New beginnings: stakeholder perspectives on the role of health trainers
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What is This?
New beginnings: stakeholder perspectives on the role of health trainers

INTRODUCTION

One of the most interesting and innovative developments in recent public health policy has been the introduction of health trainers. First proposed in Choosing Health1 as a new type of health worker, health trainers have a role in supporting individuals to make healthier lifestyle choices. A key feature of the proposed model was that health trainers should be recruited from local communities, able to relate to common concerns:

In touch with the realities of the lives of the people they work with and with a shared stake in improving the health of the communities that they live in, health trainers will be friendly, approachable, understanding and supportive. Offering practical advice and good connections into the services and support locally, they will become an essential common sense resource in the community to help out with health choices.1 (p.103)

The national Health Trainer Programme was launched in 2005 and a draft national competency framework was developed by Skills for Health.2 Initially, 12 early adopter sites were chosen to

Abstract

Aims: First proposed in the 2004 White Paper Choosing Health, health trainers are a new addition to the public health workforce. Health trainers are recruited from local communities and provide support to enable individuals to adopt healthy lifestyles. The aim of this paper is to examine the emerging role of the health trainer in the context of one of the twelve early adopter programmes. The paper describes the support and signposting model developed in Bradford.

Methods: An evaluation of the pilot scheme was undertaken using both quantitative and qualitative methods. The paper draws on two pieces of qualitative data from the evaluation. Two focus groups were held with 15 health trainers in their first months of practice. Telephone interviews were held with a sample of 16 key informants from community based placement organizations. Thematic analysis of the data was undertaken.

Results: The new health trainers were very clear about their role in listening and giving support. Clients presented with a diverse range of needs and often had complex problems. The health trainers perceived that a client-centred approach was of value but there were some issues about the boundaries of appropriate advice. Outreach and networking were considered important skills. In the telephone interviews, interviewees understood the health trainer role and identified potential benefits for service users. The significance of health trainers having local knowledge was highlighted, although some organizations were able to assist with networking. The health trainer programme was seen as an additional and distinct resource complementing existing provision.

Conclusion: The new role of health trainer is a significant development for the public health workforce. Health trainers can offer something quite distinctive and separate from professional advice, and there is potential to help individuals to access support and services in local communities. More research is needed on the relative value of different models of health trainer.
The new role of health trainer has generated much interest and discussion in the health promotion field. The national programme has been a high-profile programme and key features of the model. Section describes the Bradford district programme and key features of the model.

BRADFORD DISTRICT HEALTH TRAINEE PROGRAMME

In 2005, Bradford became one of the 12 early adopter sites to develop a service model. A multi agency Partnership board oversaw the development of the programme and Bradford District Health Development Partnerships, a district-wide health improvement service, had responsibility for developing the training course, programme implementation and supervision of health trainers. The local programme was intended to build on previous community-based work, including the experience of delivering two longstanding and successful health promotion courses for community members. The Bradford health trainer programme adopted a ‘support and signposting’ approach based on core values of addressing inequality and empowering people to improve their health, reflecting the aims of the national programme. The model has the following features:

- Health trainers enable clients to address issues and find their own solutions and do not give health advice.
- Health trainers signpost people to appropriate local services and can accompany clients to other health improvement services.

The first cohort of 21 health trainers, 16 women and five men, were recruited in October 2005. In terms of ethnic profile, 11 were White British, seven were Asian British/Asian Pakistani and three were from Black or mixed background. The recruits attended a 15-day training course, which was based on the Skills for Health2 competencies and later accredited with the Open College Network. From January 2006, health trainers were placed in different host organizations, working on a part-time, sessional basis. Placements were distributed across different localities targeting those communities – both geographical and communities of interest – with the greatest need. A formative evaluation was undertaken in the early stages of the programme, with the aims of providing feedback on the development of the pilot programme and identifying early outcomes. The next section describes the evaluation methodology and methods for gathering evidence.

METHODOLOGY

The evaluation examined both process and outcomes in relation to the pilot programme. The stage of programme development and the requirement for initial results to inform subsequent planning influenced the evaluation approach and design, as did the desire to obtain the perspectives of a range of stakeholders.

