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PAPER

A qualitative exploration of a health trainer programme in two UK primary care trusts

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Abstract

Aims: World Health Organization data illustrate a worldwide re-emergence of interest in the scope of lay health workers for extending services to 'hard-to-reach' community groups. In the UK, the health trainer model of service delivery represents one such innovative way of working, first described in the White Paper *Choosing Health: Making Healthier Choices Easier* and more recently in the Kings Fund report. The scheme was introduced into selected primary care settings in England from 2005 and rolled out nationally from 2007. The aim of this study was to examine the perceived value of the health trainer scheme.

Methods: This paper describes qualitative data from two studies undertaken in 2007–2009, comprising in-depth consultations with key primary care stakeholders, health trainers and their clients in two primary care trusts in northern and central England. Data was collected via 12 semi-structured interviews with key stakeholders and service users and from 8 focus groups with a total of 33 trainee and qualified health trainers.

Results: The UK health trainer approach was regarded as effective in contributing to the support of a broad spectrum of health and welfare issues across widely diverse communities in the two primary care trusts evaluated. Study data also indicated a wide-ranging impact of the health trainer service, extending not only to the lay health workers themselves, but also to their families, friends and colleagues.

Conclusions: The health trainer service appears to be not only 'fit for purpose', but also to bring with it certain 'added value', which was not predicted by the two primary care service providers at the outset. A critical factor in this success appears to be the unique combination of time, the 'person next door' and a 'one-to-one' approach, which facilitated an innovative and highly productive connection between the health trainer and client. However, participants in this evaluation perceived that the current format and constituents of service performance data were significantly failing to credit the health trainer scheme with the full extent of this impact.

INTRODUCTION

Typically, lay health workers are individuals who have no professional healthcare qualifications, but have instead completed a course of informal job-related training, which allows them to become involved in a diverse range of functions related to healthcare delivery and the support of consumers within their communities.

Introduced into selected primary care settings from 2005 and nationally from 2007, the UK health trainer model of service delivery represents one such innovative way of working, first described in the White Paper *Choosing Health: Making Healthier Choices Easier*[1] and more recently in the Kings Fund report.[2] Promoted as one of the key strategies for improving health among deprived communities and thereby reducing health inequalities, the underpinning philosophy of the programme rests upon lay individuals working to improve the health status of members of their own communities, by 'sign-posting' clients towards

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existing services and supporting them through subsequent lifestyle changes. The role of the health trainer therefore involves giving people the skills to set their *own* behavioural goals and to self-manage events and circumstances in their lives that they would like to change.

According to Walt,[3] despite the worldwide expansion of lay health worker programmes during the 1980s, many of these initiatives failed to produce robust assessments of their 'value' and subsequently went into decline. However, prompted by a combination of recent pandemics, the international resource crisis in healthcare and the ongoing failure of formal healthcare systems to manage chronic illness, there is now a renaissance of interest in the roles that such workers might play in substituting for health professionals, and thus extending the reach of existing health services.[4,5,6]

Although some research has been published which evaluates similar health promotion programmes in terms of life expectancy and cost-effectiveness,[7] there remain a limited number of resources that have specifically described the health trainer role and its determinants[8] and none of these studies discuss the specific *cost-effectiveness* of a health trainer intervention. Conversely, standard methods for cost-effectiveness in health and medicine have been recognized as remaining shorthanded in evaluating public health programmes, unless employed with a societal perspective.[9]

However, a number of studies and reviews have been identified in support of the implementation of community interventions to alter health behaviours,[10] while a review by Mason *et al*[11] did find tentative evidence that community engagement as part of a multi-faceted approach to health promotion 'may have positive effects and could be cost-effective'.

To improve the evidence base for community engagement, it was therefore apparent that any health trainer evaluation studies needed to involve communities more closely at all stages of the research in order to fully capture the community's priorities and perspectives, and appropriately assess the value added and opportunity cost of engagement.

