Health Trainer Models in the East of England: Spreading Best Practice

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Executive Summary

Introduction

The aims of this document are: firstly, to define the national expectation on health trainers; secondly, to outline what is happening on the ground in terms of health trainer services across the East of England; and thirdly to share lessons learnt from established health trainer services in the region.

Background

Health inequalities are persisting across the East of England. One vehicle for reducing health inequalities are health trainers, targeted at disadvantaged areas or groups. Health trainers are highlighted in both the *Choosing Health* White Paper and *Our health, Our Care, Our Say* policy documents. There is evidence that health trainers can support changes in lifestyle dependent on the model used. There is now a national accreditation scheme for health trainers and recurrent funding in PCT baseline allocations from 2007/8.

Methodology

Each PCT lead for health trainers in the East of England was asked a series of questions about their health trainer service and the results were compiled.

Results

7 of 14 PCTs in the East of England had health trainers, totalling 89 health trainers as at July 2007. The PCTs were split equally between paying a salary or not paying a salary for their health trainer service. The majority of PCTs recruited from volunteers/third parties agencies/those in existing roles. Only two PCTs targeted deprived wards during the recruitment process. The majority of PCT health trainers targeted disadvantaged groups. Training was mainly in-house, although 2 PCTs received accreditation for their courses through external organisations. A variety of models were used and they all included a group or community component, apart from 1 PCT using only 1:1 work. 3 PCTs were full or part-funding their health trainer programme, the rest used funding from the Department of Health or external sources. One PCT had completed an evaluation on outcomes of their health trainer service thus far. There is a series of lessons to be learnt from PCTs currently implementing a health trainer service. Of the remaining PCTs, there was no information on health trainers from one PCT, four are considering the health trainer service and two are not currently prioritising the service.

Recommendations

1. To support PCTs, Local Authorities, prisons and other agencies without health trainers to promote their introduction.
2. To support areas to use PCT baseline allocation/alternative funding sources for health trainers.
3. To provide a consistent regional training package.
4. To share lessons learnt from areas with health trainers.
5. To ensure that health trainers receive national accreditation where possible.
6. To support local evaluation.

1. Introduction

The aims of this document are: firstly, to define the national expectation on health trainers; secondly, to outline what is happening on the ground in terms of health trainer services across the East of England; and thirdly to share lessons learnt from established health trainer services.

It commences with some background information on the East of England context, the policy behind the health trainer concept, the evidence base on health trainers, training and accreditation and funding for health trainers. It describes the methodology used in collating information on the health trainer services across the East of England. The results of the survey are then outlined, and conclusions made. Finally, some recommendations are made in order to enhance the health trainer service across the East of England.

2. Background

2.1 Context

The East of England experiences great health inequalities with the gap in life expectancy between those Local Authority areas with the lowest life expectancy and the average for the East of England widening. The East of England Strategic Health Authority has pledged to reduce unfairness in health in its strategic document: *Improving Lives, Saving Lives*, launched on 10 September 2007. A paper on 'Tackling Health Inequalities in the East of England' was approved by the East of England Strategic Health Authority Board in May 2007 (1). One vehicle for change discussed in this paper was the development of health trainers. There is already a hub lead for the East of England to support the development of health trainer services.

2.2 Policy

The health trainer **concept** was first described in the *Choosing Health* White Paper in 2004 (2). This states that health trainers are: 'drawn from local communities, understanding the day-to-day concerns and experiences of the people they are supporting in health' (2). Health trainers should also reach the most deprived groups, according to the White Paper.

In terms of rolling out health trainers, the paper states that: 'from 2006, NHS-accredited health trainers will be giving support to people who want it in the areas of highest need[1] and from 2007 progressively across the country'. The **function** of health trainers is also described: 'NHS-accredited health trainers will provide advice and support to develop a personal health guide, including help with:

- defining the changes they want to make;
- providing advice and practical support on what they can do – such as stopping smoking, doing more exercise, healthy eating, practising safe sex, dealing with stress and tackling social isolation;

[1] Those 20% of PCTs with the worst health and deprivation indicators.

- providing advice, motivation and support – including training to look after their own health,
- advice and help with making better use of lifestyle information and– on making and sustaining changes over time; and
- explaining how to access other help locally, both from the NHS and more widely across the community.'

The **settings** for health trainers are additionally outlined: 'Just as each neighbourhood is different, each trainer will be different. In some areas health trainers may be people working in the NHS or voluntary sector who already fulfil a similar role in the community. In such cases, being a health trainer could be one element of their job role. In other areas, particularly those where there are marked health inequalities, it may be better to recruit and train new staff from the community as dedicated health trainers.'

