivery of the programme in each health board area, and the factors influencing implementation and delivery.

A collaborative approach from the outset

4.2. Across all three health board areas, the programme leads engaged colleagues, partners and stakeholders at the earliest opportunity. Even before funding bids were prepared, work was undertaken by the programme leads to understand the need at a local level and bring partners and stakeholders into discussions to explore the best way of meeting the identified need.

> "We had quite a big interest. I think we had 60 people come to watch the webinar. So we were all in a big meeting room in one of our bases. There was a lot of interest in what it was and how folk could be involved."

4.3. The engagement activity entailed one-to-one discussions, presentations and workshops with local stakeholders. This groundwork created a strong sense of buy-in and support for the programme, which provided a solid foundation on which to develop the programme and a sense of shared ownership.

> "It was helpful when we did it in person because you could really see who had a bit more motivation. Whose mind it stayed in when you brought it up. Because we did that thing in January, and then we spoke about it again in March. And then it would have been June and September, so it was constantly brought back up again."

4.4. HENRY training was identified as the preferred option for each health board area and their stakeholders. However, as has been discussed, NHS Lothian adopted a slightly different approach to that which is being taken in NHS Western Isles and NHS Shetland.

4.5. Across the four local authority areas[1] in NHS Lothian, there was little desire to implement another structured support programme for parents. The need identified was to equip staff to support parents through their usual interaction and contact. Therefore it was decided that the HENRY Core training model was best suited for the Lothians.

> "We did a really quick questionnaire with all of the stakeholders and asked them what their issues were and where they were going, and they came back, the majority of them actually, saying it's training and confidence and the fact that their staff would take a step back;, you know, if this conversation came up they might not be as keen to have it and they would kind of close it down or refer folk to their Health Visitor."

[1] NHS Lothian covers four local authority areas: West Lothian, Midlothian, East Lothian and City of Edinburgh

4.6. Another aspect to note for NHS Lothian is that in each local authority area, the training opportunity focused on a particular locality and specific settings. With limited training spaces available, this approach was seen to help ensure consistency in messaging in a specific area; providing consistency in approach and support for parents and families.

4.7. NHS Shetland and NHS Western Isles took a blended approach. Both health board areas are (i) equipping staff through the HENRY Core training to apply the HENRY approach in their day-to-day role and (ii) having staff go through the facilitator training to deliver the structured eight-week HENRY family programme.

4.8. This two-pronged approach is intended to ensure that various levels of need can be met, and to provide different options for how a family can be supported. Key to this is recognition of the importance of achieving consistency in messaging and support.

> That's always where we wanted to get to, was that everybody was singing from the same book, saying the same thing and have the confidence and knowledge to all be delivering the same messages to families who we are working with. From conversations with staff and work done previous to looking at HENRY staff had told us that confidence, knowledge, and skills in having difficult conversations around weight was something they would like more support with. So actually, if the core training can just help that continuity with what people are saying that are engaging with families between zero and five, then I think that would be a … huge win, a massive win."

4.9. THE HENRY family programme is also being used to address gaps in provision and complement other parenting support programmes available in each health board area.

4.10. Across each of the island health board areas, the intention is to provide coverage across their localities. NHS Western Isles had a mix of roles participate in the training including healthy weight practitioners, staff in early years settings and members of the health improvement team. NHS Shetland focussed their facilitator training within health improvement as there is capacity in the team to deliver the eight-week family programme. This is a result of having recently passed the delivery of the SCOTT programme to the Dietetic Department in line with recent national Child Healthy Weight Pathway updates

> The facilitator stuff is probably Health Improvement heavy. But that's purely because we knew we were replacing SCOTT with this, and we had the capacity to take it on and deliver it."

> We're trying to get as wide a spread as possible, so there's someone in each of the Nurseries who's done it, so we've got as wide a spread across all the Nurseries across the Islands as possible, so we're trying to work with that with the Early Years Manager."

Ongoing stakeholder involvement and support

4.11. Beyond the initial planning and development phases, stakeholders have maintained their engagement and provided valuable support. They are seen to have a critical role in the programme's success to date, taking on a vital co-ordination role for the services they are responsible for and ensuring staff are available for the training.

> If we didn't have them, it wouldn't work, so I'm the kind of in-between person from HENRY to them, so they only have one person to interact with, and that's me, and I send everything out to them, so that's the way that it works. It wouldn't work if we didn't have those guys."

4.12. The supporting role of stakeholders in NHS Lothian has been particularly important. Working across four local authority areas, and within each, across a range of different services and organisations, recruitment and co-ordination support from local managers and service leads has been essential to the success of the programme.

> If I think the most important part for me was the fact that everyone stayed with it. If the people on the ground hadn't stayed and hadn't been flexible and hadn't bought into it, then it would have failed miserably. I mean, it wasn't something that we could do ourselves

4.13. The value of local ownership and alignment to local priorities was highlighted across NHS Lothian. For example, in Midlothian and West Lothian, areas with the highest level of uptake, the HENRY project reports to local operational and strategy boards. Midlothian reports to their Getting It Right For Every Child Board, and in West Lothian it has been the Health and Wellbeing Strategy Group. A similar approach is planned in East Lothian through their Children's Partnership but they are at the early stages of their work. In City of Edinburgh, relationships with Children and Family Centre staff have been developed and an agreement put in place whereby staff from two centres (two in North Edinburgh and two in south) through HENRY core training. These two areas will form the focus of future work in Edinburgh.

4.14. Working across the 4 local authority areas, and with organisations and services outside the health board has brought additional benefits. Firstly, the training offer being extended from NHS Lothian is seen to be a positive for the board's reputation. A second benefit is the new relationships that have been developed. This is perceived to improve the ability to reach and engage wider stakeholders in the Maternal and Infant Nutrition work that is underway, and to more widely promote opportunities such as breastfeeding groups. It has also given local stakeholders a named contact in public health, someone they can go to if they have a query or need connected to another part of the system.

> We're kind of taking it out to other people, now I have a whole list of people that can tap into the maternal and infant nutrition work that we're doing so we can promote the breastfeeding groups that we run. And we can let people know about the training that we do around maternal and infant nutrition."

4.15. Local stakeholder engagement and support has not needed to be as extensive in NHS Shetland or NHS Western Isles. This is partly due to the smaller scale of delivery in the island health boards, but also due to project leads having existing relationships with most of the organisations and services that staff were being drawn from.

4.16. NHS Shetland provide progress updates to their Maternal and Infant Nutrition Group, and keep them aware of when programmes are being delivered. Overall, the group is seen to be supportive of the HENRY programme, but not required to provide any practical support.

4.17. NHS Western Isles delivered their planned core and facilitator training during the first half of their project. This initially put them in a good place to move forward with delivery of the eight-week HENRY family programme. However, momentum stalled and the level of stakeholder engagement also dropped, largely due to the pressures created in services by the COVID-19 pandemic and the movement of staff to help provide the COVID response. At the end of summer 2021, the project lead attempted to rebuild some momentum and reconvened their project stakeholder group.

4.18. However, after a positive meeting, and getting back to a position to start progressing again, COVID cases in NHS Western Isles started increasing and key staff were pulled from their day to day roles to be involved in the COVID response. This meant that things stalled. It is important to note that this is not a reflection on stakeholder perceptions of the HENRY programme or its value, it is simply a result of the circumstances.

Planning, logistics, timing and capacity

4.19. The planning and logistics of each training programme have proved to be the most challenging and resource intensive aspect. It is time consuming to make arrangements, as programme leads co-ordinate between HENRY and the services with staff signed up for the training, to ensure everything is in place.

> “We’d asked them what days were best or what days were particularly bad and such like, do you know, we done it that way but it’s just the logistics of the whole thing that’s been the most difficult and I don’t know if it would have been any easier if we’d just been doing two days.”

4.20. Furthermore, only the hands-on practical support provided by local managers and service leads across the Lothians made delivery of this project achievable. Without this, the project lead would not have had sufficient capacity to manage all the recruitment and co-ordination.

4.21. NHS Shetland also found the resource intensive nature of planning to be the greatest challenge in the HENRY family programme. The organisation and co-ordination required placed significant demands on the lead staff. This highlights the importance, and added resilience, of having two members of staff to manage, deliver and co-ordinate the project. One of the lead staff has taken responsibility for the coordination and ongoing management of the family programme.

4.22. For NHS Western Isles, capacity has been a significant sticking point and the lone project lead did not have the capacity to give the focus required to set up and co-ordinate the

eight-week HENRY family programme. One member of staff going through the initial facilitator training was identified to take on the coordination role; however, that person had been on maternity leave since training and has only recently returned and is picking up the coordination role.

4.23. Timings were also challenging, compounded by the shift to online training and delivery across eight weeks rather than two full days. Programme leads feel two-day training sessions would have been easier to fit around the various holidays throughout the year. Trying to arrange training for the summer months has been difficult as most staff cannot commit to eight consecutive weeks of training due to annual leave.

> "We were going to do one over the summer, but we just can't, people need to take time off. And even trying to run it over four weeks, folk trying to take time off, it's just too difficult, so we've had to wipe out summer, so we don't have anything planned in summer, and then you get into September, and you get caught up in the October week, do you know what I mean, it's just tricky, so it has been difficult."

4.24. As much as the change in delivery structure created some additional challenges, the leads do also recognise that it was a critical enabler to participation

4.25. Those leading the programme in each health board area have absorbed the project into an already busy job role. For the most part, this has been manageable, but certain pinch points demand a greater investment of time, which can then create pressures. As already highlighted, NHS Western Isles have felt the full effects of this, whereas the other boards managed to navigate these pinch points with additional resource (two leads in NHS Shetland, and the practical support of local stakeholder in NHS Lothian)

4.26. NHS Shetland and NHS Western Isles have considered whether some form of support role would have eased the challenges and pressures. However, as has been discussed already, only at certain points in the programme delivery would extra capacity be helpful. While a dedicated role may not be required, having another team member or colleague that can step in to support during the busier times would be prudent.

Reflections on delivery

4.27. Programme leads reflected on what they had learned and if they would do anything differently if they could start again.

4.28. One of the project leads described an initial concern about the training being delivered over eight sessions and whether or not people would accept that. In this regard, COVID was seen to be an enabler in that everything had changed and people were less set in their ways and more receptive to different ways of doing things.

> So in a way COVID was quite interesting because it gave us a chance to deliver this in a slightly different way. I think the beauty of COVID is that it messed everything up so no one was really set in their way. So folk were quite happy to try things which I don't think they would have been as keen to do."

4.29. Another aspect of learning came from the approach to organising and scheduling training. Throughout this project the lead in NHS Lothian tried different approaches to balancing the recruitment of participants and having confirmed training dates in place. What they have learned is that it would be easier to confirm and schedule the available training dates across the course of the year, and then recruit to each programme, maintaining a reserve list to account for drop out in advance of participation.

4.30. NHS Shetland have drawn similar learning and are taking a parallel approach to the delivery of their eight-week family programme over the next year. They want to build a constant presence and momentum and have already scheduled in a mixture of face to face and online group delivery, and also have allocated the practitioners that will be facilitating the groups. This allows continuous recruitment to the programmes, which will also build awareness of the programme over time.

4.31. Another area of learning for the project lead in NHS Lothian, stemmed from an approach taken in the City of Edinburgh. This was the one area where a locality approach was not taken and the project lead feels that it did not gain much traction. However, with the planned work with Children and Family Centres in North and South Edinburgh, a more place-based approach will be taken in the future.

4.32. The programme lead in NHS Western Isles, feels that they should have given themselves more time in the early stages for planning and set up. While they could not have predicted the disruption caused by the COVID pandemic, it has left them in the position where trained staff do not have the capacity required to organise and co-ordinate delivery of the family programme. They are conscious that staff will lose confidence over time if they do not get the opportunity to put their training into practice. It is felt that more planning in the early stages could have mitigated this scenario to some degree.

Training delivery

4.33. Programme leads reported that once the work to confirm and organise the training is complete, everything runs smoothly and little further input is required.

> “I think once we got the dates organised, and we got the participants, the whole thing just ran super smoothly. I don’t have any issues in terms of, I don’t solve any login problems, I don’t hear of any login problems, I don’t hear of any issues with people not getting resources or I don’t hear any complaints about the content of the course or anything. I only ever hear good things. So my involvement in the programme stops at the point I have the participants.”

4.34. While spreading the online training over eight weeks created challenges, it has also been an enabler to participation. One programme lead explained that training over two full consecutive days would have made it too difficult for some services to release staff, whereas arranging cover for a 2-hour session each week was more manageable.

> I thought it'd be easier to do two full days, just take folk out, and what we found is people really like the eight sessions because it was easier to cover and folk have attended."

4.35. Another advantage of online training, specifically for the island health board areas was that staff working on the outer islands were not having to travel to participate. Similarly for delivery of the HENRY family programme, the online format means that the offer to families across the island health board areas is more inclusive and accessible.

> "Our population is so spread out. And some of the outer isles – so we have got quite a few referrals that have come in from Unst. That's our most northerly isle. And usually, groups are run in Lerwick – which to get from Unst to Lerwick is two ferries plus a 40 min drive one way. It's a whole day. So people just don't have time to engage from there. So this has opened up a big door for them."

4.36. However, while online can be an effective means of maximising reach and accessibility, there is recognition that it is not a format that everyone will engage with. Therefore, NHS Shetland are planning a mix of face to face and online opportunities in future.

Progress with implementing the HENRY 8-week family programme

4.37. NHS Shetland and NHS Western Isles originally planned to deliver the eight-week HENRY family programme, with NHS Lothian opting solely to provide the core training for staff. However, due to the challenges experienced by NHS Western Isles, only NHS Shetland delivered this strand of activity. To date, three eight-week HENRY family programmes have been delivered, with a total of nine parents completing.