METHOD

This article describes the combined qualitative findings of two studies undertaken for primary care trusts (PCTs) in northern and central England during 2007–2009. Both studies used a combination of qualitative and quantitative data to explore the *perceived effectiveness* of two health trainer schemes from a range of perspectives. The first study[12] was undertaken in a north England PCT which commissioned health and social care services for 170,000 residents and had a team of 15 health trainers. This study began with the introduction of the health trainer scheme (March 2007) and continued for 12 months, during which time qualitative data was collected from:

- Interviews with eight key stakeholders (March 2007 and January 2008)
- Four focus groups with 15 health trainers (2 in April 2007 and 2 in March 2008)
- Interviews with four former health trainer clients (January 2008)

The key stakeholders were four senior managers, two primary care clinicians working within a community-based health centre and two health professionals working as community outreach project leaders. The interviews were semi-structured and explored expectations of and aspirations for the service, preconceptions of the health trainer role and barriers to service performance.

Focus groups with health trainers explored:

- Participants' personal background, qualifications and previous work experience
- Understanding and expectations of the role
- Views of health trainer training
- Initial experience of working as a health trainer
- Characteristics of the client base
- The impact of the role, both personally and within their communities
- Ongoing service experience and supplementary training needs

Health trainer clients proved to be an extremely 'hard-to-reach' group, hence only four former clients (three female, one male) were available for face-to-face, semi-structured interviews. These interviews explored how clients had become aware of the service, what had encouraged them to contact a health trainer, for which problems clients had asked for help and what they ultimately thought of the health trainer service. Clients were also asked to describe their first health trainer contact, their subsequent visits and suggestions for any service improvements.

In the second study, undertaken for a central England PCT during November 2008,[13] qualitative data was collected from four health trainer focus groups. These groups comprised a wide spectrum of participants (Table 1), including four trainers who had been in post since 2007 and a further 19 recruited throughout 2008 and who were at different stages of their training.

Each focus group used a standard topic guide which asked questions relative to:

- Participants' personal background, qualifications and previous life experience
- Views of their training programme
- Experience of service (if any)
- The nature of their client base (if any)
- The impact of the role, both personally and within their communities
- Perceptions of what constituted a 'good' health trainer
- Future career plans and aspirations

In both studies, the interviews and focus groups were digitally recorded with verbal informed consent. Resultant transcripts were rendered anonymous and submitted to framework analysis, within which emerging themes were contextualized.[14] Theme identification was further validated by individual re-reading and assessing commonalities of fields[15,16] and by inter-researcher triangulation of emergent data.

This research was funded independently by the PCTs who commissioned the evaluation. The two studies were classified as service

Table 1

Study 2 focus group participants

Number in group	Description of Group Members
GROUP 1 - 4 Females	◆ Trainee health trainers due to complete their training in Nov/Dec 2008 ◆ All currently based in local libraries and working with clients
GROUP 2 - 5 Females & 3 Males	◆ 4 health trainers recruited Mar 2007 & 4 health trainers recruited Mar 2008 ◆ All group members had experience of working with clients in a range of community settings
GROUP 3 – 4 Females & 3 Males	◆ Trainee health trainers due to complete their training in Jan 2009 ◆ No experience of working with clients
GROUP 4 – 4 Females	◆ 2 trainee health trainers due to complete their training in Jan 2009 & 2 trainee health trainers due complete their training in Jun 2009 ◆ All had some experience of working with clients in a range of community settings

evaluation, thus ethics committee approval was not required but research governance approval was obtained from the two PCTs.

RESULTS

Stakeholder views of the scheme

At initiation

Stakeholders viewed the recruitment of health trainers from within local communities as a positive development, which they felt would give residents more responsibility in taking care of their own health and changing their own health behaviours. They emphasized a number of key challenges facing this new role at an operational level. The first was the 'real tension' between pressures for the health trainer programmes to have a national (standardized) profile versus the need to maintain a 'local' focus. It was felt fundamental that, although operating within a set of common ideologies, health trainer initiatives must endeavour to remain flexible and responsive to their own neighbourhood needs, rather than workers and services being constrained into one 'stereotypical' role. A further challenge would be for health trainers to 'engage' with contemporary primary healthcare professionals, who ultimately had direct responsibility for these clients.

The most appropriate structure and content of health trainer training was felt to be a combination of practice and classroom-based education. Although the initial health trainer training programme was viewed as very comprehensive, interviewees were uncertain to what degree they would be ready for service at the end of it:

> 'I don't think anybody can be prepared for that particular role… I think that it is a very new role and a very challenging role and you can't be fully prepared for it.' (Study 1)

Twelve months after initiation

After 12 months of service operation, the health trainer programme was perceived by the stakeholders to have been successful in empowering clients to make a wide range of lifestyle choices, thereby improving health across local communities. Stakeholders commended the health trainers for adopting a variety of approaches to 'connect' both with other professionals and with members of their community, particularly those in the most deprived areas who were traditionally the most difficult to reach. There was a strong consensus on the need for sustainability of the health trainer service, with stakeholders expressing a comprehensive range of aspirations and hopes, including rolling out the programme further, building and maintaining 'credibility' and 'accessibility' at community level, and establishing even stronger working relationships with local health professionals.