Subsequent to this health trainers were also discussed in *Our Health, Our Care, Our Say* (3). This states that following a **life check** self-assessment: 'people whose initial self-assessment indicates that they are at significant risk of poor health will be able to discuss the outcome with a health trainer. The discussion will include looking at what action they can take to improve their own health, for example through diet or exercise. It will also cover the further help they might want to seek from local services, including, where appropriate, referral to seek medical advice and follow-up from more specialist services, and the development of a personal health plan.' It also adds that the 'Life Check', led by health trainers will be developed in deprived areas (Spearhead areas), in consultation with people who are least likely to access advice provided by conventional services.

Therefore there is clear national policy that health trainers should be introduced.

2.3 Evidence Base for Health Trainers

The evidence base for health trainers was published by Visram and Drinkwater in 2005 (4). However, the search strategy was not absolutely clear and the outcomes were biased in favour of those strategies that were successful. The authors divided the health trainer role into three key categories: lay health advisors, peer educators and advocates. **Lay health advisors** were defined as 'community members who work exclusively in community settings and who serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked access to adequate care' (4). The successful lay health advisor interventions included: cancer prevention, mainly amongst women from ethnic minority backgrounds; cardiovascular health; smoking; sexual health and contraception use; health of farm workers; migraine; and general health education (4). In contrast, **peer educators** have similar age, background and interests as the client group. The successful peer educator interventions included: sex education; drug abuse and smoking; nutrition/diet; prevention of heart disease and diabetes (4). The authors added that a meta-analysis of 47 programmes found that 94% were based in the USA and 70% in schools, therefore generalizability may be an issue. **Advocates** work on behalf of clients to inform them about available choices and to support them in gaining access to appropriate services. Examples of successful advocacy

programmes include bilingual interpreters trained in advocacy who decreased anxiety and distress in mental health, midwifery and community care scenarios (4). A Hackney advocacy programme for ethnic minority pregnant women found that antenatal length of stay in the intervention hospital was initially higher than the control hospital, but this then dropped to the same level; the proportion of induced labours in the ethnic minority women was high in the control hospital, but the same as the general population in the intervention hospital; lastly Caesarean section rates were statistically significantly lower in the intervention group (4). A Liverpool advocacy programme working with the homeless was cost-neutral as the additional costs of providing advocacy were offset by a decreased demand for health centre based care (4).

An independent search strategy[2] showed that for lay health workers, an increase in immunisation uptake and improved outcomes for infectious diseases was demonstrated (5). There were also fewer child related admissions to hospital, increased preventive care, and increased access to community resources on using peer educators (6). However, there was a mixed picture for increased breast feeding (5, 7, 8) and poor evidence for treatment of high blood pressure and alcoholism (5). One study noted that community heart interventions were not effective unless targeted at high risk groups (9). Community health workers working on behaviour change showed an improvement in five of six studies documented (10). In addition, interventions using an advocacy or empowerment approach decreased spousal abuse towards women (11, 12).

In summary, there are a variety of successful health trainer strategies that can be used to promote change in health behaviour. However, the success is dependent on the model used and the health intervention.