Using a theory based approach11 allowed the assumptions underpinning the programme to be tested. An evaluation framework was developed and indicators of success selected around four core elements: the recruitment, training and support of the health trainers; referral processes; individual case work with clients; and the provision of support from the Partnership. The overall evaluation included a number of distinct pieces of data collection, both quantitative and qualitative, to ensure a broad view of the programme. The training element was evaluated.
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Qualitative analysis was carried out by two researchers to validate emerging findings. All qualitative data (transcripts and notes) were coded and themes identified independently. Themes were then organized into categories and sub categories, some drawn from the evaluation framework. This paper presents findings relating to the role of the health trainer; data on client outcomes are reported elsewhere. Quotations are not attributed in order to protect anonymity.

FINDINGS: FOCUS GROUPS

Fifteen health trainers participated in two focus groups. Participants were working in a range of placements and all but three had experience of working with clients.

Role

The participants were asked to discuss their role. Overall there was a high level of clarity amongst the new trainers about the support and signposting model adopted in Bradford. They were able to articulate the different dimensions of the role and thematic analysis identified six core actions: listening, supporting, empathising, helping empower clients, giving client confidence and signposting. Some described how their original expectations had changed, as illustrated by this quotation:

I thought it might be more to do with an advising role, rather than just listening and supporting, but once you started doing the training you realized that you’re not allowed to advise your clients, just really to support them and give them direction. (F1.3)

In describing their role, health trainers emphasized the importance of being client centred. They perceived the health trainer role to be very different from a clinical role where health information, including more specialist advice, would be given. Some chose to emphasize this aspect to clients:

I tell them I’m not a health professional, I don’t even know how to count my calories, but I’ll help support you and if you need assistance then I can signpost you. (F2.1)

Notwithstanding agreement on the nature of the role, it was reported that there was sometimes a tension between giving support and the potential to give advice. This was compounded where clients’ expectations were of a motivational ‘trainer’. For some, the boundary of the role was something they consciously considered in practice:

You have to think, we’re only here to listen, we’re not here to give advice. ‘Cause that’s always going on in the back of my head, I want to give them the chance to speak and, you know, feel that they are in control, not me. I don’t want to over-take. (F1.4)

Providing support was seen as central to the health trainer role and was related to client needs. Participants’ experiences as lay people and the sharing of common concerns were also discussed as illustrated by this exchange:

None of us are experienced, well I haven’t got no qualifications, nobody else here has, we are just normal people within the community that are there to support other people within our communities which is why we were picked to do this role. (F2.4)

I think sometimes people just need that extra support. (F2.1)

They just need somebody to listen. (F2.7)

Explanation about the programme was seen as important, both to clients and health professionals. It was reported that there was misunderstanding by some clients about the name ‘health trainer’. There was also some concern about health trainers overlapping with other community health work: “it’s quite difficult trying to distinguish what we do compared to what other people do” (F2.7). It was perceived that some health professionals felt threatened by health trainers. This was due to misconceptions and a lack of clarity about role and remit:

People like health visitors and practice nurses seem to think we are there to take over their job, whereas we’re only really there to give them support, to help them really. (F2.5)
Working as a health trainer

Participants were asked to discuss their early experiences in practice. One strong theme was the diversity of client needs. While many clients were reported as attending for reasons such as weight loss, exercise and other aspects of physical health, mental health and social needs also featured prominently. Participants reported clients facing social isolation, anxiety and bereavement. The diversity of need could be challenging, one health trainer commented: ‘you get scared in your role … you don’t know what the needs of the people are going to be’ (F1.2). Clients frequently had multiple and complex needs which would often be revealed in the course of the appointments:

They want to have a healthy lifestyle, but when you get to the root of the problem it’s emotional as well, they don’t have no support … there’s more than one problem. (F2.4)

This complexity meant that it was sometimes difficult to identify just one issue to address and clients required different periods of support. In addition, many clients were perceived to lack confidence and have low self esteem. Despite being very new to practice, health trainers were able to describe examples of where they were able to support clients to make behaviour changes or progress towards goals. Where clients lacked confidence, health trainers were able to provide appropriate support:

... most of them have real low, very low self esteem and confidence levels and you need to build that up and the group wouldn’t have given them that, wouldn’t let them express how they felt. I think the more you see them, the more they get that trust, the more they open up and tell you more so you can help signpost them. (F1.2)

I had a client who kept on cancelling ‘cause she did not have the confidence to come. So we met at a zebra crossing and I walked with her to the centre. There’s a community centre near her house but she did not even know it existed, five minutes away. (F2.3)

Sometimes there was a ripple effect:

And you know, I’ve just seen this young girl take off with it. And it is small steps that she made like wanting to eat healthier and also to walk. And I think, the older members of the staff, seeing someone young like that doing it, has really encouraged them to you know walk to Morrisons for their dinner and walk back again. (F1.4)

The importance of flexibility and working at the pace of a client was emphasized:

Every client’s different, so I think you’ve got to deal with each client individually and I think each one comes up with different things that you’ve got to deal with. (F2.5)

The support given by health trainers with community languages was seen as positive for women from the Asian community:

The communities we are working in now, they are really excited about it, that we’re there. Because we’re working in deprived areas of the Asian community as well, and they’re really excited that somebody is actually there to listen to them, to support them. So they quite appreciate why you are there. (F2.4)

Some participants reported that clients had little knowledge of alternative services, and therefore health trainers had a role in facilitating access to local services and community groups. However, the signposting role was not always successful where there was a lack of amenities or appropriate services.

One significant theme related to expectations around the potential for change. Participants discussed the value of supporting clients taking small steps towards behaviour change, for example, small changes in diet. There was a high level of awareness of the balance between helping empower clients and the need for supporting those who lacked confidence. Overall there was consensus that control should lie with the client:

You’re there to help and support them but it’s up to them to actually do the work. (F1.6)

There was acknowledgement that a proportion of clients wanted a more directive approach, with the responsibility for delivery resting with the health trainer:

Several of my clients are expecting a miracle worker. They see a health trainer and I think they expect to see a set programme which will reduce their weight in two months or two weeks and they’ll be cured, and we’ll do the work for them. (F1.7)

Another theme raised in the focus groups was the challenge of attracting clients, including men. Assumptions that clients would be there waiting for them when they started were not realized and this had led to frustrations. While this may be a feature of the early stage of programme development, more general issues around the importance of promotion and outreach were discussed. Some believed that actively contacting people and promoting the service needed to be an integral part of the role:

It’s making the contacts somehow, getting into the community, getting where the people meet in the community, talking to groups. (F1.7)

I feel that community development is alongside this post, you have to keep it going, make people aware, go to meetings that are advertised when you are working. (F5.1)

FINDINGS: PLACEMENT ORGANIZATIONS

As an early adopter site, there was a decision to pilot the programme in a range of settings. A sample of 16 contacts from placement organizations were interviewed (see Table 1). All the interviewees had experience of one or more health trainers working within their organization. Three organizations had ‘linked appointments’ where the health trainer was also an employee. The extent of contact with the health trainer in the organizations varied. Some interviewees described having infrequent contact while others regularly met the health trainer to review progress or manage referrals.

Hosting health trainers

The interviewees were asked to reflect on their experience of hosting health trainers.
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Whilst the existence of local knowledge was evidently significant, there were examples where placement organizations facilitated introductions and overcame barriers, as illustrated by these quotations:

We did not do a formal induction, we invited her to a few of our events so she could meet a good cross-section of people with learning disabilities. And she knows everybody here now by first names and they’ll come in and chat to her. (T14)

Because she came from a different area, it could have been difficult for her to engage in the local communities but because of the links that we have we took her out to the major organizations. (T12)

Relationships and roles

Interviewees were asked to describe the role of a health trainer. All the interviewees had a clear understanding of the role as offering one-to-one support. Other aspects highlighted were motivating and supporting health behaviour change, a listening role for people with problems and signposting to community resources, information and services. There were some concerns expressed by a minority of interviewees over the nature of the role and the lack of formal qualifications.