Health trainer views of the scheme

Health trainer training

In the UK, health trainers are currently assessed against National Occupational Standards[17] and accredited by a Level 3 City & Guilds qualification through the Royal Society for Public Health.[18]

Although health trainers in both studies found their training beneficial in terms of gaining knowledge of health conditions and existing community initiatives, a range of suggestions for improvement were made.

A significant gap in training provision was the lack of counselling and motivational interviewing training; participants discovered that once in practice they did not have the knowledge required to actually *support* members of the community with specific problems:

> 'We have been taught about some of the substances but we haven't been taught how to tackle the problem – it's just a case of well that's what alcoholism is, but we were not shown how to interact with people on that level, or how it affects them, what you need to actually do to help them change. I think counselling skills would come in very handy.' (Study 1)

The majority of health trainers felt that working one to one with clients before completing their training was 'too demanding and inappropriate' (Study 2) and should be avoided. Participants felt instead that training needed to be more 'practical' and include role play, case studies and shadowing qualified

colleagues to enhance the learning experience. However, health trainers did acknowledge that a considerable part of their skill base could only be gained in 'live' settings:

> 'I think that's the same with any job, you can do all the training but until you actually get doing the job you learn more while you are doing it than you ever will training.' (Study 2)

Many participants felt that a more formal process of individual assessment would have been valuable in consolidating learning and developing self-confidence.

Work experience of health trainers

Health trainers were unanimous in feeling that their role was not clearly defined and, in practice, was not quite what they had expected:

> 'I don't think I could have possibly envisioned the impact and the things that we were going to come across, or what we were going to do. I mean I wouldn't have envisioned it, no way… even when we did the training I wouldn't have envisioned this job.' (Study 1)

In discussing their initial experiences of working within individual communities, newly qualified health trainers described feeling that they were 'left to get on with it' and 'make their own way' (Study 1). Each health trainer worked within a defined area of the community, and although some were able to work quite closely with a colleague, others were not; this led to feelings of isolation. As a result, several participants had set up personal support networks, which were working well.

A key message from all groups was that the role was 'still evolving and changing' (Study 2). This resulted in a degree of uncertainty about what individuals were expected to do and consequently had a detrimental effect on the perception of the role among other health professionals and community members:

> 'I think there is no consistency… every week the rules change and we are not allowed to do what we were doing the week before. …it changes to suit whatever they want. They let you go and do something and then you are stopped because they suddenly realize there are implications in that. You feel a bit of fool then, because you are there in the community, preparing people for something, and then you are told to stop.' (Study 2)

The health trainers had tried hard to develop working relationships with a wide range of organizations and professional groups within their communities, with this being more successful in some areas than others. Participants described how other workers in their communities were not only unclear about precisely what their role involved, but were often completely unaware of the existence of their role. Many had also experienced a marked degree of conflict between themselves and existing community workers, particularly health and social care professionals, who were perceived as 'feeling threatened' (Study 1) by the health trainers:

> 'I think part of the problem is they feel that we are taking their patients away from them. One answer we get, especially from some of the doctors, is "Well, how do *you* know he is an alcoholic? How do *you* know this? Have they been diagnosed by a *doctor*?" Some of them are quite, you know, alien to us.' (Study 1)

Conversely health trainers described how the perceived 'non-professional' nature of their role among their client base meant that they were often better able to encourage disclosure from the client than were these other 'professional' groups:

> 'They disclose to us because they are not afraid. There are a lot of people who don't go to the doctor to disclose; they are afraid of the agencies that they might get involved, social services, or anything like that. But they know us and they tell us, because we are not a "professional" as such… I find it in one way quite amazing, and in some ways quite worrying, how people will trust what we say, in some cases above what governments, doctors and other people tell them, who are much more highly trained people.' (Study 1)