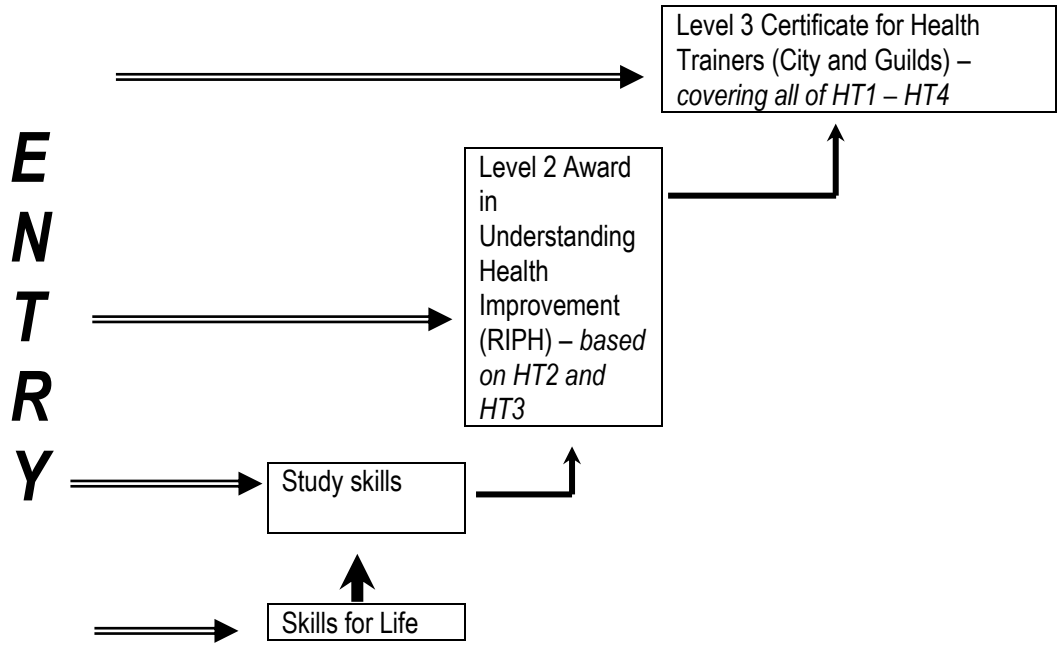
2.4 Training and Accreditation

There is a national accreditation scheme for health trainers. This is based on the Derbyshire model. There is an entry level numeracy and literacy qualification, 'Skills for Life'. This is followed by the Royal Institute of Public Health Level 2, which takes 1-2 days training and finally, there is the City and Guilds Level 3 qualification, which has a total of 120 classroom hours. Health trainers can also enter at any given level, see Figure 1. These qualifications are based on four health trainer competence areas:

HT1 Make relationships with communities
HT2 Communicate with individuals about promoting their health and wellbeing
HT3 Enable individuals to change their behaviour to improve their own health and wellbeing
HT4 Manage and organise your own time and activities

[2] The search was restricted to systematic reviews, which are syntheses of studies, (in the Cochrane and DARE databases), as they are the most robust form of evidence attainable. The search terms: community development, lay education, advocacy, advocate and peer education were used. The school setting was excluded.

Figure 1: Health Trainer National Accreditation awards



2.5 Funding Health Trainers

From 2007/8 there was recurrent funding earmarked for health trainers in baseline PCT allocations across the East of England totalling an estimated £6.5 million. However, given the financial position there have been competing priorities for the budget. The expectation from the Department of Health is that this funding will be used for a full year's deployment of health trainers. On average, one w.t.e. health trainer will cost £30,000 per annum according to the Department of Health. This is based on salary (Agenda for Change Band 3), on costs and support costs. Therefore, based on this allocation, there should be funding for around 216 w.t.e. health trainers across the East of England.

3. Methodology

Each Primary Care Trust (PCT) in the East of England was asked for the contact details of their lead for health trainers. The lead was then asked a series of questions on their health trainer service:

- The stage of development of the health trainer service (early development phase, first recruitment phase, training phase, service delivery phase).
- The number of health trainers in post during July 2007.
- The background of the health trainers.
- What type of recruitment process was used and how many were recruited.
- Who the target groups are for delivery.
- What type of training was used and which modules.

- If there was any accreditation for the training and the organisation it was accredited to.
- The type of educational model used.
- What funding streams were used.
- What the evaluation results showed.
- What worked well. Secret
- Any concerns they may have about the health trainer service.

When asked about the health trainer models used, this was divided as per the theoretical models outlined for health trainers typing by Visram and Drinkwater, which favours using a 1:1 approach and dissemination of generic messages by health trainers. This included questions on whether the interaction was made on a 1:1 basis, in a group, or in a community; whether the health messages were targeted or generic and lastly whether a lay health advisor (a community development worker); a peer educator (a person of the same age and background as the client group) or advocacy approach was used.

The results were collated together to gather a picture of what was happening across the East of England and recommendations were made.

4. Results: Health Trainer Models in the East of England

Bedfordshire PCT

Health Trainer lead	Martin Westerby
E-mail address	martin.westerby@bedfordshirepct.nhs.uk
Contact phone number	01525 636854
Stage	Service delivery phase: 12 months
Number of health trainers in post at July 2007	7 active part-time health trainers (volunteers) plus one part-time admin/co-ordinator
Background of health trainers	Including from disadvantaged and BME groups.
Recruitment process	Volunteers and third party agencies working with communities at greatest risk of health inequalities targeted. In the first round recruited 12 health trainers and in the second round, 6 health trainers.
Target groups	Disadvantaged communities Communities accessed during the course of their duties
Training	In-house training in: Introduction to health inequalities and health improvement, knowing your communities and level I smoking cessation.
Accreditation	None
Model used	Mixture of community, group and individual work dependent on context. Predominantly generic information, but in some contexts a targeted approach is used. Use a combination of lay health advisor, peer education and advocacy models.
Funding mechanism	Department of Health funding given during early adopter phase. Currently no ring-fenced PCT funding.
Evaluation results	Evaluation process has been running for four weeks. It was formulated through a participatory methodology and is mainly qualitative in nature. Results will be pooled together once sufficient data is collected.