4.38. NHS Shetland started promoting the family programme while staff were being trained. This generated sufficient demand to run the three programmes that were delivered. The board are not targeting any specific demographic or attaching any eligibility criteria for the programme. The intention is to promote it in a way that highlights the potential value to all parents with young children, and minimise perceptions being created that it is a programme just for those struggling. This approach is seen to be working so far, with a mix of parents attending each of the programmes.

> I think just being able to put it out there to the wider public like this. This is what it is, this is what it includes. And the people that have been coming forward for it is really interesting. It's a really broad range of families coming for lots of different reasons, which I think is really lovely, actually really what we want to achieve by it."

4.39. The first two programmes ran during summer 2021, and on reflection this was not an ideal time, as there was more disruption to family routines and other commitments that impacted on attendance due to the school holidays. However, things had been delayed enough and the project leads were keen to get started and did not want to lose seven

weeks through the summer. The third programme was delivered during August and into September.

4.40. There was an early IT challenge in the planning for the first groups; the difficulty of identifying a platform that could be used, as the Health Board's IT policy does not permit the use of Zoom or Teams to facilitate delivery of the programme. In the end NHS Shetland were able to use the Webex platform.

4.41. To ensure future delivery can be maintained, staff participating in the facilitator training must commit to delivering two to three group programmes per year. Coupled with the structured planning in place to schedule the next year of programme, this adds a certain degree of resilience to the programme.

> "I think we put in the working agreement to deliver 2-3 groups a year as a minimum. So the recruiting stuff as well, so you keep up those skills. What I don't want to happen is that you do one group and then have a two-month break from it. Hopefully, it is just something that is on people's workload; if you are not delivering, then you are recruiting for the next one. We'll see how that goes."

4.42. To enable face to face delivery, the 11 participants who completed the HENRY facilitator training will undertake a face to face conversion course. This is an additional component of training, that those who have completed the online facilitator training must complete before they are able to deliver the eight-week HENRY family programme in a face-to-face format.

4.43. As discussed earlier in this report, the member of staff taking on the coordination role in NHS Western Isles has recently returned from maternity leave and will lead the coordination of the families programme while also providing some admin support. They have also had additional staff trained in the HENRY facilitator training, which adds extra capacity to the delivery team, and replaces someone who had left post after completing the training.

Support for staff

4.44. Both NHS Shetland and NHS Western Isles organise regular sessions for those delivering the eight-week HENRY programme to come together. These peer support sessions are put in place to encourage and enable sharing of practice and experiences, collective problem solving and to discuss plans for future delivery.

4.45. In addition, both areas are also setting up a similar model of peer support and sharing for those that have been through the HENRY core training. As well as being a support function it also hoped that this will help to maintain a focus on the learning that has been gained and help to ensure changes to practice are embedded.

4.46. Another component of support is provided by HENRY. They host regular group sessions for the co-ordinators in each of the areas across the UK that are delivering the HENRY family programme. This gives those in NHS Shetland and NHS Western Isles access to a vast pool of highly experienced coordinators for advice, guidance and support. HENRY

also allocates a Partnership Support Officer to each region to support co-ordinators, providing a direct point of contact for any issues, queries or support needs.

Working with HENRY

4.47. Overall, experiences of working with HENRY were described positively by each health board area lead. Staff at HENRY were highlighted as being approachable and responsive to enquiries, clear in their communications, and reliable at ensuring that resources and participant information are distributed in a timely fashion. Another positive highlighted was that dedicated members of staff support different aspects of the programme.

> Really good – they have been amazing. There are very distinct people speaking about different things with you. [member of staff] has been doing the organisation and training, and then there has been [member of staff] that does the sending out information about the core training and then someone else for finance. We've also got our own local co-ordinator for the actual groups. I've just gone to her with any questions, and she comes right back. And they've linked me into a group with other HENRY co-ordinators."

4.48. However, a couple of minor issues and frustrations were raised. The first related to agreeing dates, days and times for the training delivery to take place. Feedback from programme leads suggests that there was not much flexibility, and in NHS Lothian, who organised the most training sessions, it has proved to be an ongoing challenge. At times, it has been a matter of making things fit with what HENRY have offered rather than being able to discuss and negotiate what would work best for service staff participating in the training. There is a perception that ongoing communication is needed to ensure access to available slots in delivery. A recent example has been with NHS Western Isles trying to confirm a date for training delivery in the new year. A date has been suggested by HENRY but not confirmed, and time is running out to ensure staff are given enough notice to attend.

4.49. A lack of flexibility was also mentioned about changing the delivery format, for example, moving to four-hourly sessions spread over a reduced number of weeks.

> "What made it doubly hard was the Covid thing because what was a two-day structured programme has migrated into an eight-week programme, an eight-session programme, and it has to be two hours and we'd wondered if we could have done four, four-hour sessions for half days because that would have hugely reduced the amount of time it would have taken for us to get through it but we weren't able to do that, it had to be the eight, two-hour sessions."

4.50. A challenge reported by NHS Shetland was a perceived lack of clarity about the need for conversion training to deliver the HENRY family programme face to face, if facilitator training had been delivered online. While HENRY feel that this was made clear to commissioners from the outset, something has been lost in communication. This has

held up plans to provide face to face HENRY family programmes, and also brings a significant cost. What further adds to the frustration is the project leads are still not sighted on exactly what they will gain from the training, and what the online facilitator course has not covered that would prevent them from delivering face to face.

4.51. From HENRY's perspective however, the conversion training is required because the way in which they deliver programmes face-to-face is perceived to be distinct from the way many other programmes are run, and from their point of view, is part of why the programmes are effective. HENRY also highlighted the different level of training hours between their face-to-face facilitator training (26 hours) and the online version (17 hours). The difference in training hours is that the one-day face to face delivery skills training is not part of the online delivery, hence the need for conversion training.

4.52. Another area of frustration has been a lack of clarity about whether those participating in the facilitator training need to have completed the core training first. In conversations with HENRY it had been explained that this should have been the case, and would have been made clear. However the project lead reported that they had raised the question of participating in core training prior to the facilitator training early in the project but didn't feel this was addressed by HENRY.

4.53. It is also important to acknowledge the context in which HENRY has been operating since the emergence of the COVID-19 pandemic. For 6-months, they were unable to deliver any training while they implemented changes in-house that would enable a shift to online delivery. This created a significant backlog of training that had been committed to but hadn't been delivered. When the online delivery format was operational, they had a lot of catching up to do. Furthermore, they have also experienced some staff turnover, which placed further pressure on their capacity and the training programmes they could offer. The other important factor to bear in mind, is that the online programmes delivered in Scotland were among the first to be delivered in that format. This was a new approach for HENRY, operating and delivering in a very different way, and it is perhaps unreasonable not to expect a few teething issues or glitches along the way.

4.54. HENRY are committed to making a success of the programme in Scotland and are focused on working with each programme lead to meet their needs. They also have a culture of reflecting and learning from their experiences. To this end, HENRY took the decision that the online version of the facilitator training programme will not continue in its current form, as they believe they can do better in preparing participants to feel equipped and ready to deliver the eight-week HENRY family programme. A redesigned model has been launched and will be utilised in future.

Future delivery

4.55. All project leads feel that their HENRY projects have been a success, and are committed to the intervention as a means of equipping staff and ensuring parents and families can access effective support in relation to nutrition, healthy weight and behaviour change. Each health board area has been successful in applying for a second round of funding to continue and expand their work.

4.56. In this second phase NHS Lothian has partnered with NHS Fife. The focus on core training remains, as well as maintaining a focus on condensed delivery in particular localities. Additionally, the intention is to engage with organisations that can help to extend the reach of the HENRY approach into particular communities or demographics, and those that are harder to engage.

4.57. The other new component to the second phase of NHS Lothian's HENRY project is the introduction of the 'training for trainers' model. This involves upskilling and equipping people to be able to deliver the HENRY training, which would offer greater flexibility and responsiveness across NHS Lothian and Fife.

4.58. Another aspect that the project lead feels was missing from this first phase, is the creation of a peer support group for those that have participated in the training core training. During this second phase the funding allows for a dedicated member of staff to manage the project and therefore the capacity will exist to create such a group.

4.59. NHS Shetland plan to forge ahead with delivery of their eight-week HENRY family programme, and following the face to face conversion training that staff need to undertake, will be able to provide the course face to face and online. They have facilitators trained that reside outside of the main Island so that face to face delivery does not require extensive travel for participating parents.

4.60. They will also be organising further HENRY core training, though this time it will be specifically focused on staff in the antenatal department. Some funding will also be used to equip antenatal staff to deliver the six-week HENRY antenatal group programme. There are already known challenges in relation to this activity due to staff shortages in the department.

4.61. The final element of NHS Shetland's second phase is the introduction of Raise, Engage, Refer training. This is delivered over two sessions with each session lasting two hours. The training is intended to equip practitioners to raise weight and lifestyle issues with parents, learn more about the HENRY parent programme, and understand the referral pathway into the HENRY programmes locally. It is designed to enable practitioners to have sensitive conversations with parents, explain the HENRY programme to them, and make referrals.

4.62. NHS Western Isles have similar plans to NHS Shetland. Their trained facilitators will go through the face-to-face conversion training to enable the delivery of the HENRY family programme to be provided in both formats.

4.63. Furthermore, training to equip facilitators to deliver of the 1-to-1 version of the HENRY early years programme is also planned so that families can be supported on a 1-to-1 basis. HENRY's Healthy Families Growing Up group programme for children aged 5 to 12 and their families is also being implemented.

4.64. There are also plans in place to start delivering stand-alone HENRY workshops - starting solids and eating well for less - and hope that these will be an introduction to the HENRY approach for families and encourage referral to the programmes. NHS Western Isles are also including provision of the Raise, Engage, Refer training for other frontline practitioners, with two sessions having been delivered involving 20 practitioners.

5. Need and aspirations for HENRY

5.1. To understand how the HENRY programme aligned with and contributed to local priorities and service provision in each area, we interviewed a range of stakeholders involved in supporting the programme and identifying services and staff that would benefit from participation. Stakeholders tended to be service managers in health, local authorities or third sector organisations, and a few participated in the training.

The recognised need for HENRY

5.2. Three key themes emerged in stakeholders' comments about the need for the HENRY programme:

- To complement provision and address gaps in support;
- To build knowledge, skills and confidence of frontline practitioners to support families; and
- To respond to an observed need to tackle obesity, with a consistent approach to supporting families.

Fit with services and priorities

5.3. Across NHS Lothian and NHS Shetland, stakeholder feedback suggests strong working relationships exist across different roles and services, with a multi-agency approach to providing holistic support for families across public and third sector organisations.

5.4. NHS Shetland took a blended approach to HENRY training, and stakeholders described different programmes that were available in the past and those that are still in place to support families. These included the Counterweight programme, SCOT programme, Incredible Years parenting programme and the PEEP programme.

5.5. While those parenting programmes have been potential support options for families, stakeholders viewed HENRY as offering something different.

> "Existing programmes are more reliant on families recognising or accepting there is an issue. Whereas HENRY, it's more inclusive, it's more just come along, find out, it's more supportive I think."

5.6. Stakeholders referenced the different policies (e.g. healthy eating policies in nurseries, Eat Well Guide) in place across different early years settings that are intended to support healthy lifestyles. However, they also reflected that childhood obesity has been less of a priority in recent years, and said the HENRY programme brought some impetus to the issue.

> "It has been in the past, but maybe not so much at the moment, which is why I think HENRY is going to be particularly important. I think it's slipped a wee bit. Like I say, it's not really been picked up again, there's not really been an awful lot done more recently with it."

5.7. In NHS Shetland, stakeholders view the HENRY family programme as filling a gap in provision and forming part of a structured pathway of family support. HENRY's strong evidence base on its effectiveness was seen as a key strength.

> "We lost the SCOTT programme, and we didn't have anything, because initially we'd refer to Health Improvement, and they would deliver the SCOT programme. That was fairly straightforward. When we lost that, we had a gap."

5.8. A similar picture is evident across NHS Lothians, with some variation across each locality on the availability of support programmes and services for families. Existing provision and services were described by stakeholders as being universal and not necessarily fully equipped to deal with the specifics relating to childhood obesity and the parenting support required without referral to clinical specialists. Stakeholders report that HENRY allows them to tackle issues before they require clinical intervention.

> "Selfishly I think HENRY fits a lot of our gaps, so it really suits what we see has been missing and what we feel we've needed."

5.9. Across NHS Shetland and each local authority area with NHS Lothian, there was a clear and evident need to equip services and staff to support families with issues relating to child healthy weight.

> "The staff contacted me just coincidentally, they don't know nothing about the HENRY project, and they said, "I've got a tricky conversation, can you help me out with it?" Again it was to do with weight. So there's a definite need in our communities for it, so it is."

5.10. Stakeholders also suggested that obesity is not a new issue or a newly identified need; they have been aware of the problem for some time. The HENRY training has given a sense of momentum, and a concerted effort to put the right support in place is valued.

> "It's a regular problem, it's a society which feeds each other. So if you go round to a friend's house and accept a cup of coffee, there will be a huge plate of food that you're expected to eat. So yes, there is a lot of obesity here, we've done the statistics regularly collecting data, we're showing that we've got a significantly high rate of obesity."

> "It is a priority, but I suppose the fact that it's been on our plan for a number of years without any real progress made, I think our numbers have fallen slightly on the percentages, but that wasn't for any active work that we were doing in this area."

Gaps in knowledge and skills

5.11. Training opportunities specific to supporting families with all aspects, and interconnected issues that influence healthy lifestyles, have not been readily available to

frontline practitioners. That is not to say there have been no development opportunities but what has been available has not provided the holistic approach offered through HENRY training.

> This is a catalyst if you like and to get that because I haven't had any training on how to deal with it... as I say, there's not been any. We've had training on dealing with difficult conversations, and building up the bones, and all that with working with parents, parent involvement, we haven't really tackled the obesity issue."