Despite a well-established professional service provision in many areas of the community, the health trainers frequently found that what was available did not meet their clients' needs. There were therefore frustrations and participants felt constrained by their role description, which stipulated that they could not set up alternative, more appropriate services for clients, or accompany (and thereby support) clients to pre-existing events or groups. This, they felt, had a negative impact on their effectiveness:

> 'And we've got to know them and they've started to trust us, they think, well she's a member of NHS and she can go and source this for us. I sometimes find that I walk into centres and people say, "well why can't we do this" and "why can't you organize this" and "what's going on". But I can't…' (Study 2)

Despite these issues, participants in both studies were unanimous in expressing high levels of job satisfaction and perceived the scheme to have had a tangible and comprehensive impact on their communities:

> 'I have seen massive lifestyle changes in some of my clients. I had one guy that was living on the streets, who was a heroin addict, who, when he left me, had his own house, with his ex partner back with him and his child and a job. The lifestyle change was just massive, just vast, to the point that sort of I couldn't envision he could have changed that much; he was just completely a different person.' (Study 1)

Although confident that the majority of their clients actually complied with the guidance they were given, this was seen to vary and, to some extent, was felt to depend on the client's personality and situation.

Client base of the scheme

Health trainers were asked to describe the types of problems their clients regularly asked for help with. They described a wide and varied workload:

> 'Depression, weight, stress, anxiety, drug dependency; theoretically everything, everything that's out there; confidence building, college courses, doctors, children's centres, Social Services, debt management, absolutely everything that exists, that you can think of…' (Study 1)

Health trainers also described how, in reality, clients frequently contacted the service under the auspices of requiring help to stop smoking, lose weight or improve levels of fitness, and only once a trusting relationship had been established did they reveal their *true* needs, which were more frequently related to mental health, welfare or lifestyle issues:

> 'You may start with diet, which leads on to self esteem, which soon leads on to mental health problems and social health and everything; it's just changing people's whole attitude to themselves and life, isn't it, sometimes? I have got a couple of clients who just come to talk; they came wanting to lose weight, or do something else, but when it actually came to it, they just wanted somebody to sit down and talk to, to just sit and listen.' (Study 1)

Added value of the scheme

Health trainers felt that a key (and unpredicted) area in which they had been particularly successful was in the determination of the true *incidence* of public health issues within the community, something they felt was grossly underestimated in the media:

> 'The amount of issues that we get, as well, that nobody else knows; I mean you sort of look at figures in the papers, statistics – you see the statistics in the papers and you think not even close. You can probably multiply them by four or five easily.' (Study 1)

Participants also described how they had exposed a striking lack of *understanding* of healthy eating messages among their client groups:

> 'We had set a goal to eat breakfast… and he came in and said I have been eating breakfast; I have been eating pop [jam] tarts. Really proud of himself that he had been eating breakfast, but he had been eating pop tarts for breakfast! It was like okay, when we said a healthy balanced meal – where did you get that from? And he said "well I'm having the strawberry ones, so that's fruit, so that will be all right then, yeah?" Not quite what was meant!' (Study 1)

Some clients even struggled to understand what a vegetable was:

> 'Most of them had never seen a carrot. We were actually showing them a carrot, how a carrot grows in the ground, asking them how they grow, how you pick them. They thought they grew like this [demonstrates holding a carrot upside down] that they grew above the ground, like this!' (Study 2)

A key advantage of the health trainer role was in having the time to develop a rapport, to clarify and facilitate interpretation and understanding of health promotion messages:

> 'I think the establishment tends to have one view that the information is out there and people know it and listen to it; they give out leaflets, but not everybody is educated to a standard where they can understand… Whereas because we sit and talk to them and when we do give them a leaflet we explain what's on it, so even if they can't read it, or understand it, we don't embarrass them and they get the message!' (Study 1)

Finally, participants described experiencing a 'ripple' effect of the health trainer scheme within their communities, which had also spread to their own lives and their families, friends and colleagues:

> 'It's made me look at my own problems in a different light as well, because I haven't got any compared to some people. It has made me a happier person, because you look at the problems that some people have got and you think, "And you were moaning about this?" It makes you reassess everything.' (Study 1)

> **'**What happens, is if you change, just for instance, the eating habits of one parent, often the other parent will follow suit, and also the children tend to follow suit, so then, obviously, it becomes you are reversing the trend of so called obesity every day.' (Study 1)

Attributes of a 'good' health trainer

There was a consensus among health trainers (Study 2) that being a 'people person' was the main attribute of a 'good' health trainer. Effective health trainers were described as being approachable and very much a part of, and having a good understanding of, their communities, all of which were seen to enhance the positive impact of the role.