What worked well	Local people identifying priorities for their communities by giving them ownership of the issues, leading to informed action.
Concerns	Barriers to recruitment included explaining the health trainer concept and how it fits into their day-to-day work; knowing what the expectations of the health trainer are and funding for paid workers. No health trainers are paid; therefore it is onerous for them to collect data on clients. Providing support for health trainers was vital and required 1:1 supervision. This has implications for capacity and resources. Group support sessions were not effective as each individual had a variety of needs.

Cambridgeshire PCT

Health Trainer lead	Dr Fay Haffenden and Sue Smith
E-mail address	fay.haffenden@cambridgeshirepct.nhs.uk
Contact phone number	01223 885826
Stage	No health trainers at present but have joint proposal with Ormiston for health trainer service with the Gypsy Traveller community across Cambridgeshire and are currently seeking funding
Number of health trainers in post at July 2007	0
Background of health trainers	Ideally from community but working in a team with health professional(s)
Recruitment process	TBC
Target groups	Gypsy Traveller community
Training	TBC
Accreditation	TBC
Model used	Advocacy / peer workers
Funding mechanism	No funds available; approaching LSPs for LPSA reward grant funding but would rather access mainstream funds to ensure sustainability
Evaluation results	N/A
What worked well	N/A
Concerns	Funding

East and North Hertfordshire PCT

Health Trainer lead	Dr Joel Bonnet, Consultant in Public Health, West Herts and East and North Herts PCTs
E-mail address	joel.bonnet@herts-pcts.nhs.uk
Contact phone number	01923 281650
Stage	No health trainers and not considering developing the role at the moment.
Number of health trainers in post at July 2007	0
Background of health trainers	N/A
Recruitment process	N/A
Target groups	N/A
Training	N/A
Accreditation	N/A
Model used	N/A
Funding mechanism	N/A
Evaluation results	N/A
What worked well	N/A
Concerns	Lack of resources (financial and other) to enable the success of the venture.

Great Yarmouth and Waveney Teaching PCT

Health Trainer lead	Lyn Blizzard, Health Improvement Principal, Great Yarmouth and Waveney Teaching PCT
E-mail address	lyn.blizzard@nhs.net
Contact phone number	01502 719529
Stage	Service delivery phase: 7 months
Number of health trainers in post at July 2007	1 wte co-ordinator (AfC Band 5 equivalent), 2.8 wte health trainers (AfC Band 4 equivalent) (totalling 4 paid health trainers). 2 volunteers planned for 2007/8.
Background of health trainers	1 with GCSE qualifications, 2 with A levels and 1 with a University degree.
Recruitment process	Targeted Local Priority neighbourhoods/BME/Young mothers and young people through local press, local newsletters, vacancy bulletins and local networks.
Target groups	People living in socially disadvantaged neighbourhoods Young people, especially young women/mothers People with long term conditions Minority ethnic groups
Training	Training has been modular and ad hoc so far, structured training is planned. Examples include MEND training, first aid, food hygiene, smoking cessation level II, risk assessment, safeguarding children, training for trainers (OCN).
Accreditation	Via modular certificates
Model used	Combination of mainly group and community work, plus a small amount of 1:1 work (10-20%). A generic approach is used, although some targeted approaches are planned for the future. A Lay Health Advisor/community development role is used.
Funding mechanism	NHS and multi-agency cash in kind and NRF
Evaluation results	Evaluation carried out for all campaigns and projects. Plan to evaluate in September 2007.
What worked well	Embedding health trainers into the local community

	partnerships structure in Great Yarmouth was a success. Health trainers working generically gained acceptance and opened doors to signpost clients to other services such as smoking cessation and the young men's sexual health worker. A successful 'choices game' was developed that discussed the implications of choices that people make at different times in their lives.
Concerns	Barriers to recruitment included the establishment of credibility amongst health and social care professionals. This was resolved by creating appropriate boundaries to complement roles. There was a poor recruitment response from BME groups, however the PCT is endeavouring to identify the barriers for this. They will try to recruit volunteers from BME groups. At the time of developing the health trainer role no national guidance was available to steer the way forward.