> I've worked in West Lothian since 1992, and I've accessed all sorts of training in the different roles I've had, and there's never been anything like this at all, nothing. This is the first role, see when I saw it, I just jumped on the chance and said to "Yeah, we'd like to be on board."

5.12. There was an acknowledgement among stakeholders of expectations that frontline staff will support families with issues that they had not necessarily been equipped with the knowledge and skills to address. HENRY was seen as the missing piece of the jigsaw to support this work, whether through delivery of a structured programme for families or through other types of support and interaction that services have with families.

> So that is always something that practitioners struggle with is how to have those conversations, particularly if it's challenging conversations where there's issues."

> We thought it would be beneficial just to expand on a lot of our knowledge and sort of make sure everyone's following the same guidance and everything given to families."

> There was in terms of a gap in terms of knowledge and confidence to have any of these conversations with parents in general about children's weight."

Building confidence, skills and tools to tackle the subject of child healthy weight

Stakeholders saw discussions about a child's weight to be among the most sensitive conversations that you can have with a parent. They explained how these conversations could seem accusatory and viewed as apportioning blame when that is not the intention. This causes staff to feel hesitant about broaching the subject and affects their confidence in initiating those conversations.

> Staff are very cautious of the whole thing around body image and that kind of thing. I think also when we're looking at younger children as well, parents get very defensive, if you bring up diet and nutrition and that kind of thing, they're almost on the back foot straightaway about,

"Oh, you're saying this is my fault," so they get very, very defensive I think. Whereas other kind of issues that might be more societal be it poverty or things like that, you know it's somebody else, this is something that's happening to us."

> So it feels like a real criticism of their parenting, and you're desperately trying not to do that, and you're saying everything to say, "Look, this isn't a criticism, we want to help you, this is what we can do to help you." They still usually get very emotional about it, and that's really difficult. I think the younger health visitors, who I am not one of, I'm quite mature, they're not as used to the difficult conversation, even though we're used to the child protection conversations because we know we have a legal obligation there."

> But we find a lot, especially this Health Visiting Team, really were quite scared of raising this issue of weight."

5.13. For stakeholders, this is a core aspiration for HENRY – they want to ensure that their staff are equipped and confident to provide effective support for families and have the courage to open difficult conversations about lifestyle and healthy weight.

Embedding a consistent approach

5.14. One of the drivers behind stakeholders' support of HENRY was to create consistency across staff and across different services within a locality.

5.15. Stakeholders acknowledged that providing families with consistent messages and the same techniques and approaches would be more likely to support sustained positive change.

> The priority was around a collective, everybody working together and sharing the same messages, it's in keeping with our multi-agency approach to it, and it was really in keeping with our strengths-based, starting with positive and preventative work."

> It was the content of what HENRY can offer, and making sure that they're delivering consistently what other people are as well so that we continuing in partnership. So we don't have people coming in saying, "No, my health visitor said this, so and so said that," we wanted to make sure that we are saying the same things, we're singing from the same hymn book sort of thing."

5.16. Furthermore, it is intended that those who have participated in HENRY training can share their newfound knowledge and skills more widely with colleagues to embed a consistency in approach more widely.

Changing perceptions about remit

5.17. Some stakeholders, predominantly those working in early years educational settings, reflected that obesity and child healthy weight are not always seen as within the remit or the role of education. This view can be held by staff in some instances, or by parents.

> "Parents and probably staff don't see that as coming under an education sort of umbrella, because we can talk about all sorts of things like child protection issues, learning issues, and we can even talk about poverty issues. But when it comes to weight, it's such a sensitive issue for the parents anyway, and I think they think, 'Oh, what a cheek they've got.' I've actually had that response."

> "We've always had an issue in early learning and childcare with being able to appropriately approach parents if we see that there's an issue when it comes to obesity. It's quite a hard one because usually it's never really fell into the education sort of remit, it's always been health visitors that have done that, parents are not really open to us speaking about it."

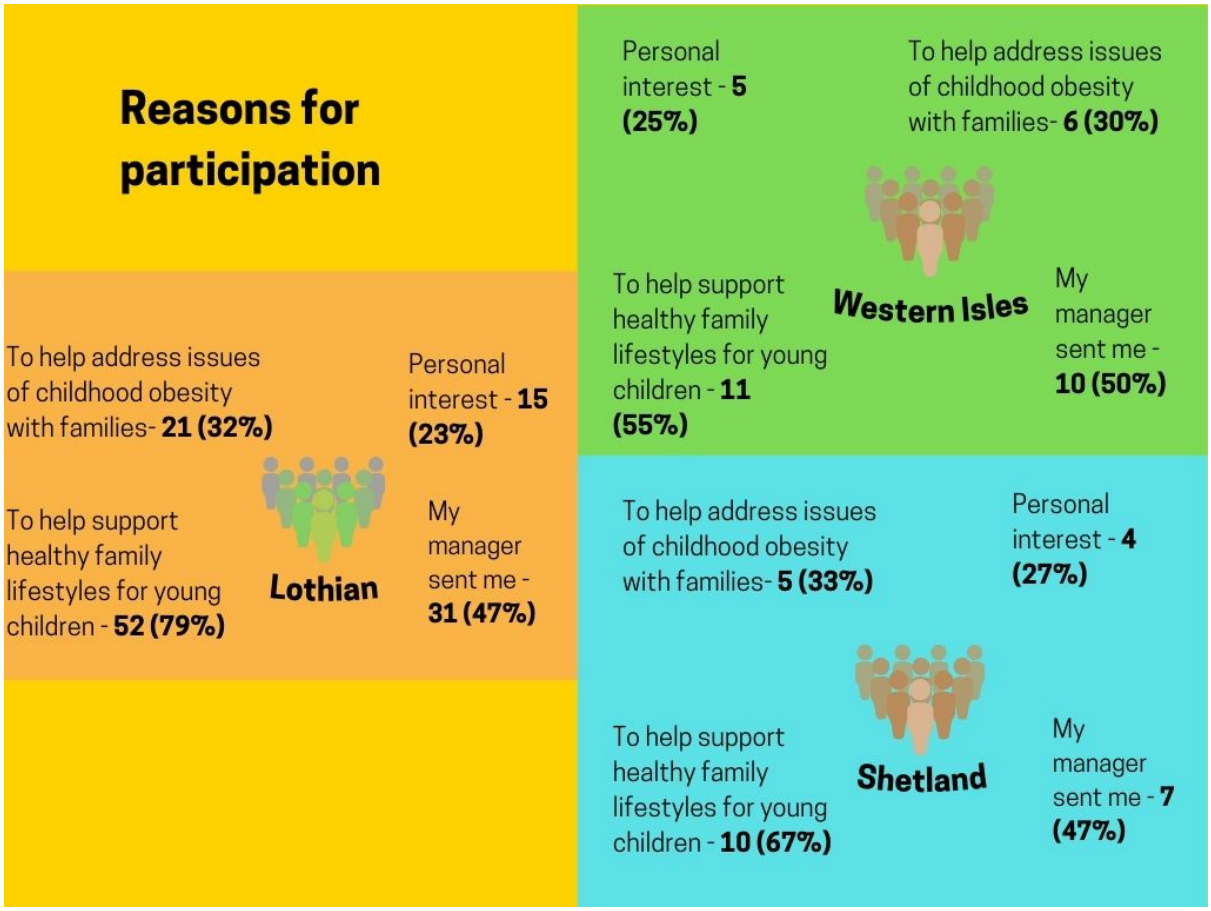
5.18. Stakeholders expressed an aspiration that making the HENRY training available to staff can reinforce their role in supporting families with child healthy weight. It gives permission and encourages them to broach the subject and engage parents when they identify an issue and see the opportunity to provide support.

6. Participant experience and outcomes – Core training

6.1. This chapter sets out the experiences of those participating in the HENRY core training and the difference the training has made. The findings are drawn from survey responses from NHS Lothian, NHS Shetland and NHS Western Isles participants as well as follow up interviews with a sample of participants from each area.

Why did people attend training?

6.2. The HENRY feedback survey asks participants to select from various options about why they chose to take part in the training. A breakdown of the responses is shown below.



6.3. Many respondents selected more than one option, with 'My manager sent me' and 'To help support healthy family lifestyles' being the most common combination. The specific aim of helping address issues of childhood obesity was also a popular reason.

6.4. This message was reinforced during interviews, where participants suggested it was less about their manager 'sending them' and more that it was presented as an opportunity by their manager. However, what came through strongly was participants' desire to continually develop and improve to support the families they work with as effectively as possible. This opportunity was particularly valued by

those in the third sector who reported that development opportunities can be more limited than for their public sector counterparts.

Experiences of training

6.5. The end of course survey asked participants how they had found the style and delivery of training, while other aspects of training experience were also explored during interviews. We discuss the various aspects and findings in the following sections.

Accessibility and online format

6.6. No participants reported any accessibility issues. The training was booked in advance with enough time to ensure adequate cover or necessary changes to delivery put in place. For some, the training was taking place at a time when usual services weren't being delivered so it was a welcome opportunity.

6.7. Course content was described as being pitched at the right level and with participants able to easily recognise the relevance to their roles. Participants were also aware in advance of what would be covered in the next session, and the comprehensive workbook mean they could prepare in advance, and also refer back to.

> "I mean, I'm not kidding, when I say it's one of the first resource books I've ever been given where I've thought I really want to read all of this book, because it's useful."

> "I think it was pitched at a level that was suitable for everybody that was present because some people didn't have a scientific background, I should add that there is at the end of each chapter, links you can look up yourself if you wanted to. And because we were such a mixed group, you know, some people had degrees, some people would have had PhDs, some people wouldn't have gone to college. So in that sense, it worked."

6.8. For many participants, aspects of their role and service delivery had moved to online during COVID-19 restrictions, and this has made the online nature of the training more acceptable and familiar than would otherwise have been the case. While some participants expressed a preference for a face-to-face format, there were also those that found the convenience of participating online a benefit.

6.9. No participant reported that the online nature detracted from their experience or training outcomes, even for those that expressed a preference for face-to-face training.

> "I like, you know, face to face training. I'm not normally too interested in online ones. Because, you just feel like nobody actually really cares or knows if you're there. But this one, I don't think they could have done anything better. You know, with it being online, it was probably the best

or one of the better ones that I've ever had online, because but it was just, you know, quite interactive."

6.10. However, some participants reported that it took a little longer for the group to gel and get to know one another than it usually would during face-to-face delivery. They missed the informal chats and jokes that would often arise during breaks. A few mentioned slight frustrations with group-based online work, such as the delay in speaking or knowing when to speak to not talk over someone or starting to say something at the same time as someone else. However, there were also reports of the opposite, with examples of groups quickly developing rapport, and the use of break out rooms being an effective way of getting people speaking with each other and sharing ideas and experiences.

> "At first I was a bit apprehensive because I thought, you know I like face to face interaction of that but after the first 20 minutes or so I thought this is quite good actually. Because we could break up and go into small chat rooms and speak to each other."

Weekly sessions and session length

6.11. The weekly session format was seen to be a positive by all interviewees, with a few reporting that full-day training is often much harder to organise in terms of staff cover. This was particularly important for those in the island health boards, where travelling to a central point can involve hours of travel in each direction.

> "So I found that really, really beneficial. And I think because we didn't have to go off the Island or go away for a couple of days to do training because everyone has commitments at home so I found it really really good."

6.12. However, the most significant and most commonly reported benefit of weekly sessions was the ability to apply learning between sessions and discuss how it went at the next, and draw on the thoughts and experiences of peers.

> "It was a new way of communicating. And it was really good to have a week to maybe practice that we're communicating. And then coming back and reflecting on that with the group and hearing their reflections. But that would not have been possible if we were doing it in two days."

> "It was good actually, doing it in little bits because then at least you were able to apply the strategies that they were giving you in your daily work and then bringing it back and asking if that's how I should have done it and so it was good having it spaced out to then go back to the tutor to ask if that was the right way and any other strategies that I could have used. So it was good to have that feedback and constant checking as well."

6.13. Another strength of the short regular sessions was that participants found it easier to absorb and retain the learning. Many participants reflected that had they covered that much content over a compressed timeframe they would not have been able to embed as much learning as they had.

> "I find it quite good and beneficial. If it was packed into two days, there's probably a lot of things I wouldn't have taken in as much. Whereas having the time to go back and read over it and secure in your brain, was really quite good."

6.14. Participants also reported that this would have likely affected their ability to apply their learning and make positive changes to their practice. Being able to take a chunk of the learning and consider how to apply it in practice was perceived to be much more manageable than completing it all in a short timescale and wondering where to start.

6.15. The majority of interviewees reported the two-hour sessions to be just around the right amount of time. It provided enough time that you could progress through content and cover enough ground in any single session, but also did not feel too long staring at a screen. Some participants reported that they were initially apprehensive about the two-hour sessions, but after experiencing the sessions found it to be fine.

6.16. A small number of other participants however, thought that some of the sessions felt a little rushed toward the end to fit in all the content that was being covered. It was also suggested that moving to longer sessions of around 3 hours and reducing the number of sessions to 5 or 6 would be a better balance. One interviewee reported that the programme they attended was delivered across two two-hourly sessions across a four week period, which they found to bring the same benefits of absorbing and applying learning, while completing the training in a shorter period.

> "It was a long eight weeks. Part of me thinks that some of the HENRY stuff could have been condensed to make it shorter."

> "Well, we actually did it so that we had two sessions a week. So that made it easier in terms of you weren't having to block off a huge section. Because when it comes to trying to arrange holidays and leave and things 8 weeks would have been really difficult."

Trainers and delivery

6.17. Feedback on those delivering the training was wholly positive and without criticism. Participants acknowledged the role of the training deliverers in making the sessions engaging and enjoyable. They were described as friendly, knowledgeable, and enthusiastic, with a manner that quickly put the group at ease.

> "They were excellent and they really worked well together as well and got their point across quite effectively and I thought they were brilliant."