Interviewees identified benefits for clients in terms of having improved access to services, raising awareness of health issues and, more generally, health improvement. Another theme was the value of employing people from the local community. One interviewee discussed health trainers being seen as role models, thereby highlighting opportunities for local people to get involved in health work:

A lot of people in the community believe that to go into health you either have to be a doctor or a nurse. So the opportunities are there now for people to get in. (T12)

Interviewees were asked to consider how health trainers fitted with the work taking place in their organization. Responses indicated the significance of health trainers as an additional service which could complement existing provision. Many of the interviewees saw the health trainer programme as fitting with their organizational goals and therefore something that could be easily incorporated in the mainstream business. One interviewee from a Healthy Living Initiative said:

The reason we got involved was because of the nature of the work we were doing – which is health promotion – looking at issues of healthy living and how to add value to the existing services we were providing rather than overlapping. (T12)

The role of health trainers in working one-to-one with clients was particularly valued by some community-based organizations where the focus was more often on group work. In general practice, the health trainers programme was seen to fit with the Expert Patient Programme as well as to complement what clinical staff could offer. One general practice manager expressed an aspiration that there would be a decrease in the number of consultations and time spent with health care professionals as a result of receiving support from a health trainer.

For most interviewees, having an additional resource was seen as complementing their organization's current remit and responsibilities. The potential for mutual referrals and signposting was recognized. In one of the Extended Schools, the health trainer had led to improved service utilization:

There are some people who wouldn’t normally come to our school who have been coming in for the past few weeks. I have seen people that don’t have any children at this school that have been accessing the classes. Sometimes because they don’t have the confidence the health trainer has accompanied them for the first time and the second if necessary. (T13)

For some, however, there was a risk of duplication and role confusion. One interviewee expressed concern about the whole concept of the programme:

Well just the fact that it’s very hard when you’re doing a job that’s similar. It’s like someone comes up with (what) they

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Table 1

<table>
<thead>
<tr>
<th>Placement organizations participating in telephone interviews</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP surgeries/health centres</td>
<td>4</td>
</tr>
<tr>
<td>Extended schools</td>
<td>3</td>
</tr>
<tr>
<td>Sure Start</td>
<td>1</td>
</tr>
<tr>
<td>Healthy Living Initiatives</td>
<td>5</td>
</tr>
<tr>
<td>Support Centres (voluntary and social services)</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>16</strong></td>
</tr>
</tbody>
</table>
think is this super-duper scheme that has been going on for years. And I find that very difficult, there’s a duplication of services. (T9)

DISCUSSION
The aim of this paper has been to explore the health trainer role in the context of one of the early adopter sites. The two sets of findings presented here provide very differing perspectives. The first set of findings illuminates the personal experience of individuals purposively recruited for their lay rather than professional experience. The other set of participants represents different types of health and social care organizations, for whom health trainers were additional to the mainstream work. Some strong themes have emerged and this section discusses the significance of the findings in relation to the development of a new public health role. Prior to this, the limitations of the research are identified.

The original purpose of the evaluation was to provide formative feedback on the development and effectiveness of a new local programme. This undoubtedly limits the transferability of the findings, particularly in light of the range of different models developing across the country. The evaluation attempted to make a comprehensive assessment, including obtaining the views of a broad range of stakeholders, but this limited in-depth exploration of issues. This tension between depth and breadth is one that is common in evaluation.13 There may have been under-reporting of negative aspects because of the political and social context of the evaluation, including the collaboration between university and programme leads.18 One factor which may further limit the transferability was the professional and personal development of the health trainers as interviews later in the programme life may yield very different results. Considering the diffusion of innovations,19 the perspectives of the first cohort of health trainers and early adopter placement organizations are likely to differ from the perspectives of those involved as the programme is mainstreamed.