Luton Teaching PCT

Health Trainer lead	Karen Tate
E-mail address	Karen.Tate@Luton-PCT.nhs.uk
Contact phone number	01582 709128
Stage	Service development: 8 months
Number of health trainers in post at July 2007	Total of 39: 23 Local Authority and 16 Children's Centre Health Trainers
Background of health trainers	Employed by LBC or Children's Centre
Recruitment process	Staff currently employed by LBC and Children's Centres. Engaged 7 LBC managers in July 2006, 18 LBC officers in September 2006, and 16 Children's Centre staff in February 2007 in health trainer training. However, 2 LBC officers did not complete the training.
Target groups	Service users
Training	One day training session: key priorities (e.g. Choosing Health); key health messages and key health issues in Luton.
Accreditation	Nil
Model used	Depends on the health trainer role: a combination of 1:1, group and community. Generic messages are used The health trainers act as frontline staff from a range of backgrounds and services, therefore they do not fit into the lay health worker, peer educator or advocacy roles.
Funding mechanism	No official funding but time in kind was used.
Evaluation results	There was an evaluation of the training by delegates in September 2006 and recommendations were made. Recommendations included: the need to run the course as a full day; the course to become part of corporate training; the course to be targeted towards particular services as a priority, to include disadvantaged groups; each officer completing the course to be followed up by facilitators to offer support and capture outcomes.
What worked well	The 'speed dating' session on introductions to other services was successful. Key messages for Children's Centre staff were

	appreciated. The model is good, but needs to be implemented by LBC managers first and needs a champion to make it work. Worked well having the training over one day. The training was particularly successful for children and families as the target audience.
Concerns	Funding bid for BLF was unsuccessful and would have supported the programme. Need someone to champion the cause with LBC Needs top level sign up and commitment to be integrated. Need to ensure the right managers and then their staff are on the training. No funding or dedicated staff to roll out as yet and these are required for sustainability. There is a post in the new structure which would take forward the health trainer role.

Mid-Essex PCT

Health Trainer lead	Sarah Southerby, Healthy Living Co-ordinator (NB: this PCT joined the London hub before the existence of more appropriate ones)
E-mail address	sarah.southerby@midessexpct.nhs.uk
Contact phone number	01621 727357
Stage	Service delivery phase: 3 months
Number of health trainers in post at July 2007	3 health trainers working 15 hours a week (1 at AfC Band 4 and 2 at AfC Band 3).
Background of health trainers	One has A-levels and working in NHS. One from overseas living in the UK and unemployed prior to appointment. One was being made redundant from a funded advocacy charity.
Recruitment process	Advertised through the local newspaper. PCT recruitment approach used. Three candidates selected due to their advocacy skills and working with individuals on a one to one capacity previously.
Target groups	The health trainer service targets those adults over 18. Four week quitters and work with Smoking cessation service Clients discharged from mental health services Befriending schemes Clients post-nutrition and weight management programme Clients post-exercise referral scheme Clients who have not improved following physiotherapy outpatients Self referral Those seen in OPD and being told they have to lose weight prior to surgery Clients referred via a new 'Social prescribing pad' soon to be launched from health/social care
Training	Internal training on: mental health awareness, child protection, smoking cessation level I and II, healthy eating, sensible drinking, PCT induction, IT one day programme. This was followed by SEEVIC College (12 hours training based on the Choosing Health priorities). In addition to this OU Understanding health Y158 has started.

Accreditation	OU Understanding Health Y158. SEEVIC Sports College also considering seeking accreditation
Model used	Mainly community development but also some group and individual work Generic approach Lay health advisor and advocacy roles
Funding mechanism	Healthy Living Solutions (Big Lottery) and Department of Health funding
Evaluation results	Too early to have completed an evaluation of the programme but considering the St Mungo's Outcomes Star amongst others
What worked well	Setting up the service from scratch meant being able to design it to meet the demands of the local community, having established partners, good reputation, and good relationships with other agencies. Setting targets for health trainers around: firstly the number of people they have engaged (based on smoking cessation work stream figures) and secondly the engagement of new partners (e.g. through community newsletters) such as businesses and community groups. The face-to-face and non-judgemental attitude is something new and effective when compared to the delivery of traditional health messages.
Concerns	Commitment from the PCT to take on the service HT role is new to Commissioners – use the excuse of 'provide evidence' or we will not commission the service Must be seen as an essential part of future service & could be best placed in LA as part of the Healthy Communities agenda, not purely a health one. The length of time it takes to train health trainers due to the wide health inequalities challenges they may have to deal with- health, housing, poverty, education etc Ensuring the health trainers are fully supported. Managing this project is a senior full-time role which was carried out on top of other responsibilities.