> The trainer was really good, explaining the different methods and ways of learning, the role play you know, the homework, the presentations, just different things that made it an enjoyable experience. It was probably one of my favourite training courses to be honest."

6.18. The pace of delivery and the blend of whole group work, small group activities, and role-play were well received. This delivery approach was engaging and kept people interested and involved throughout with a high level of interaction.

> But this was totally interactive. And it was nice, there was constantly a question and you were answering or somebody else was and you went to wee breakout rooms and things together. So you were always, you know, engaged with them."

6.19. In a small number of examples participants reported they would have liked longer group discussions for certain topics but overall, they enjoyed the blended approach.

Content and resources

6.20. Every participant we spoke with felt that the content was relevant to their role and work with families. The blend of knowledge, skills and strategies was highlighted as a strength of the programme, with all participants coming away from the training with new learning and techniques that could be applied in their day-to-day roles.

> "I found huge sections of the training really relevant and valuable, to the role I do, with the age 3-5s. So much that built on what I already knew and thought I did quite well. And then I realised, actually I really need to hone in on this and focus on it a bit more."

6.21. Another significant aspect highlighted by participants was the opportunity to hear perspectives on the knowledge, skills and strategies from other participants that are in different roles. This brought an extra dimension to the learning experience and supported reflection and the sharing of new ideas.

> So meeting and hearing other agencies' opinions, that was really interesting; family support sort of workers and then there was health visitors and nursery teachers, I think early years so there was quite a wee mixture. "

> That was a plus just hearing what else is out there and what other people are working on? And, you know, I see my own team enough, like, you know, we have team meetings and we talk about things. And so being able to hear other people's roles and hear what they've done to overcome something, and you know, stuff like that. I think that was actually really good."

6.22. Resources were perceived to be high quality and the workbook in particular was seen to be comprehensive, well structured, and supported learning inside and outside of the training sessions.

> The book was great. I mean, there's so much reading in the book. I have not even read it all, there's so much information about everything, not just foods, but everything, so that it's an excellent, excellent book."

6.23. Participants also described the usefulness of the resources when working with families. Interviewees spoke about using the tools as a gentle way to introduce a topic with a parent. Another strength of the resources was how visual they were, which made them more applicable to work with a broader range of families.

> The resources are really visual, which is good for all families. And as I said, good for people whose brains are wired slightly differently."

> And the handouts, I can say, they were great, because we're not sounding like we know everything. We're just like, "oh, we've got these things. And they're interesting."

6.24. The only criticism was that some of the resources were not perceived to be relevant to the families that participants worked with day to day, and therefore did not see them being used.

> With some of the resources, I felt they were quite middle class, home counties. So you'd be asking people to have a glass with a slice of lemon in it? Well, I don't know anyone who's going to drink a glass of water with a slice of lemon in it. It mentions avocados and things like that. I wouldn't necessarily use all of them."

Did the training meet the intended learning outcomes?

6.25. The HENRY feedback survey asks respondents to rate several training components linked to the intended learning outcomes. Respondents provide a score out of 10 (with one being the lowest and ten the highest) for how effective they were in each area before participation and then again after participation. The average respondent rating for each component measured is broken down by health boards are in the following graphics.

Core training learning outcomes - Lothian participants

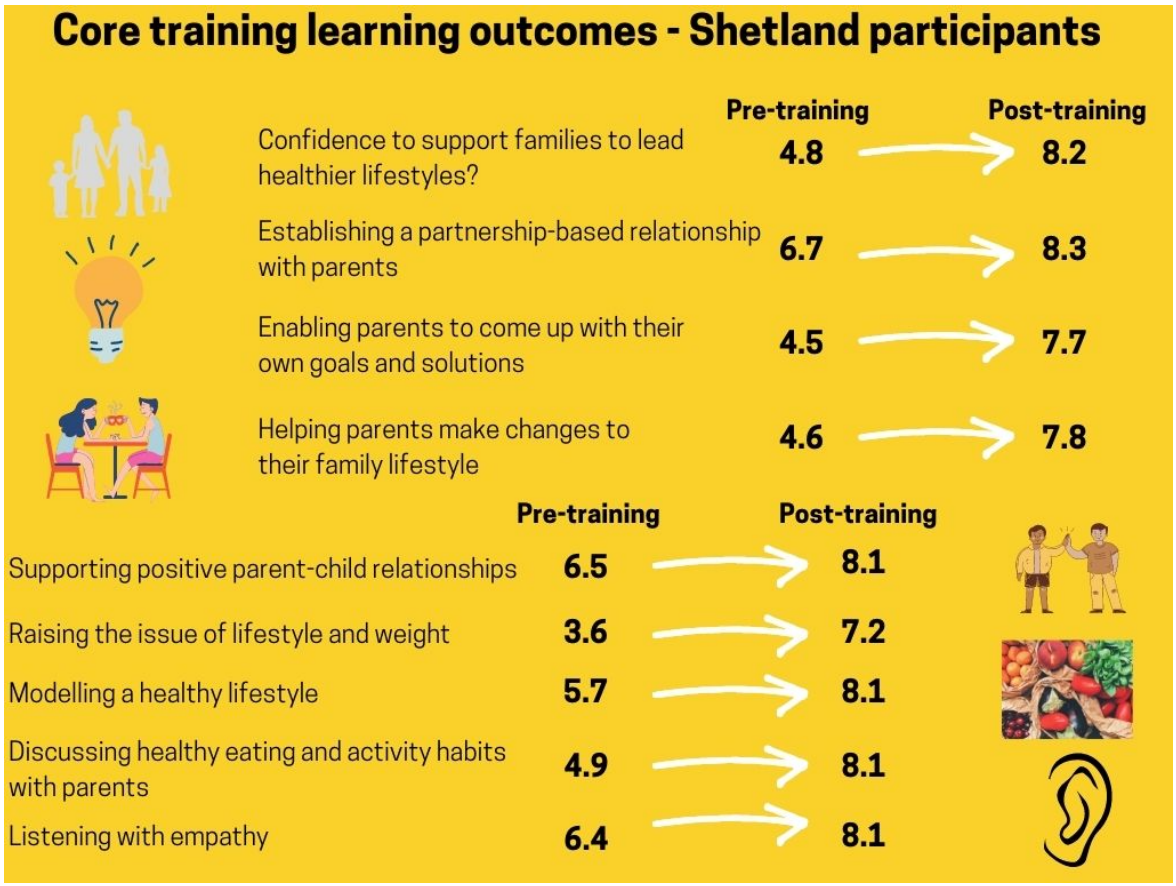
	Pre-training	Post-training
Confidence to support families to lead healthier lifestyles?	4.9	8.1
Establishing a partnership-based relationship with parents	6.3	8.2
Enabling parents to come up with their own goals and solutions	5.2	8.1
Helping parents make changes to their family lifestyle	4.8	8.0

	Pre-training	Post-training
Supporting positive parent-child relationships	6.4	8.4
Raising the issue of lifestyle and weight	4.2	7.4
Modelling a healthy lifestyle	5.7	8.2
Discussing healthy eating and activity habits with parents	5.1	8.4
Listening with empathy	7.0	8.9

Core training learning outcomes - Western Isles participants

	Pre-training	Post-training
Confidence to support families to lead healthier lifestyles?	5.1	8.2
Establishing a partnership-based relationship with parents	6.1	8.0
Enabling parents to come up with their own goals and solutions	4.4	7.9
Helping parents make changes to their family lifestyle	4.5	8.0

	Pre-training	Post-training
Supporting positive parent-child relationships	6.0	8.2
Raising the issue of lifestyle and weight	3.9	7.6
Modelling a healthy lifestyle	5.6	7.9
Discussing healthy eating and activity habits with parents	5.0	8.2
Listening with empathy	6.3	8.5



6.26. As shown above, participation has resulted in an increase across every component. Interestingly the pre-training and post-training scores for each component are broadly consistent across all three of the health board areas.

6.27. Feedback during interviews suggests that the components with the highest pre-training scores tended to be areas that are core to the job roles of participants, such as establishing partnership-based relationships and supporting positive parent-child relationships. However, even in areas where participants began the training with a greater level of confidence or ability, a noticeable increase in scores is evident.

> "And it was quite interesting to know that, you know, what's in there, is what we know and what we practice every day."

6.28. Perhaps unsurprisingly, the areas with the lowest baseline scores had the biggest increases. Again, feedback through interviews suggests that participants had the least initial confidence in these areas (e.g. raising the issue of lifestyle and weight), or where their practice before participation was different (e.g. trying to fix things for families rather than enabling a parent to come up with their own goals and solutions).

> "Just trying to pull out some of the skills that we've learned and just make that a better experience for the parent. I want the parent to feel like they're really motivated to make the change or, you know, to come up with their own solution that's going to work for them."

> Nobody really wants to hear it, but those conversations need to be had and I think what I wanted to get out of HENRY was the information basically underlying why it is such an important issue but also how to deal with it nicely, like deal with it in an appropriate manner and not sort of belittle the parent or make them feel judged or anything like that."

Skills, knowledge and confidence

6.29. All participants interviewed reported that they felt better equipped to support the families they work with since having completed the training. For some, the biggest impact has been on knowledge, whereas others placed a higher value on the skills, techniques and strategies they gained.

> "The knowledge was a great part for me. I think I knew some of it, but like I wasn't really confident that I was right, I kind of doubted myself a bit."

> I'm more prepared to have conversations about the food and portion sizes when that happens naturally in conversation. Really simple things like using your fist and fingers to work out what portions of food, so I can have those conversations and I bring it in, I offer sleep advice for families who are struggling with bedtime routines or to get their child to sleep through the night."

6.30. Regardless of which element has brought the most value, the combination of knowledge, skills, strategies and techniques has resulted in increased confidence to carry out their role and provide effective support to the families they work with

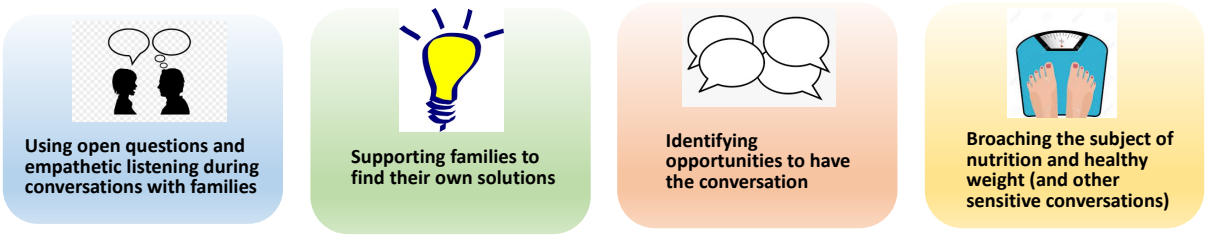
> It's given me more confidence in how to approach certain things as well. So I think, it's good for the parents, and it's good for me, to feel a little bit more settled, and how I ask certain things. Because there will always be things that come up that you've never come across before. And it just gives you the tools to kind of think right how am I gonna deal with this?"

> I wasn't very used to that kind of dynamic between parent and child or things like that. And I think the training gave me a lot of confidence and different skills and different ways to approach it, especially to do with parenting because there's so much information about parenting and parenting styles and things."

7. How learning has influenced practice

7.1. This chapter explores the different ways that participants have applied what they have learned, and the changes in practice it has led to.

7.2. The HENRY feedback survey asks respondents to provide examples of the learning they have applied and the changes to practice that they have made. Every survey respondent provided at least one example, and this area was also explored during interviews with participants. Commonly reported ways in which participants have applied their learning and made changes to their practice are summarised below:



7.3. Each of these aspects is discussed in the following sections.

Using open questions and empathetic listening in conversations with families

7.4. Survey respondents and interview participants reported being more conscious and aware of the questions they ask and how they ask them. They make a concerted effort to use open questions that enable them to gain full insight and understanding of the perspective and circumstances of the families they work with. This has led to a better understanding of families' needs and wants, and how they could best be supported.

> "What I found most valuable was talking to parents, not asking them like a hundred questions at once and the kind of questions to ask them to prompt them to continue speaking rather than the conversation just coming to a close."

> "One of the main things is the questions with the magic wand approach, I use that quite a lot. It's a way to approach things and it was looking at, what can I think about if I had a magic wand and a scale that went zero to 10, kind of where are you now, what's realistic and where do you want to get to - that kind of thing. It's quite a useful way to approach a lot of conversations."

7.5. Listening with empathy is perhaps not so much a change to practice, as an improvement on the extent to which this approach is being used. The majority of participants acknowledged that empathy is a core skill for their job and something they try to remain mindful of in their communication with service users.

7.6. However, feedback from participants suggests that since the training, they have been more deliberate and conscious of ensuring they are listening with empathy and using this to respond to parents and families they are having conversations with.

> What HENRY has done is, it makes me think now every time I go and have a conversation with a parent, I'm like, right, take a step back and actually listen to what they're saying and really sort of empathise with them and really understand them."

> Giving them information isn't enough. You've got to actually have ways of communicating and listening to what they've got to say and really get to the root of what support they need, and find ways in order to help them."

Enabling parents to find their own solutions

7.7. Several participants described how their default position was often to try to fix things for a family by sharing knowledge, giving advice and making suggestions. This was done with good intentions, as practitioners wanted to make things better for the families they work with. However, the HENRY training, and their experience of applying their learning has helped them to recognise that the best person to identify a solution that works for them, is the person themselves, albeit with the right support and encouragement.

> I feel like we are empowering parents to make their own like decisions but being there to support and guide them if they needed any extra support and I think like sometimes when I was talking to parents, there would be like, you know they would say things like, oh I can't, my child's sleeping really poorly, and in the past, like I'm such a fixer, I would say like, oh okay this is a really good bedtime routine, you can try this, you know, but instead after doing the HENRY training I'd kind of be like, okay so when you did get them off to bed at a good time, what did you do?"