Heath trainers viewed themselves primarily as *facilitators* rather than *directors* and felt that this was an extremely important factor in the success of the role:

> 'We can sit down and, instead of having five minutes to sort out a lifetime of abuse, we will say well how are *you* feeling about it, what do *you* want to do and how far do you want to take it – not you *will* do this, this, this and this.' (Study 1)

Not being perceived as a health professional but being viewed instead as 'still human and having their weaknesses' (Study 2) also made health trainers more approachable and closer to their potential clients. Indeed, health trainers felt that people living in deprived areas viewed them as 'friends and

neighbours who are there to help them' (Study 1) and that their role was successful because of this unique approach:

> 'They see us around in the street because we live in the areas that we work in; they see us about; they know we are just normal people like them. So they seem to disclose a lot more to us. In some ways you're treated as a mate, with a bit more knowledge!' (Study 1)

Health trainers described difficulty in certain male or female dominated areas in their communities for a lay worker from the opposite gender to gain access; hence, in these settings, the gender of the health trainer was an important attribute to consider.

Challenges within the role

There was consensus among health trainers that their role had continued to evolve into something far broader and more complex than the original vision; participants therefore expressed growing concerns relative to their personal confidence and competence, and raised a need for more-structured peer support and mentorship. Several PCTs have now introduced senior health trainers for precisely this purpose.[19]

Another key challenge was the level of client dependability placed on the health trainer, which was difficult to cope with at times. Many described how they frequently had to learn to 'switch off' from the job in order to 'survive' (Study 1).

Several more experienced health trainers (Study 2) expressed their frustration with current Department of Health performance measures, which they deemed inappropriate and consistently failing to credit the scheme with the full extent of its influence on health behaviour change.

Career aspirations

All health trainers expressed a strong commitment to the National Health Service and expressed an interest in staying in a similar role, although detailed plans for the future varied. Younger health trainers with a more academic background wanted to progress in public health:

> 'You've got that [health trainer qualification] then there is not another qualification specifically in that area, so you've got to go out into wider public health.' (Study 2)

Older and less formally educated health trainers wanted to stay in their communities. However, some wanted to specialize in certain areas, or possibly move to a supervisory role where they could recruit and train new health trainers:

> 'I would like to stay in because I enjoy what I do… so as we start on we go up to a level more supervisory and we take more health trainers on and we can work with them.' (Study 2)

Clients' views of the scheme

It is acknowledged that the client group with which health trainers engage are by nature 'inaccessible by most traditional and conventional methods'[20] and, consequently, that the small number of clients who were motivated to take part in this evaluation may not be representative of the client base overall. However, the interview and documentary evidence presented provides a positive foundation for further exploration.

All clients interviewed described the appeal of the health trainer service in terms of offering one-to-one contact with an impartial stranger, which was unhurried, confidential and targeted their needs:

> 'I think perhaps my doctor has enough to cope with… and a doctor has to write everything down, or it goes on the computer, but with this you are talking to someone who is completely unknown to you and what they do will be kept within that service. I felt it was completely confidential.' (Study 1)

> 'Well the thing is that when I go to the doctors he looks at the list of medication I'm taking and they don't understand what it's like. He just looks at the computer, says "keep taking the tablets" and sends me home.' (Study 1)

Other support services within the local community were often found to be unavailable to this group of clients when they needed them:

> 'They have quit smoking times during school, which is great, but I work… and I've got children as well, so it's really difficult.' (Study 1)

Or the services made a prohibitive charge for their support:

> 'I've been to Slimming World, but I thought it was expensive to be honest… you were paying five pounds just to get weighed… I lost nearly a stone, but I lost a lot more from my pocket. [laughs] I couldn't afford to do that.' (Study 1)

Clients had contacted the health trainer service with a range of concerns, several describing a complex mixture of problems, not always linked directly or solely to 'health':

> 'I wanted to stop smoking and I also wanted to lose some weight as well… and then I had this problem with work… and because I suffer from dyslexia she'd actually help me with that… I was very, very down, very depressed.' (Study 1)

Clients valued the 'holistic' approach that the health trainers could provide:

> 'I could have gone to my GP but it would have been one person for slimming, one for smoking, one for the other… three different people. She works it around me.' (Study 1)

All the interviewees had developed close working relationships with their health trainers, a factor undoubtedly regarded as important to their subsequent success; all the clients interviewed had been successful in achieving their key targets. As might be expected (given the

nature of this sample), all the interviewees were very complimentary about the health trainer scheme:

> 'As the health trainer scheme goes I think it's a very good idea I really do… because we are so used to looking after old folks, young folks, you know, and our families, that we perhaps don't look after ourselves as much as we should.' (Study 1)

DISCUSSION

The aim of this paper has been to present perceptions of the effectiveness of the Department of Health health trainer scheme, in the context of two UK PCTs.