There was no blueprint for the introduction of the health trainer programme in local areas, although the underlying approach was defined in national policy. The findings presented here show that a distinctive model of individualized, client-led support in the community was created. There was considerable clarity within the health trainer cohort about the nature of their role. Notwithstanding expectations from some quarters of a more motivational trainer, the new role was perceived to be relevant and acceptable by different stakeholders. The client-centred nature of the approach, based on supporting individual choice, fits with the current public health policy agenda.20 The white paper Our health, our care, our say21 proposed that health trainers would be linked to NHS life checks for individuals at key stages of their lives. While some have critiqued the perceived shift from collective action,22 the findings show health trainers were using an empowerment approach. This matches Jones’ concept of an ‘empowering face-to-face encounter’ with its core processes of communication, facilitating decision-making and providing support.22 It is notable that health trainers were working with individuals presenting with a range of health and social needs. However, the findings highlighted dilemmas around the boundaries of the role in relation to advice and support, particularly when there were client expectations for greater direction. There are therefore clear issues for clinical governance, supervision and professional support.

The national model for health trainers was of a ‘person next door’ improving health in their own communities.1 In Bradford, the emphasis was on matching health trainers to client groups but not necessarily in their own residential area. The concept ‘lay’ and the complexity of the relationship between such workers and their constituent communities needs to be interrogated. It is too early to judge if the model works best as local neighbourhood support or as a more generic lay-led (non-professional) approach. Just under half of the health trainers were from Black or Asian communities, including some health trainers with bilingual skills who were able to provide valuable support. This would support other research on link workers.23 Local knowledge was found to be a significant facilitating factor, although local organizations could bridge the ‘gap’. There are wider debates about the nature of community health workers and factors that increase effectiveness.24 Nemcek and Sabatier25 point to the value of community health workers who are ‘culturally sensitive and possess strong community rapport’, while a UK health trainer scheme for childhood obesity found that selection on the basis of personal qualities and community skills was effective.26 In conclusion, assumptions about recruitment strategies need to be made transparent and more research is needed on what qualities are required for health trainers to work effectively with disadvantaged communities.

One theme to emerge was the need for the health trainer role to encompass promotion and networking. The extent to which health trainers need have community development skills has been the point of discussion nationally.27 A minority of those interviewed viewed this as a fundamental weakness of the programme. Certainly there is some evidence that such skills are needed and may improve the reach of the programme. In Bradford, a senior health trainer role has been introduced whereby those with enhanced community skills can support health trainers. Skill mix is a complex issue, because requirements for specific skills or qualifications may counter the drive to recruit people without prior experience in order to build capacity in public health. It is notable that just under half of the Bradford cohort were not in employment when recruited. This reflects the aspirations of the national Health Trainer Programme for不合格 people to gain skills and enter the public health workforce.1 The majority of recruits have continued to work as health trainers, although two have moved on to take up other positions. This move to new roles can be seen as a positive outcome and fits with the notion of a skills escalator.4 The evaluation raised questions about where health trainers fit in relation to the broad spectrum of health and social organizations involved in public health. Community and voluntary organizations also offer individualized support, for example through befriending schemes. There are also questions around how methods supporting behaviour change can fit within initiatives aimed at tackling the wider determinants of health.27–29 In the Bradford evaluation, two models were identified from the thematic analysis: a jigsaw model, where health trainers are seen...
as one piece in a whole picture of health improvement resources; and an overlap model, where the risk was of duplication with existing provision. Health trainers can offer one-to-one support in the context of community health programmes and partnerships, a strength which was acknowledged by interviewees. A further theme was the significance of providing essential support for individuals lacking confidence to access services. The health trainer programme should therefore be seen as an addition, not an alternative, to large scale structural and environmental interventions.27,29 There are inevitably wider questions about the cost effectiveness of such intensive support which need to be answered by further evaluation research.

CONCLUSION
The introduction of health trainers represents an expansion of the public health workforce. The whole national programme is in its infancy and the shape and scope of the service is still being developed. What this paper has done is explore what that new role of health trainer might look like and how it can fit with existing provision. But not without controversy: some feared health trainers represented a backward step to individualized health education. The evaluation of the Bradford health trainers programme has shown alternative, client-led models can be developed. Findings indicate that health trainers, as front line public health workers, can offer much needed one-to-one support in disadvantaged communities. This has huge implications for public health practice and education. One of the most significant features of the new programme concerns the qualities health trainers bring as non-professionals, offering empathy and support to people in their own or similar communities. It is this aspect that may yet prove to be of most value in addressing health inequalities at a micro level, but there needs to be wider debate on the assumptions about delivering ‘support next door’.

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