Norfolk PCT

Health Trainer lead	Sue Green, Health Improvement Manager, Joint post between Norfolk PCT and South Norfolk District Council
E-mail address	sgreen@s-norfolk.gov.uk
Contact phone number	01508 533717
Stage	Early development phase: Voluntary Services are recruiting for 10 health trainers at present
Number of health trainers in post at July 2007	0
Background of health trainers	Volunteers
Recruitment process	N/A
Target groups	N/A
Training	N/A
Accreditation	N/A
Model used	Hope to use a mixture of group and 1:1 Generic messages will be used A mixture of lay health advisor and peer educator roles
Funding mechanism	Volunteers
Evaluation results	N/A
What worked well	N/A

Concerns	N/A

North East Essex PCT

Health Trainer lead	Chris French, Senior Public Health Improvement Practitioner, North East Essex PCT
E-mail address	chris.french@neessexpct.nhs.uk
Contact phone number	01255 206202
Stage	Training phase is complete and will commence service delivery phase in September 2007
Number of health trainers in post at July 2007	30 peer educator volunteers, plus 20 hours administrative time
Background of health trainers	Year 11 young people from deprived wards
Recruitment process	Across three secondary schools, year 11s about to commence Social Care A levels were contacted and other year 11 posts were also advertised. Application forms were received and a Q&A discussion group was also held.
Target groups	Disadvantaged groups Youth (i.e. young people in deprived wards)
Training	In-house training: level I smoking cessation, child and adolescent mental health, sexual health, teenage pregnancy, eating habits including eating disorders, children's services, Connexions, physical activity, alcohol and substance abuse, health promotion techniques and personal safety
Accreditation	Level I smoking cessation. Certificate of attendance from PCT.
Model used	Combination of group and 1:1 work. Messages will be predominantly generic, although there will be some targeted work around signposting to teenage sexual health, CAMHS and Connexions. Peer education model.
Funding mechanism	PCT and Interaction Partnerships/Neighbourhood Regeneration funding
Evaluation results	Initial health trainers' training was interesting and informative according to the health trainers evaluation. Plan to evaluate health trainer service at end of academic year 07/08. This will include number of contacts and numbers signposted to which services. There will also be focus group discussions with the health trainers.
What worked well	Having a dedicated co-ordinator for the health trainers. Having a clear process for child protection issues.
Concerns	Too early to tell.

Peterborough PCT

Health Trainer lead	Shakeela Abid, Health Improvement Practitioner Specialist, Peterborough PCT
E-mail address	Shakeela.abid@peterboroughpct.nhs.uk
Contact phone number	01733 758409
Stage	Service delivery phase: 14 months
Number of health trainers in post at July 2007	5 health trainers in post. 2 are paid at AfC band 2, and 3 are paid as per their existing roles.
Background of health trainers	Either no qualifications or up to GCSE.

Recruitment process	Through existing community groups and agencies, volunteers and service users. 10 recruited initially and 5 went on to paid employment following this.
Target groups	Disadvantaged groups
Training	Internal tutors, assessed by OCN. Introduction and icebreakers; what is health?; health promotion and health inequalities; behaviour change; goal setting and monitoring; who can help? 1; Who can help? 2; Communication skills 1; communication skills 2; knowing your limits; record keeping; keeping your own records; equality and diversity; CPD.
Accreditation	OCN level II
Model used	80% 1:1 and 20% other community work Targeted messages used around diet and exercise mainly. Lay health advisor role and a small amount of advocacy work.
Funding mechanism	PCT funding
Evaluation results	For the period January to August 2006 there were a total of 388 contacts (by 70 clients) made between 5 health trainers, totalling 129 episodes. For HT1, there were 53 episodes of more than one consultation, and 67.9% saw an overall improvement. For HT2 this was 3 episodes of more than one consultation and 33% saw an overall improvement; for HT3 this was 4 episodes with 75% showing an improvement. For the remaining two health trainers, there were only 2 episodes of greater than one consultation recorded, of this one had no code and another saw no change.
What worked well	Targeting the hard-to-reach communities straight away meant that health trainers felt they were making a difference. The health trainers improved in their self-confidence.
Concerns	Need to have a nationally recognised qualification at NVQ level. Ensure that training is on-going and not one-off. Recruitment process demonstrated that community members felt threatened by formal set-up. Difficult to recruit males. Paperwork can be overwhelming for health trainers. Ongoing commitment from the PCT for funding.

South East Essex PCT

Health Trainer lead	Dr Andrea Atherton, Director of Public Health, South East Essex PCT
E-mail address	andrea.atherton@see-pct.nhs.uk
Contact phone number	01702 224648
Stage	No health trainers currently, but considering the role
Number of health trainers in post at July 2007	0
Background of health trainers	N/A
Recruitment process	N/A
Target groups	N/A
Training	N/A
Accreditation	N/A
Model used	Likely to be using a combination of 1:1, group and community work. Generic messages and a lay health

	advisor/peer educator role.
Funding mechanism	N/A
Evaluation results	N/A
What worked well	N/A
Concerns	Limited capacity, but being addressed.