> We have to be mindful of the fact that the individuals and the clients are the experts in their own lives. They know what they can do; they know what they can achieve. They know what their timetable is, like, I'll be talking about food. So they know what the tastes are. They know what their budget is. They know their time constraints. So it's realistic. And it means that people can make small steps and small changes that are sustainable, and quite frankly, realistic changes."

7.8. Practitioners shared several examples of beginning conversations with parents with a solution in mind. After working with and supporting the parent to identify their solution and the actions they were going to take, the solutions that emerged were very different to the practitioner's initial ideas. Furthermore, practitioners acknowledged that by fixing someone's issue, is not equipping them to deal with problems in the future.

> In the past, I've probably been too prescriptive. And I think some of the goals that they come up with is not the goals I would have, I would have wanted, but there's no point in me wanting them."

> Encouraging the parent to identify their own strengths and their own goals. So it's given me the skills to be more conscious and actually to pull

myself back when I am about to go into old habits. I think no, I'm not going to suggest this, I'll leave that. In terms of the healthy eating and nutrition, that's never been a particular focus of the work that I've done. It comes into the initial assessment under the health and nutrition, so now, I probably spend a wee bit more exploring that during the initial assessment but unless the parent says that's what their goal, that's what they want to change, I'm not going to impose on them what I think they need to change. Because that just completely contradicts my role – it's driven by the family."

7.9. During interviews, some participants suggested that the combination of open questioning and empowering families leads to productive conversations where families felt better understood and feel they are not being judged.

> "I feel like they're a lot more open with me and able to discuss a bit more with me, whereas before, they probably looked at me and thought I was quite direct and straight to the point. You get what I mean - they're relaxed with me."

Identifying opportunities for discussions about nutrition and healthy weight

7.10. Some participants reported feeling better able to recognise opportunities to raise nutrition and healthy weight during their interactions with families. This was prominent among those whose role was not necessarily focused solely on this healthy weight, or staff who were not as confident about the subject matter prior to the training.

7.11. There are two aspects to recognising opportunities. The first is having the knowledge and awareness of where eating habits and behaviours, for example, could affect other areas of a child's life. The second is having the confidence to identify the opportunities and be more observant and proactive in relation to it.

> "So I now will bring in things like, well what are they eating near bedtime, and things that are best avoided. So it's more to not miss opportunities to bring in conversations about healthy eating and exercise when it happens naturally in conversation."

Broaching the subject of weight – and other sensitive conversations

7.12. A few respondents reported that they were already confident about having difficult or sensitive conversations, but most acknowledged that they were often apprehensive. Discussing a child's weight with their parent was one of the most sensitive conversations described by practitioners; fraught with the potential for causing harm, making judgement and apportioning blame.

7.13. Confidence in their ability to have sensitive and difficult conversations in a productive and empathetic way is one of the most significant benefits reported by training participants. Some practitioners reflected on their reluctance to tackle the issue of a child's weight directly before participating in the training; instead providing parents with information or signposting/referral to another service or health professional.

> I don't think I would have had the confidence to bring it up before. I think I certainly would have had concerns and I probably would have raised them with [manager] and just said, look I don't know what to do about this; but I certainly wouldn't have addressed it with the parent I don't think. I feel like now, although it is still a touchy subject, HENRY's given me the skills to go like, right okay implement your empathy and implement all that sort of stuff and make the parent feel comfortable and guide them in the right way."

> Because I have the knowledge, I have new approaches; I'm just more likely and more confident about opening up those kinds of conversations in a sensitive and non-judgmental way. Knowing you can do that just makes it so much easier. Less intimidating."

> People respond quite well to it. And like I said, I've not got an awful lot of experience before using this approach. But I think it's initiated some quite good conversations. And yeah, given them that little bit of confidence that they can make the behaviour change that we're kind of talking a

How have families responded to the changes in practice

7.14. Different techniques, strategies and approaches have been implemented by practitioners, leading to changes in how they support clients. Practitioners reflected on how families responded to changes in practice and the difference it has made.

> Parents are just so much more involved in the conversation because you're asking them questions and you're really taking their opinion, you're really considering their opinions and what's worked well for them in the past."

7.15. Overall, practitioners feel the changes they have made have contributed to improved relationships, better and more involved conversations and increased understanding of need. They also believe that when families identify change, they are more committed to it and enthusiastic about it, which creates the conditions for sustained change.

> It'd be easy for me to give them all the answers, but they've got to come up with something that works for them and their family. Maybe they might not have the answer at the time, but they may come back and say, you know, we were talking about this last week? Well, I tried this and it worked or, you know, so it has been really positive."

> We've often had positive comments, and people have talked about changes that they've implemented, and they have been managing to maintain. Which is great."

> Whereas actually asking them what they can do, and kind of getting them to come up with their own suggestion to it makes it more one, realistic and to think then they're actually able to do that and empowers them to actually then do that because it feels realistic."

Enablers and challenges

7.16. The HENRY survey does not explore the enablers or challenges to applying learning and changing practice. Our findings are based on feedback gathered through participant interviews.

Enablers

7.17. The delivery structure was the most significant and commonly cited enabler. Splitting it over a series of sessions created both the opportunity and encouragement to apply learning in between sessions. The forum to share and reflect on the application of learning in a supportive environment also provided added impetus.

> Often there would be times that someone might describe a situation that happened to them or happened to someone even within that week between the sessions. "Oh this happened, I wasn't sure how to approach it", or "I used this approach instead and felt that worked out better" - that kind of reflection. And that puts it into real life. It's really helpful having different people from different backgrounds in different areas, because it brings more to it."

> You were able to apply the strategies that they were giving you in your daily, or in your week, and then bringing it back and asking if that's how I should have done it and so it was good having it spaced out to then go back to the tutor to ask if that was the right way and any other strategies so it was good to have that feedback and constant checking as well."

7.18. Success has helped to encourage participants, and given them the confidence to try other changes and apply different aspects of learning. Practitioners were motivated by the results they saw and the responses from the families they worked with.

> Before they would probably have been quite disengaged and actually, not negative as such but, not really positive to improve their development or their kids' development but after HENRY, yeah, the parents are more engaged, the kids are more engaged and they understand more about what they need to do to help their health and improve their health, both parent and kids, as well as the strategies that we've learnt and brought to them, it has helped them in the house and, yeah, they've definitely improved their food, their eating habits."

7.19. Participants provided examples of using the many resources supplied by HENRY. They were seen as valuable tools in supporting conversations with parents, and helpful techniques and strategies to support families. These included reward charts, eat well guide, videos, various posters and leaflets, and the HENRY Healthy Families book.

> The handouts were handy, because it was kind of a conversation starter. It was nice to have that visual there, and to approach it like that with families. I really like that."

7.20. Participants spoke about having autonomy to make changes to their practice. They were supported and encouraged by their managers and colleagues, particularly colleagues who had also been through the HENRY training. This helped to create a mini peer network where they could discuss ideas and experiences and talk through different approaches to dealing with challenging situations.

> It's kind of developed that network that we can use. What did you think about that? What did you think about this? Have you found this with your families? And identifying families on the course that would need that support, direct support, and then going out of the call and talking about that as well with the team. It has really helped I would say, yeah. If I went on individually it probably wouldn't have helped me as much but because there was four of us on it, it has really helped that support network."

7.21. Finally, as was a common motivation for participation, the desire to provide the most effective support for their clients is a significant enabler and driver of change.

Challenges

7.22. There was no consistent or common themes in discussions about challenges in applying learning. A small number of participants described challenges which specifically related to their circumstances. These included:

- Being consistent with new approaches and not slipping back into the ways of doing things previously.
- Limited contact with families due to restrictions in service delivery.
- Limited time during each parent appointment to comprehensively apply learning and have in-depth conversations.
- Delivering a prescriptive programme that does not align with the HENRY approach. In this example the respondent explained that course delivery was much more directive in the provision of advice and guidance and made it more challenging to introduce the HENRY approach

Suggested improvements

7.23. Only a small number of respondents made any suggestions for improvement. Each of the following was cited by a single respondent:

- Addition of a follow up session that brings participants back together to share progress and experience from implanting their learning.
- Removing role-play activities.

- More time for role-play activities.
- A feeling that some sessions were cut short due to time limitations.

8. Participant experience and outcomes – Facilitator training

8.1. Findings in this chapter are based on 15 responses (11 NHS Shetland, 4 NHS Western Isles) to the post-training survey administered by HENRY. This is supplemented with feedback gathered in interviews with six facilitators from NHS Shetland that have delivered the HENRY family programme.

Experience

8.2. The HENRY post participation survey asks respondents two questions about their experiences of the training:

- How have you found the style and delivery of the training?
- How have you found the training in general?

8.3. Experience of the training was also explored during interviews with facilitators, and the combined findings are discussed below.

Style and delivery

8.4. Survey and interview feedback highlighted the quality and effectiveness of the training deliverers. Trainers were described as friendly, approachable, knowledgeable and supportive. Participants reported that they very quickly put the group at ease, and their delivery style was inclusive and engaging.

> "Fantastic training facilitators [who] put everybody in the group at ease so that it could be a very effective and positive place of learning and sharing."

> "The trainers were great, I learned a great deal from the content, and they modelled group facilitation brilliantly."

8.5. The nature and style of the trainers were seen by participants to create a friendly, relaxed and supportive environment, which encouraged participation. It was seen as positive that facilitators modelled the HENRY approach and language, giving participants valuable insight into the application of the approach.

> She really modelled how we would go on to do the course ourselves. So I thought she did a really good job of that. Because I kind of picked up a lot of the kinds of tips and thought, oh, yeah, that's really good."

> I'd really enjoyed working through the process of it. The way it was delivered very much mirrored the kind of feel of the programme itself, which was really nice. It was lovely to kind of see that in action."

8.6. The structure of the programme, being split into eight weekly two-hour sessions was found to be a positive among the majority of participants. This approach was seen to

help embed the learning, as it was being taken in and processed gradually, rather than receiving it all over a more condensed period.

> "As much as you miss being in the room with people and with the trainers, actually having it in smaller chunks, once a week made it easier to kind of take on board information, go away, process it, think about it, reflect on it, and come back to the next one. So I found that really useful."

8.7. The content was described as being very thorough in terms of understanding and applying the HENRY approach, and covering the different topics and subject matter that they would be delivering when facilitating a HENRY family programme.

> "I thought the training was good, really good. Very thorough."

> "We spent a lot of the sessions actually breaking down what we deliver to parents in sessions but the first couple of sessions was about having that supportive conversations and motivations and kind of how you have that conversation with families and how we support them to make changes."

8.8. Participants also appreciated the opportunity to carry out mock delivery of some of the sessions. However, some felt that not enough time and opportunity was given to this aspect of training.

> "We had to go away and pick a bit of one of the sessions and then present it as if we were presenting it to a family. So that was really useful, because you'd seen lots of activities being delivered by one of the group already."

8.9. The only other perceived gap was related to group facilitation skills. While this was covered in general terms and a facilitation style that reflected the HENRY approach, there was a gap in the actual practical skills around group management. Even though the majority of participants brought experience of group facilitation, it was perceived to be a weakness in the training content.

> "There wasn't anything that we had on how to actually facilitate a group. And particularly, like, we asked questions about, what if a parent does this? What if they don't stop talking? What do you do? So there was none of that. And it was kind of just, you would just bring it back to the principles and you'd be empathetic. And you're like, but practically, what would you do? So that is something that we to think about a bit more on I would say."

> What would have been useful, I think, which maybe wasn't covered in the training as much as like group management skills. I guess that was new to HENRY as well so maybe that was not possible. But, again, a lot of practitioners that completed the training were seeing people one to one or seeing families, but maybe not necessarily all run in groups. I know some of us have done that and health improvement. But actually, the group setup was quite a new thing to people. And that was not really touched on in the training."

General experience

8.10. The overall experience was reported to be positive. Online delivery has not negatively impacted the participant experience, largely due to the familiarity with online activity that COVID-19 restrictions had led to.

8.11. Feedback from participants suggests they valued and enjoyed the experience.

> Online didn't really bother me because all our work is being done online right now. So we're a year down the line, now we've kind of sussed that out, that's fine.