Key stakeholders viewed the recruitment of health trainers from within their local communities as a positive and exciting model of service delivery, although there were concerns about workers' ability to engage with, and obtain the support of, key strategic partners and primary healthcare professionals. Such concerns, relating to how health trainers 'fit' into current service provision, are not new;[19] in the literature stakeholders have frequently expressed fears that such new roles represent 'a retrograde step'.[21] However, this study demonstrates that service managers and clinicians undoubtedly became more confident as health trainer programmes progressed, and the initiative was perceived to have been extremely successful in improving community health and lifestyles.

A wide range of individuals from different backgrounds, with a broad spectrum of skills and life experience, were in post as health trainers in these two PCTs. Two key motivating factors and aspirations for the health trainer role were evident: those less academically orientated aspired to remain deep-rooted in their communities, while the more academic hoped to move on to a higher-status, 'professional' role in public health.

All health trainers who participated appeared to have developed effective working relationships with a variety of organizations and professional groups within their communities (although more successfully in some neighbourhoods than in others). During this process, their role had also evolved into something far broader and more complex than commissioners had envisaged, with clients contacting the service with an assortment of concerns, particularly relating to mental health, social welfare and general lifestyle.

Given that the health trainer role appeared to have been continually changing and evolving during these two studies, the key attributes of a 'good' health trainer that the two groups identified were remarkably consistent. A major strength of the health trainer role was its ability to *facilitate*, but not to *direct*, change. To do this, health trainers felt that they needed to be approachable, trustworthy people, who were regarded by clients as 'credible' members of the community. It was also extremely important to the participants that they be perceived as 'only human' and not 'super human'.

The most significant findings of this study, however, related to the health trainers' descriptions of the 'added value' of their role, which was both unpredicted and, to some extent, unexpected when the role was originally conceived and introduced across the UK. The first aspect of this lies in the health trainers' inherent ability to determine the true incidence of public health issues within areas of deprivation, which they felt was grossly underestimated by national statistical sources.

The second was the health trainers' recognition of a marked lack of public *understanding* of health promotion messages and their subsequent ability to facilitate lay *interpretation* of such messages. This is undoubtedly an extremely important aspect of the role, especially if one considers, for example, that the UK Food Standards Agency[22] found that although more than half (52%) of the members of low socioeconomic groups questioned had knowledge of the National Health Service's 5 A DAY fruit and vegetable message, only a third of them were able to demonstrate appropriate levels of understanding of this message.

The third 'added value' of the health trainer programme was a 'ripple' effect that had apparently extended the impact of these programmes not only into the health trainers' personal lives, but also into those of their families, friends and colleagues across the wider community.

Although small in number, all health trainer clients were complimentary about the scheme, and had all achieved their desired goals and targets. They described how the opportunity of building a close working relationship with their health trainer had impacted on their lifestyle changes and they were unanimously appreciative of the accessibility of the service, the time made available to them by the health trainers and their confidential, one-to-one approach.

CONCLUSION

The UK national model for health trainers is that of the 'person next door' working to improve the health of their own communities. Given that there is strong evidence to suggest that the provision of such support, in conjunction with psychological skills to alter behaviour, can help to reduce inequalities in health,[23] it still remains to be proven whether this programme is the optimum approach. However, the stakeholder health trainer and client data collected from these two evaluations do much to add to, explore and illuminate the complexity of this relationship.

Whilst acknowledging that the shape and scope of the UK National Health Trainer Programme is still being developed, these two studies do serve to demonstrate that current health trainer initiatives are perceived as achieving positive health behaviour change in a variety of community settings. However, participants in both studies suggest that further attention be given to the current format and constituents of service performance data, which was felt to be significantly failing to credit the health trainer scheme with the full extent of its impact across the UK.

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