South West Essex Teaching PCT

Health Trainer lead	No information available
E-mail address	N/A
Contact phone number	N/A
Stage	N/A
Number of health trainers in post at July 2007	?
Background of health trainers	N/A
Recruitment process	N/A
Target groups	N/A
Training	N/A
Accreditation	N/A
Model used	N/A
Funding mechanism	N/A
Evaluation results	N/A
What worked well	N/A
Concerns	N/A

Suffolk PCT

Health Trainer lead	Sally Hogg, Head of Health Improvement Partnerships, Suffolk PCT
E-mail address	Sally.Hogg@suffolkpct.nhs.uk
Contact phone number	01473 770122
Stage	No health trainers but considering the service
Number of health trainers in post at July 2007	0
Background of health trainers	N/A
Recruitment process	N/A
Target groups	N/A
Training	N/A
Accreditation	N/A
Model used	N/A
Funding mechanism	N/A
Evaluation results	N/A
What worked well	N/A
Concerns	N/A

West Essex PCT

Health Trainer lead	Helen Dear, Health Improvement Specialist, West Essex PCT
E-mail address	Helen.Dear@WestEssexPct.nhs.uk
Contact phone number	01279 694733
Stage	Service delivery phase: 17 months

Number of health trainers in post at July 2007	1 (AfC band 3)
Background of health trainers	Not known.
Recruitment process	Recruited using the local newspapers. 5 health trainers recruited in total, with preference for those who had experience of working with people
Target groups	Currently receive referrals from health professionals, but would like to work within more deprived wards, and with those with the worst health outcomes.
Training	3 month in-house training, modules in: Introduction to public health and health promotion; health behaviour change; motivating clients to change their behaviour; communication, assertiveness and conflict management; personal safety for lone workers; locality working and practicalities of the role; stop smoking training: level 1 training; physical activity training; overview of mental health; assessing risk in mental health; mental health and well-being health trainer specific training; sexual health awareness; healthy eating and 5-a-day; alcohol and drugs awareness; parenting and parent support; case studies; mandatory training (fire training, manual handling, what governs you?)
Accreditation	Nil (except for level 1 smoking cessation training)
Model used	1:1 model Generic messages Lay health advisor/community development role
Funding mechanism	Department of Health funding, applying for Big Lottery funding in future
Evaluation results	Awaiting input of data onto database for evaluation of health trainer activity.
What worked well	The pay banding needs to be at least AfC Band 3 to retain health trainers due to the level of responsibility required.
Concerns	The health trainer role has a lot of responsibility it is not just about giving information and signposting and supporting people to make changes. It's about knowledge and awareness of boundaries of the role, knowing when to refer on, knowing when to get help, upholding various PCT policies as well as trying to form a rapport with the client. A small number of hours and the fragmented nature of the role can be a disadvantage to the health trainer. Being paid on an ad hoc basis for the clients that are seen and the promotional work that is done can be problematic. For example the time taken to organise childcare to cover the period worked and the cost of travelling to and from various venues can be more in terms of the cost/time spent than what is earned. Having no permanent base means that much of the ground work has to be done at home or out when doing a clinic, where all the appropriate resources may not be available. To improve sustainability, ongoing recruitment and training is needed. There is a need to have a person in the PCT dedicated to managing and co-ordinating the health trainers.

West Hertfordshire PCT

Health Trainer lead	Dr Joel Bonnet, Consultant in Public Health, West Herts and East and North Herts PCTs
E-mail address	joel.bonnet@herts-pcts.nhs.uk
Contact phone number	01923 281650
Stage	No health trainers and not considering developing the role at the moment.
Number of health trainers in post at July 2007	0
Background of health trainers	N/A
Recruitment process	N/A
Target groups	N/A
Training	N/A
Accreditation	N/A
Model used	N/A
Funding mechanism	N/A
Evaluation results	N/A
What worked well	N/A
Concerns	Lack of resources (financial and other) to enable the success of the venture.

5. Summary

Of the 14 PCTs in the East of England:

- 7 PCTs have health trainers, making a total of 89 health trainers, as at July 2007. Of these: 3 PCTs are paying their health trainers between AfC Band 3 and Band 5; 2 PCTs are using volunteers, 1 PCT is using frontline staff and 1 PCT is using a combination of payment (AfC Band 2) and staff in existing roles.
- 6 PCTs currently have no health trainers, but four are considering the role.
- There is no information available from 1 PCT.

The background of health trainers varies from those with no qualifications to one person with a degree.