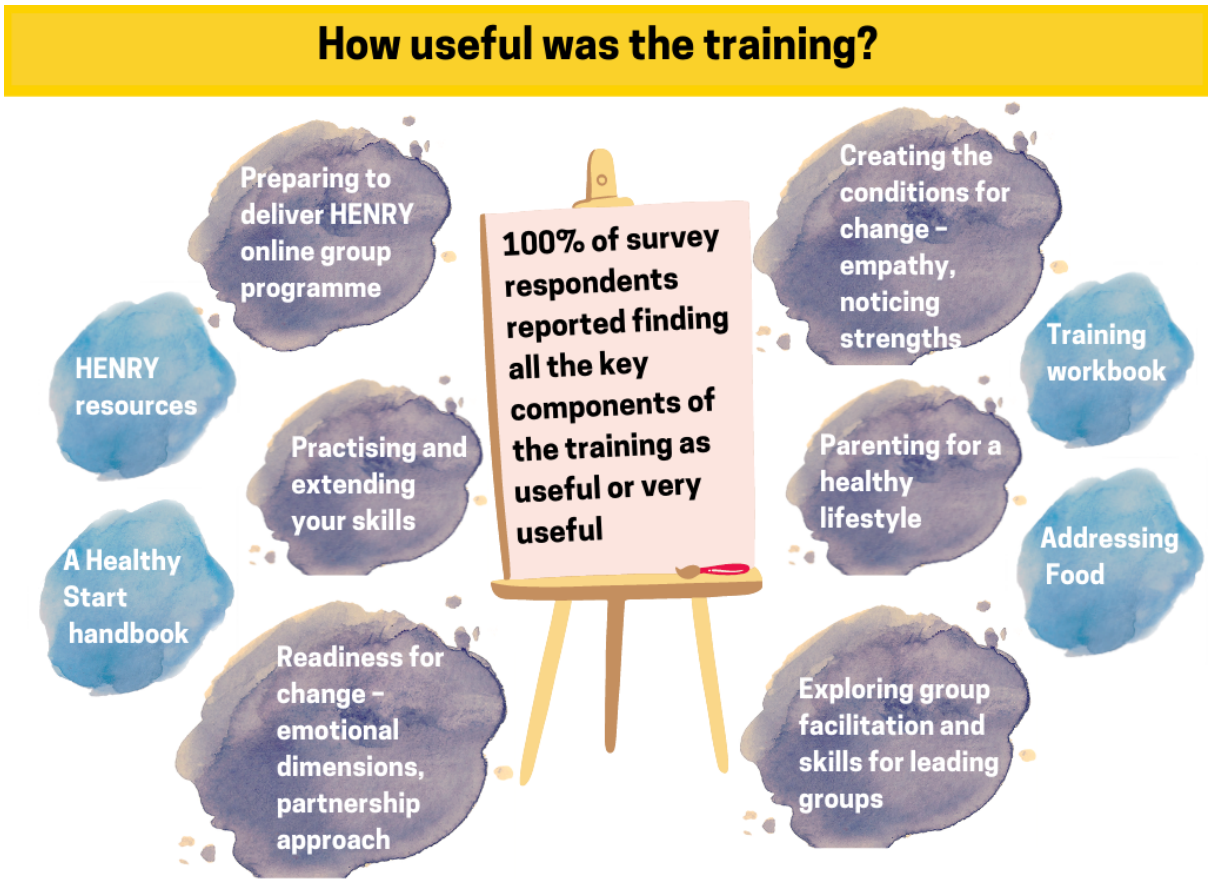
> And I suppose firstly, I really enjoyed it, I really enjoyed the training, I thought it felt like a lovely group to be part of, I felt quite sad coming to the end of

> "One of the best training packages I've ever attended, I have no comments to offer in terms of improvement; the training is excellent.

Usefulness of the training

8.12. The HENRY survey rates the usefulness of training components and resources. It is encouraging that all survey respondents found all aspects of the training and the resources provided to be 'useful' or 'very useful'. In most instances, the majority rated all aspects as 'very useful'. However, there was a closer split between respondents, rating them 'very useful' and 'useful' for two components. These were:

- Addressing food (7 'very useful', 8 'useful')
- Preparing to deliver HENRY online group programme (9 'very useful', 6 'useful')



8.13. In terms of the usefulness of the 'addressing food' component interview feedback suggests that this is simply where participants professional background has meant they were already familiar with a lot of the content, and therefore, it was less useful than some of the other subject matter.

> "The content probably wasn't necessarily new to me as a professional, as in the health messages that are in there are the same things that we've been saying as well, that's great. The having a way to put them into practice, I think is the bit that's quite useful."

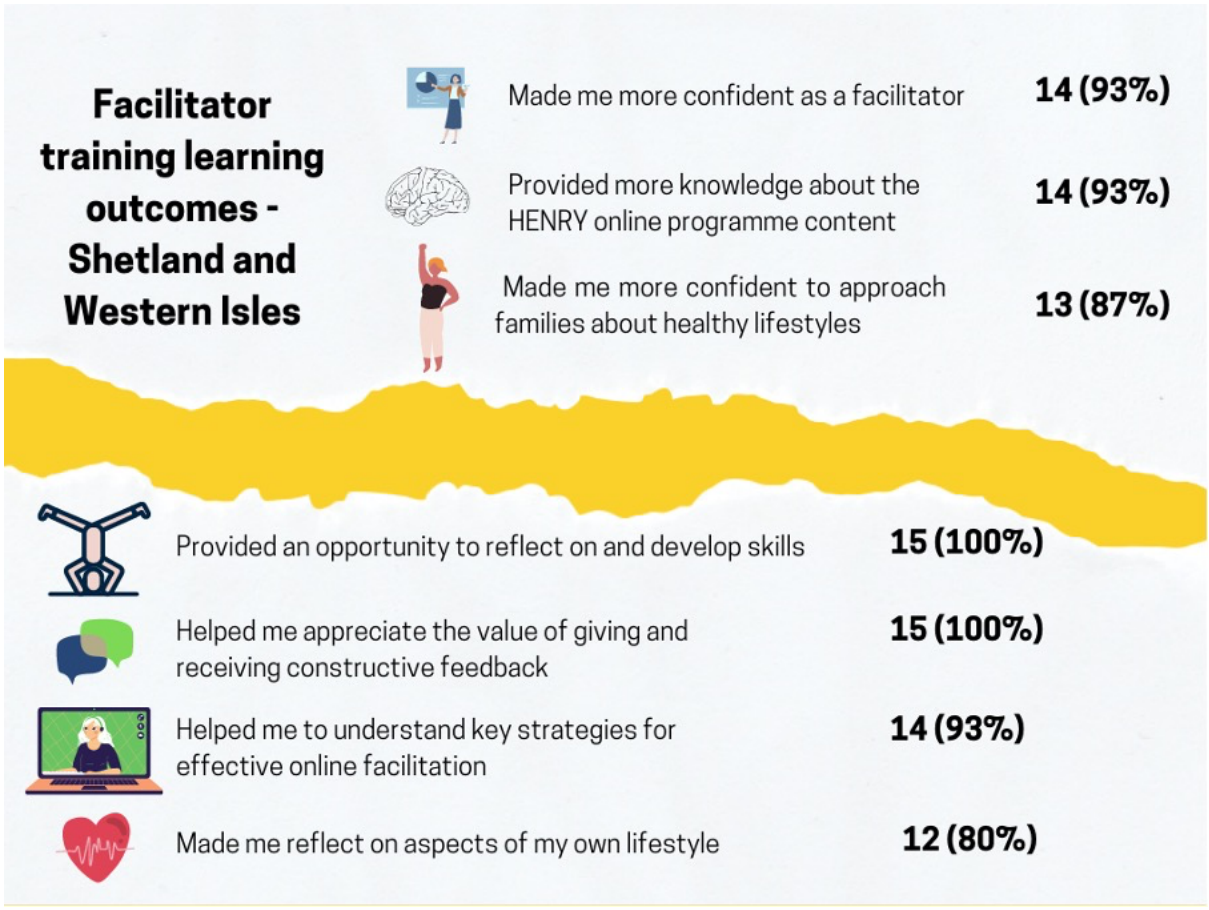
8.14. As discussed earlier in this chapter, participants perceived gaps in relation to group facilitation skills and some felt there were limited opportunities to practice delivery. This has contributed to the extent to which participants felt equipped and prepared to deliver the HENRY family programmes. It is important to note though, while participants reported that these gaps influenced their feelings of preparedness, overall participants did feel adequately equipped for delivery. This is likely to have been bolstered by participants' prior experience of group facilitation.

> "I felt that I didn't know the content of the programme, is how I felt. But I felt equipped that I could, yeah, I could sit down and I could learn the content. And I would be happy delivering it. Because I had the skills to

deliver. But I then had to go back and learn the content was how I felt at the end."

Learning outcomes

8.15. Respondents to the HENRY feedback survey are asked to select options linked to the intended learning outcomes and confirm which have been achieved. The infographic below sets out each of the learning outcomes and the proportion of respondents that indicated they had been achieved.



8.16. The findings from the survey responses are strongly positive, with all learning outcomes achieved by most participants. However, some aspects appear to contradict what has been discussed earlier in the chapter. Almost all (94%) of survey respondents reported that the training had made them a more confident facilitator and that it had helped them to understand key strategies for effective online facilitation.

8.17. Given that facilitation skills was a reported gap, we explored this during interviews. Feedback suggests that while it is perceived to be a gap overall, the training is not devoid of facilitation tips and skills. Therefore, the training contributed to some development in confidence, but is not seen as providing the comprehensive facilitation skills development that participants had hoped for.

Preparing to deliver the HENRY family programme

8.18. All participants interviewed reported feeling a degree of nervousness or apprehension in the lead up to facilitating their first HENRY family programme. This was eased by knowing they would be delivering in tandem with another facilitator, where possible pairing participants so that there was a blend of experience and expertise.

> "That was also alleviated a little bit with the delivering in pairs and knowing that there would be somebody else there to kind of help out with that."

> "No, I wasn't comfortable with it at all. But yeah, more so now. I had a few wobbles a bit, because I didn't feel comfortable."

8.19. Before each session, the two facilitators would meet to plan delivery. This involved reviewing and getting familiar with the planned content, and agreeing different roles and who would lead on which activity and topic area.

> "We would meet and go through what the session was and then break it down into who was delivering which parts. And then I spent time by myself planning that part. So yeah, we spent quite a bit of time planning."

8.20. Facilitators also had a reflection session at the end of delivery. This provided an opportunity to think about what had worked, what could be done differently and anything else they had learned that could inform future sessions.

> "So we would deliver our session and then right after our session we had an hour set by to do work, you have to do reflections after each session, send an email summary to everyone in the group what we covered that day and attached any other slides that we used and filled in as part of the session."

8.21. As an additional support, and a forum to share learning and practice, all the facilitators get together at regular sessions. These are highly valued as opportunities for support and learning, but also to remain updated on programme plans.

> "I think they were really useful when we were delivering the programme because we could ask how other people had found delivering a session or we could run something past somebody. Yeah, now that we're not delivered in the it's still it's so good to know where we're at, with what's coming next in the programme in NHS Shetland."

8.22. The HENRY Facilitator Manual was also spoken about positively by those facilitating the HENRY family programme. It was described as very prescriptive, but this was seen as a

key strength, setting out in detail each step of delivery, what is covered, how it is communicated and the supporting activities. This leaves little scope to go wrong.

> "The actual trainer handbook is brilliant. I mean, you could, you could lift it, and read it word for word. It's a really, really thorough handbook that we get that lays out. This is what you say, this is the point you've got to weave in. This is how you introduce. So it really is step by step."

8.23. A final and important step in preparation was an initial conversation with each parent. This gave the facilitator a chance to introduce themselves, chat through the programme and what could be expected, and ensure that everyone was OK with using the online platform.

Experience and learning from delivery

8.24. As much as there were feelings of nervousness and apprehension, the experience of delivering the HENRY family programme has been positive. It was reported that it can take a couple of sessions for the participating parents to really gel, when they did, it led to productive discussions and sharing of experiences. While there was some drop out in the three programmes that have been delivered, at least three families complete the programme in each area. Follow ups with the participants that dropped out part way through identified that for some did not enjoy the group setting, but others are still keen to participate but circumstances meant they could not take part at that time.

8.25. The main learning drawn from initial delivery is summarised below:

- Timing – one programme was delivered during the summer holidays, and this was found to create some barriers to engagement during delivery. Facilitators feel that term-time delivery would be better as parents are in a steadier routine.
- Limitations of online delivery – online delivery of the family programme is broken down into hourly sessions. However, the face-to-face format is delivered over two and a half hours as it involves active play that includes the children and other activities. Facilitators feel that parents miss out on this aspect during online delivery, and it also makes it harder for the group to bond due to the short sessions.
- No eligibility criteria – the programme is open to any parent and is not targeted at any specific demographic. This is seen as a strength as it has brought a diversity to the views, strengths and experiences shared among the parents that participated.
- Identifying suitability – as mentioned above, there is no specific targeting for this programme. However, some practitioners identified that a sample of those referred to the programme might have benefitted more from another intervention, or some more intensive one to one support in advance or as an alternative. The project leads are revisiting the referral documentation to ensure information can be gathered that would help to identify this in advance.

Response from parents

8.26. Facilitators believe that the families who participated in the training have experienced a positive impact and gained the tools and confidence to make change.

8.27. Parents were observed to be enthusiastic and engaged. Facilitators feel that the knowledge and learning was sticking and translating into doing things differently at home. They offered examples of different things that families had tried after one session and sharing their experiences at the next. The stepping stones technique was highlighted as an effective approach to support parents to identify the change they want to make and break it down into manageable chunks.

> “I think the stepping stones idea was brilliant for that because it really broke it down into just tiny bits instead of being overwhelming and big changes. That's really that really got across just tweak it just a little change each week and try something new and I think that was really manageable actual trainer handbook is brilliant. I mean, you could, you could lift it, and read it word for word. It's a really, really thorough handbook that we get that lays out. This is what you say, this is the point you've got to weave in. This is how you introduce. So it really is step by step.”

8.28. Parents’ experiences of participating in the HENRY programme, and the benefits they have gained, are discussed in more detail in the following chapter.

9. Parent experience and outcomes

9.1. In this chapter we explore the experience of parents that have participated in the HENRY family programme, and the difference that it has made for them. The findings are drawn from baseline and follow up surveys that parents complete at the beginning and end of the programme, and from follow up interviews with four parent participants.

Awareness and reasons for participation

9.2. The survey asks participants how they found out about the HENRY family programme. Half reported that they had found out through social media advertising, and the other half through a health professional such as a health visitor

9.3. During interviews we explored why parents had decided to access the programme. Two parents reported facing specific challenges that they were hoping to find solutions to. For the other two parents, it was less about any specific challenge or issue and more related to how you can best manage family life, and trying to make sure they were doing all they could as a parent.

> “There was a couple of aspects like the examples they gave, I suppose it was like just how to manage, I suppose family life and difficult situations. So that's probably what kind of pulled me in the most.”

Experience of participation

9.4. Feedback from parents during interviews suggests that the online delivery format was a critical enabler of participation, with three stating that attending face-to-face sessions simply would not have been possible.

9.5. Being online enabled participants to manage the logistics of attending. Whether this was during the window of time they had between finishing work and picking up their child from school, or co-ordinate attending with their toddler’s nap times. One parent explained that they worked night shift, so being able to get up and attend without having to travel made participation possible and for another, face to face participation would have meant a four hour round trip.

> I predominantly work night shift so when the sessions were on, I can't remember the time our class was, say one o'clock. I could actually get up and I could probably still be in my pyjamas to be honest, and just sit and be there. Whereas if it was, I had to say drive 13 miles to Lerwick to sit in a class, I wouldn't have gone.

9.6. Participants reflected that a face-to-face group may have gelled more quickly and easily, but reported that after two or three sessions participants seemed to be comfortable in the group and interacting with each other and during group discussions. Hearing the experiences and ideas of other parents was particularly valued by participants.

> But it was also when the parents had bits that they had done differently. And I was like, actually, that's really handy to know that's how you

handled it, or because I think I'm handling it wrong, or like if I had ideas for them as well. And they were like, well, thanks for that kind of tip. So it was really handy to have the parents sort of bouncing off each other."

9.7. The short sessions, split over a series of weeks, was valued by participants as it made it easier to absorb and retain the information, and to try things out between sessions.

> "Yeah, that was really good because you could come away and I suppose think about things that you done, before you kind of get on to the next stage of work."

9.8. Feedback about the group facilitators was wholly positive. They were reported to create an environment where everyone felt at ease, and under no pressure to contribute if they didn't want to or feel comfortable doing so. They were reported to be supportive and available even outside the sessions if participants wanted to discuss anything.

> "Yeah, they're brilliant, they didn't push you and I felt like I could really open up to [facilitator] about a lot of stuff."

9.9. The content was another highlight for participants, with those interviewed speaking enthusiastically about the relevance and applicability of what they had learned, things that surprised them, and the little tips and tricks they picked up. This ranged from knowledge about nutrition, diet and snacks, to techniques for communicating with their children and the language that they use.

> "Ways to speak to them instead of speaking in a negative tone. I liked those ones. Getting him outside was the frame bit that I needed because it was the whole, I'd say to [child's name], we've got to go outside, and then it gets quite negative. And I'm like get your shoes on and he gets really annoyed at me. And I'm like, no, please get shoes on, which doesn't do it. So the HENRY programme came with like little tips and hints on how to say things to them, and how to make it more fun rather than negative. "

> "For example, in our diet, like the bairn's snacks and stuff, like they did a bit about helping us read the labels of the snacks, and there is still some things in the bairns snacks that you think, actually yeah, that's silly and unhealthy. The bairns would have like a muller corner, and that's like, probably got the sugar in for most of the day, and actually, we could have natural yoghurt and try to jazz that up."

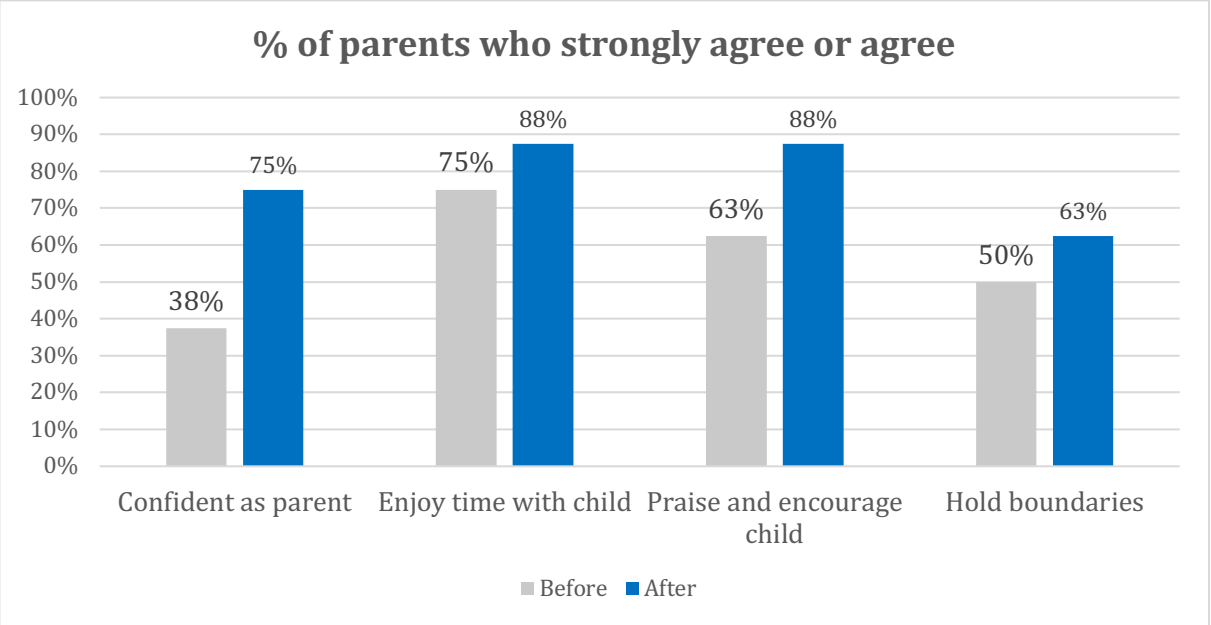
9.10. Parents also reported that as well as learning a lot about what they could be doing differently, it was also reassuring that they were doing a lot 'right', and that other parents were experiencing the same challenges as they were.

> Because you're constantly questioning yourself as a parent on how the kids are doing, so to hear other mums as well say, that they did that, they did this and I was like that's really beneficial. Because I felt judged about some things. But then you realise that actually, everybody's in the same boat. Everybody's doing exactly the same thing. And yeah, it did reassure me."

What difference has participation made?

9.11. The participant survey asked parents about the extent to which they agreed with four statements about being a parent before and after taking part in the programme. These related to their confidence as a parent, enjoyment when spending time with their child, regularity of praise and encouragement and the extent to which boundaries were set and maintained.

Figure x – Increases were seen across all areas of parenting being measured



9.12. As demonstrated in the chart above, all areas have seen a positive increase in the proportion of parents agreeing or strongly agreeing with the statements.

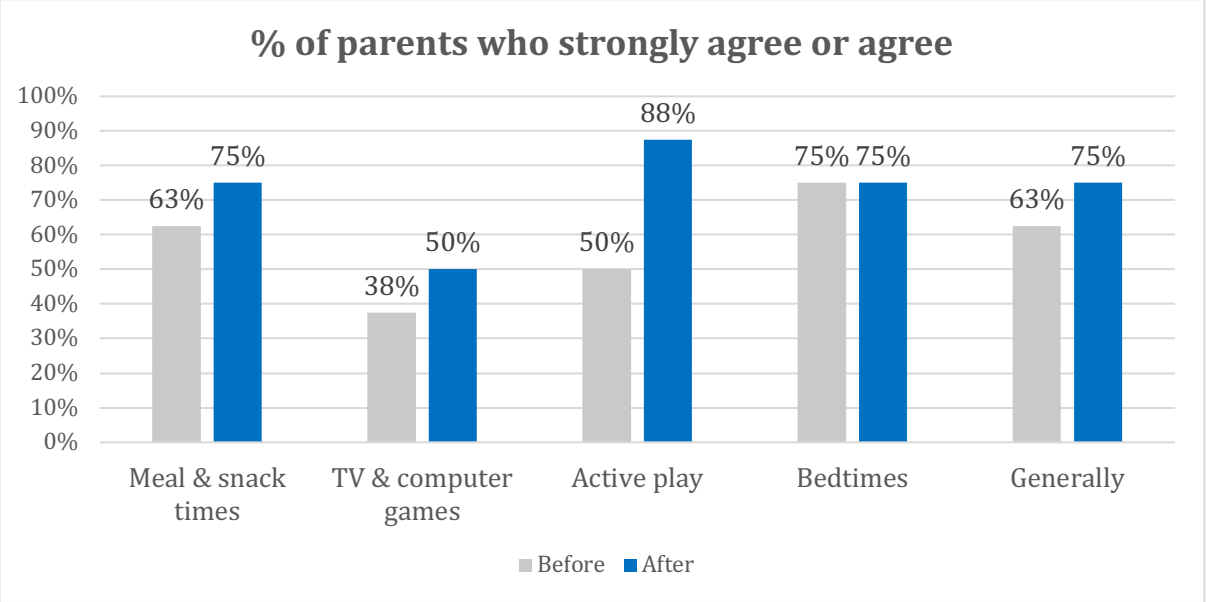
9.13. Feedback from parent interviews also highlighted learning or changes that they had made which relate to the statements. This included making a more conscious effort to have play time with their children and also the use of reward charts to acknowledge good or helpful behaviour.

> I'd come home from work tired, and [child] asked me to do things and I was just like, no, no, not right now, I'm too tired. And you don't realise the impact it has on him. So during the HENRY programme doing that, it's like, yeah, it's only two hours really, you spend in the day with him after work and it's really not that much time if you look at it, do a little bit fun here and there and get that imagination running."

> I find it's how you're, I suppose like, reinforcing positive behaviour with the children. So I've tried to start a reward chart, we tried that at the holiday."

9.14. The next aspect of the survey explored parents' abilities to set limits and hold boundaries, by rating the extent to which they agreed with statements relating to different aspects of family life.

Figure 2 – There was an increase in the proportion of parents that agreed or strongly agreed that they set limits across all areas of family life being explored



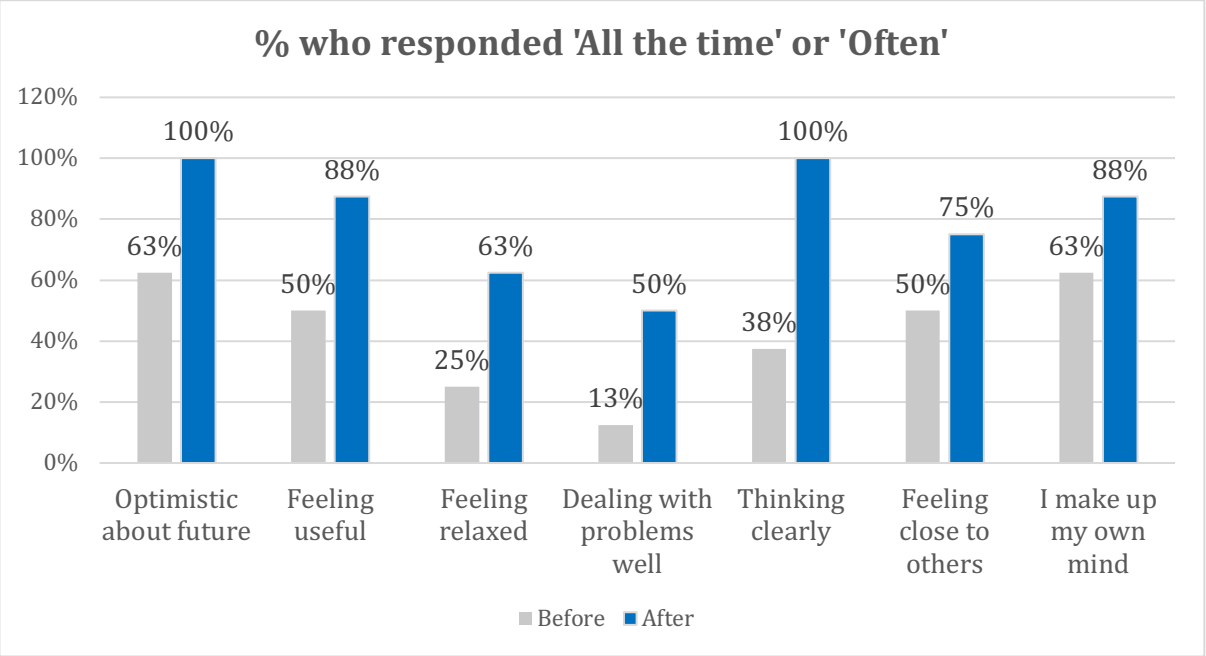
9.15. The biggest increase has been in relating to parents ensuring that their children and participating in active play, while setting limits for bedtime was the only area that did not see any change.

9.16. During interviews with parents, one of the most commonly reported changes was about setting limits in terms of 'screen time' and when technology could be used.

> So he's very positive on that. And he keeps me on my toes, like as well with the no tech at the table. So he's very like, no tech at the table, you're not allowed it kind of thing."

9.17. The parent survey also measured change across different components of mental wellbeing.

Figure 3 – All areas of mental wellbeing showed an increase

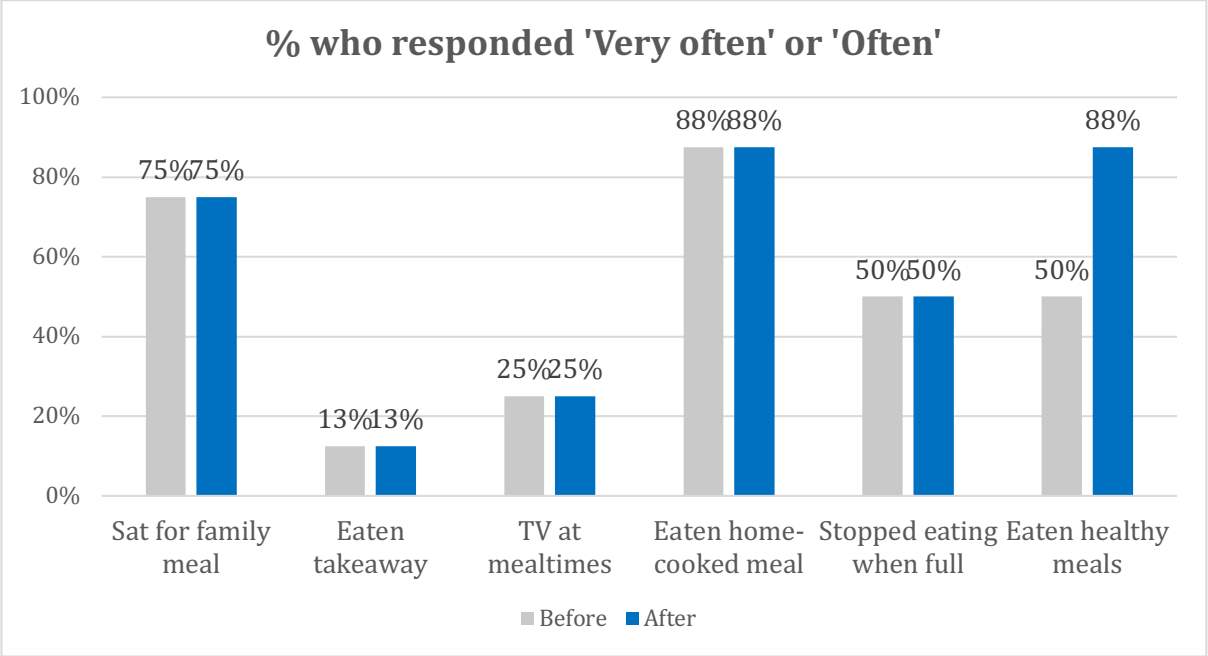


9.18. As the chart above demonstrates, each component of mental wellbeing being measured has seen an increase in the proportion of parents selecting the two highest response ratings. This aligned with interview feedback which suggested the changes that parents have been able to make, and the difference this has made to day-to-day life has an overall impact on wellbeing

> "I suppose it probably helps me to be more chilled out about, that we're doing good, which is definitely not a bad thing. And maybe makes me realise more, that actually it doesn't matter if the house is spotless, or that every single meal is perfect, because actually, if I sit down and do a jigsaw with my bairns, then that's really important, too. So the balance is probably one of the main things that I think that is maybe coming to it for me."