Of the 7 PCTs with health trainers, the groups aimed to recruit from include:

- Volunteers/third party agencies/existing roles: 4 PCTs
- Local priority neighbourhoods/deprived wards: 2 PCTs
- General community: 2 PCTs
- Young people/schools: 2 PCTs
- BME groups: 1 PCT
- Young mothers: 1 PCT
- Community groups: 1 PCT
- Service users: 1 PCT

Of the PCTs with health trainers, target groups include:

- Disadvantaged groups: 4 PCTs

- Service users: 2 PCTs
- Young people: 2 PCTs
- Medical problem/risk factor present: 2 PCTs
- BME groups: 1 PCT
- Referral from health professional: 1 PCT

Of the PCTs with health trainers, training/accreditation has been:

- In-house training for 4 PCTs
- Modular with certificates for 1 PCT
- OCN Level II for 1 PCT
- Open University for 1 PCT

A variety of health trainer models have been used. They all include a group or community component, apart from 1 PCT using a 1:1 approach.

Funding mechanisms for PCTs with health trainers:

- Department of Health: 3 PCTs
- PCT/NHS: 3 PCTs
- Time-in-kind: 2 PCTs
- Neighbourhood Renewal Funding: 1 PCT
- Healthy Living Solutions/ Big Lottery Funding: 1 PCT
- Interaction Partnerships/Neighbourhood Regeneration funding: 1 PCT

Evaluations:

- Completed evaluation on health trainer outcomes: 1 PCT
- Plan to or are in the process of evaluating health trainer outcomes: 4 PCTs
- Evaluated training: 2 PCTs
- Considering evaluation: 1 PCT

What worked well?

- Local people identifying priorities
- Setting up service to meet the demands of the community
- Targeting deprived areas straight away
- Embedding health trainers into local community partnerships
- Health trainers opening doors for other services
- Development of a ‘Choices game’ that discussed the implications of choices that people make at different times in their lives
- ‘Speed dating’ session on introductions to other services
- Producing key messages
- Introducing health trainer concept to local authority managers first
- One day training was better than half-day

- Setting targets for health trainers on number of people and number of partners engaged
- Non-judgemental attitude
- Having a dedicated co-ordinator
- Clear process for child protection issues
- Paying health trainers at least AfC Band 3

Concerns:

- Barriers to recruitment included: explaining the health trainer concept and how it fits into day-to-day work; knowing what the expectations of the health trainers are; funding for paid workers and establishment of credibility amongst health and social care professionals.
- Poor recruitment response from BME groups and males.
- Onerous to collect data on clients, particularly when not paid
- Support for health trainers is intensive requiring 1:1 supervision, which has implications for capacity and resources: they need to be fully supported.
- At the time of developing the health trainer role there was no national guidance available
- Need to have a nationally recognised qualification
- Funding
- Need someone to champion the cause
- Need for top level sign-up/commitment from the PCT
- Need to ensure the right managers and then the relevant staff are on the training
- Needs to be placed in the Local Authority as part of the Healthy Communities agenda
- Health trainer role has a lot of responsibility
- Paying health trainers on an ad hoc basis is problematic
- The length of time it takes to train health trainers
- Need to ensure that training is on-going and not one off
- Having no permanent base makes the ground work more difficult
- Ongoing recruitment and retention is needed

6. Conclusion

The health trainer concept is embedded in the reduction of health inequalities agenda, both regionally and nationally. There is also an evidence base for the effectiveness of the health trainer intervention, dependent on the model used and the health subject. National training and accreditation is available, as is funding in baseline PCT allocations.

Following a survey across the East of England, it was found that 7 of 14 PCTs had health trainers, totalling 89 health trainers as at July 2007. The

PCTs were split equally between paying a salary or not paying a salary for their health trainer service. The background of health trainers varied considerably between those with no qualifications to one person with a degree. The majority of PCTs recruited from volunteers/third parties agencies/those in existing roles. Only two PCTs targeted deprived wards during the recruitment process. The majority of PCTs targeted disadvantaged groups. Training was mainly in-house, although 2 PCTs received accreditation for their courses through external organisations. A variety of models were used and they all include a group or community component, apart from 1 PCT using only 1:1 work. 3 PCTs are full or part-funding their health trainer programme, the rest used funding from the Department of Health or external sources. One PCT has completed an evaluation on outcomes of their health trainer service thus far. There is a series of lessons to be learnt from PCTs currently implementing a health trainer service.

Of the remaining PCTs, there was no information on health trainers from one PCT, four are considering the health trainer service and two are not prioritising the service at present.

7. Recommendations

1. To support PCTs, Local Authorities, prisons and other agencies without health trainers to promote their introduction.
2. To support areas to use PCT baseline allocation/alternative funding sources for health trainers.
3. To provide a consistent regional training package.
4. To share lessons learnt from areas with health trainers.
5. To ensure that health trainers receive national accreditation where possible.
6. To support local evaluation.

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