9.19. Few parents reported changes in their families' mealtime habits. However, a higher percentage of parents reported the family were eating healthy meals either often or very often than before, as demonstrated in the chart below.

Figure 4 – There was not a great deal of change across family meal habits



9.20. Parents were asked about both their own and their children's food consumption. Almost two thirds (63%) reported that both they and their children were eating more portions of fruit and vegetables each day. Aligned to this, two parents described involving their children more in the kitchen at mealtimes, and preparing more food from scratch.

> "Probably teaching me more to get my kid involved in cooking in the kitchen. And showing her the foods."

> "The way I look at foods now as well and what it does for him and what I can do for him."

9.21. A quarter (25%) of parents also reported that their child was spending more time being physically active per day. In one case, a young person had gone from spending less than 1 hour being physically active to having 3 hours of active time per day.

9.22. Parents were asked to rate the healthiness of their family's lifestyle at the beginning of the programme and at the end, on a scale of 1 to 10 (where one is not at all healthy and 10 is very healthy). Five out of 8 families (63%) rated the healthiness of their lifestyle higher at the end of the HENRY programme. Three families' score had increased by 1 point; two families' score had increased by two points. The remaining three families score did not change.

Other changes made by families

9.23. As the previous section highlights, parent participants made a variety of changes using the knowledge, skills and confidence they gained.

9.24. Two other changes were consistently cited by each of the parents that participated in interviews. These were related to how they communicate with their children and how they used choice.

9.25. Communication related to the language they chose to use, and also being more deliberate about really listening to their children. Parents spoke about a shift to using more positive language and trying to reduce the use of negative framing.

> We've started that to see if we can really praise like the positives, I suppose and try not to focus on the negatives. And like, obviously, he's having a bit of a challenging time in school. So I'm trying to get that, he's had a bad day at school today because he's had to come home. But also there has been positive things in the day. So it's time to focus on them and not just be like, you've done this wrong this wrong this wrong this wrong."

> So now I try and do the whole "oh, if you're going to go up there, what happens if you can't get down?". Or "how was the safest way to get up there?", "do you think you can get up there?", "what do you think's going to happen if you can't get up there?" Instead of just being "oh, be careful!" Just like shouting at him.

9.26. They also spoke about the importance of trying to understand why their child was doing something. Rather than immediately telling their child off, they would ask them why they were behaving in that way.

> It was the way if they were maybe jumping up and down on something, and then you'd say something like, "don't do that!". That's what I tended to do. It was more like, "oh, why are you doing that? Is there a way that we can not do that?"

Enablers and challenges to making change

9.27. Parents' feedback indicates that a key enabler is that the changes do not feel like big changes, are largely within the parents' control, and are not dependent on anyone else. These changes are made possible through the knowledge, skills, techniques and tips that they gain from participation.

> The HENRY programme really opened my eyes to a lot of stuff. Like there was things I was doing in it, so there were a lot of things in the HENRY programme that made me feel confident in what I was doing, there's a lot of things I looked at that I can improve. And I'm very much so, in my mindset that you can always improve no matter what."

> Yeah, I don't think we've changed anything massive, drastic changes, but I think that, it's just tweaks and I think that that is more maintainable."

9.28. The confidence and reassurance provided by the programme was also important to parents. They described feeling constantly judged, by others as well as themselves, and always questioning themselves about whether they are getting things right. While the

programme highlighted areas where they felt they could improve, it also helped them to see they were already getting a lot right.

> “I felt that I wasn't doing that great. I'm a single parent. I split up with my ex, and she's going between two different parents. But I do feel more confident from doing the courses from being who I was before, and be more confident about myself with my daughter and how I react to her issues. And how she reacts to me, I suppose.”

9.29. For two parents a main challenge was consistency, particularly with the changes in their communication with their children. As they explained, they are trying to undo habits and subvert ingrained ways of talking to their children, and can find themselves reverting back to their old ways.

> “I still think about what I say to him, mainly, because I think it's gone on four years of me saying that, and it doesn't come naturally to me. Because the first thing I think of is “be careful”, or like the things I normally say, and I got to shout it and I'm like no, right? No. So I really have to be careful in the things I say and do.”

9.30. The other two parents had challenges that related to particular circumstances. One had separated from their partner, and this made it difficult to ensure there was consistency in the changes they had made. For the other, the shift in routine from summer holidays to the start of the new school term had made it difficult to maintain some changes.

9.31. However, even though parents described some challenges in making, or sustaining changes, they were committed to sticking with it. Two parents mentioned the usefulness of the workbook they received as part of the programme and still refer back to it to refresh knowledge and remind themselves of some of the tips and techniques.

How have children responded to the changes

9.32. Two parents reported that, as a result of the different approach at home, they have seen a positive change in their children. This was reported to be children mirroring more of the positive language and praise being used by parents, and seeing their children being more willing to help out around the house.

> “Yeah, I think she just thrives to be more helpful, she might help cutting up vegetables for the tea, and she'll say, “Oh, can I help mum?” Or she'll put away jackets and shoes, and then be like, look now do I get a sticker. It's only little things, but it all helps in the long time.”

> “I think they're slowly developing as we go healthy food as well. He's gotten really good with that, like with water. If he's thirsty, he's like, I have to have water first and then I'll have some juice. And I'm like, yep, that's what we need to do. And he knows he has to have fruit. So he's

very quick to tell me Mum, I've not had any fruit today. And I'm like, okay, so go get some fruit. So it's just small little steps that we are taking."

Or like, the day I said to [partner], I was like I love you. And then [child] goes mum, that's so lovely of you to say to dad, and I was like thank you. So it's little things like that as well. And I've noticed his demeanour towards stuff, like helping me with the washing or the hoovering."

10. Conclusions and recommendations

Project delivery

10.1. From a project management and delivery perspective, performance across all three health board areas has been strong. NHS Western Isles exceeded its targets for the number of practitioners that completed the core and facilitator programmes; their only shortcoming is not being able to deliver any eight-week HENRY family programmes. Both NHS Lothian and NHS Shetland have fallen slightly short of their targets for core training participants, but this will be made up through future planned delivery. NHS Shetland also successfully delivered three eight-week HENRY family programmes, and have a group of 11 trained facilitators that brings resilience to their future delivery plans.

10.2. When you consider these achievements within the wider context, the implementation and delivery of these project have largely been successful. Given the circumstances, the progress has been impressive. NHS Shetland and NHS Western Isles are on track to meet their target for the number of staff trained, and NHS Lothian are close to meeting theirs. Programme leads have faced a number of challenges throughout, but remain confident that the programme can achieve what it set out to do. Stakeholder feedback demonstrates enthusiasm for the programme and also clearly evidences how it aligns with local need and priorities and contributes to an enhanced service for families.

Training experience

10.3. Overall, participation in the training has been found overwhelmingly positive for both core training participants and those undertaking the facilitator training.

10.4. Online delivery has been well received and has not detracted from the participant experience or outcomes. If anything, feedback from interviews with participants of the core training suggests that it has been a key enabler to the application of learning.

10.5. The training deliverers played a key role in ensuring that online delivery did not detract from participants' experiences, through their engaging delivery approach and style. The core training content was accessible and relevant to participant job roles, which is a credit to the recruitment as well as the HENRY training content.

10.6. While some participants identified gaps in the content of the facilitator training, this does not appear to have negatively influenced the overall experience. Furthermore, the survey findings demonstrate that all components of the training were found to be useful or very useful.

Participant outcomes – core and facilitator training

10.7. The intended outcomes of the core training differ from that of the facilitator training; the aim of the HENRY facilitator training is to equip people to deliver the eight-week HENRY family programme, and to feel confident about doing so.

10.8. Survey data demonstrates that the majority of participants gained or developed relevant skills and knowledge to support facilitation of the HENRY family programme. This was supported through interview feedback with those that had experienced facilitating a

HENRY family programme. Perhaps the strongest indicator of the success of this training is the effective and successful delivery of three family programmes to date.

10.9. The core training is intended to equip people with the knowledge, skills and confidence to support and work with families on issues relating to nutrition, healthy weight, lifestyle and parenting. During interviews, participants discussed the areas of new knowledge they had gained, skills they had developed, and new techniques and strategies to support sensitive conversations and behaviour change.

10.10. Furthermore, the examples of how learning had been applied, and what that looked like in terms of changes to practice further reinforced the achievement of outcomes.

10.11. The high level of consistency across survey responses and participant interviews gives us confidence in concluding that the intended outcomes of the core and facilitator training have been met.

Experience and outcomes for families

10.12. Given that there has only been a total of nine parents that have participated in and completed an eight-week HENRY family programme in Shetland the evidence base relating to outcomes here is not robust enough to draw conclusions with confidence. However, The HENRY programme has an existing evidence-base for sustained positive lifestyle changes for families in England and Wales that have participated in the programme.

10.13. However, the emerging evidence from survey data and interviews indicates that the experiences with the programme are positive, and that parents' knowledge and confidence improves across a range of measures, and changes are made to diet, levels of physical activity and overall wellbeing. For most parents it seems that participation is a catalyst for change, even if those changes are relatively small. Those that have taken the learning and started to apply some of the techniques and tools, were able to describe the different ways it has benefitted them, their children or family life overall.

10.14. When you consider the above, alongside the existing evidence base that HENRY has gathered, it would suggest that these programmes can expect similar outcomes if delivered effectively.

10.15. The evaluation was unable to engage with parents and families that had been supported by practitioners that had participated in the core training. Therefore, we cannot provide direct evidence of any impact generated through the application of learning by those practitioners. However, practitioners themselves provided anecdotal evidence of the positive impact they had observed their changes in practice contributing to. Despite a lack of evidence, logic suggests that where training has improved knowledge, skills and confidence, this is likely to translate into improved outcomes for those they work with.

Learning and future considerations

10.16. This evaluation sought to evidence and understand the difference that the training has made and the impact it is generating. The learning from this first phase of delivery is can also help other health board areas that are considering implementing HENRY training. We discuss the different components of learning below.

10.17. **Resourcing** – capacity and having the resource available at key points in implementation and delivery created the biggest challenge. While there is no 'one size fits all' solution, careful consideration is needed when planning the resourcing of the project. In particular, those absorbing it into an already busy role should identify sources of support that can be drawn in at pinch points, to ensure progress does not stall.

10.18. **Scheduling** – this applies to the training for professionals and the family programmes. Health boards' experiences suggests that block scheduling is the most efficient approach and can reduce the overall coordination time. There were few challenges in recruiting participants and generating interest in the programmes. Therefore, there should be little concern about scheduling training delivery over a 12 month period, and giving enough lead in time to identify and recruit participants for each programme.

10.19. **Online vs face to face** – when each health board embarked on this project the accepted format of delivery was face to face, structured over full-day sessions. COVID-19 and the resultant restrictions led to the development of the online delivery format. Initial concern that it would affect interest and engagement with the training opportunity turned out to be unfounded. However, a small number of participants reported a preference for face-to-face training, and it is not known whether the online format did put people off that otherwise would have participated. Furthermore, there was also feedback that suggested online delivery was not appealing to some parents that were interested in participating in the eight-week HENRY programme. Being able to provide a blended model that gives people choice is the suggested way forward.

10.20. **Enabler to applying learning and making change** – for those participating in the core training, the multiple short sessions spread over a series of weeks had two very important benefits. The first was that participants did not feel overwhelmed by the volume of new knowledge, skills and strategies, which meant it was absorbed and retained more effectively. The second aspect is the critical enabling role it played in participants applying their learning and making changes to practice. These are two of the most important aspects that contribute to the achievement of outcomes. With a blended approach, and the potential for face-to-face delivery not providing the same enabling factor, the value of a peer support network that provides participants with a space and opportunity to reflect and share is heightened.

10.21. **Local support and ownership** – a significant contributor to the success of the project in NHS Lothian has been the project lead's ability to develop relationships and encourage local ownership. Furthermore, identifying where and how the project can align itself with, and contribute to local priorities and the aims of strategic groups can also raise visibility and focus on the project, and further encourage local ownership and support.

10.22. **Securing commitment to safeguard the investment** – the approach taken in NHS Shetland appears to be an effective way of ensuring resilience and future sustainability of the eight-week HENRY family programme. The quid pro quo arrangement whereby participants can access the training but must commit to delivering an agreed number of family programmes per year provides a solid platform for future planning and makes clear the expectation from the outset. We would suggest that this approach is adopted by any others that are implementing the HENRY facilitator training and HENRY eight-week family programme.