

Obesity – working with local communities. The contribution of health trainers, community health champions and the general public.

Introduction

This paper aims to provide a summary of how health trainers, community health champions and those in other lay health worker roles, are engaging with communities in ways which are preventing and reducing obesity at a local level. There is a growing body of evidence on how lay engagement can contribute to improved health outcomes (South et al 2010, Yorkshire and Humber Health Trainers 2011, White et al 2010) but the focus here is on process ie what do successful programmes do which enables them to engage lay people in improving health? The paper draws on research and evaluation conducted by the Centre for Health Promotion Research at Leeds Met University over the last few years – in particular a recent study funded by the National Institute for Health Research called ‘People in Public Health’ which looked into the role of volunteers in health improvement programmes (South et al 2010), on six evaluations of local health trainer services carried out over the last five years (see list under references), and on an evidence review and evaluation of Altogether Better, a community health champion programme in Yorkshire and Humber. (South et al 2010, White et al 2010) None of these programmes had a specific focus on obesity but healthy eating, weight management and physical activity are central to all of them and the lessons learnt about how to work effectively with local communities apply, whatever the focus.

A brief overview of the key findings of the Centre’s studies of health trainers, community health champions and ‘people in public health’ in relation to process is set out below, followed by a summary of our conclusions re the essential elements needed to engage communities, build effective local partnerships and make a difference to health outcomes and health inequalities.

Health trainers

Health trainers were introduced in ‘Choosing Health’ (DH 2004). They should be drawn from local communities and aim to provide ‘support from next door rather than advice from on high’ and contribute to reducing health inequalities by working with disadvantaged communities. Central to the health trainer role is one to one support for people who want to make changes. Some health trainers are based in GP practices and rely on referrals but many are community based and are expected to ‘make relationships with communities’ (DH 2008) rather than rely on people coming to them. To do this health trainers have to get to know a community, including the organisations and informal networks that operate within it, as well as the community members themselves. Health trainers need to be flexible in how they do this in order to engage effectively. Their work might include:

- establishing a community base somewhere accessible, in order to be available and build up trust with the client group (eg libraries, pharmacies, housing offices, Sure Start centres, community centres)
- engaging with clients whilst they are using other services (eg GPs, mental health drop-in, stroke clubs)
- outreach work, including door knocking in order to make direct contact with people
- operating an informal drop-in session where individuals can access health trainers but are not committed to making appointments
- being available at venues / places / events to make contact with target communities (eg football/rugby matches, working men’s clubs, cafes, agricultural settings, schools, supermarkets, outdoor locations that the community uses)

- building up an information base of health promoting activities and support agencies to 'signpost' people on to
 - accompanying individuals or groups of clients to events and activities that promote their health and wellbeing (eg cook and eat session, walking group) and setting up activities where none exist.
- (Mitchell et al 2010)

The majority (58%) of health trainers come from the 40% of the population living in the areas of most deprivation (BPCSSA 2011) and many have the same background as the people they are working with – for example health trainers from a gypsy and traveller background and ex offenders have been recruited to work with those communities (Yorkshire and Humber Health Trainers 2011). Peer approaches have been shown to achieve good results in terms of behaviour change and to be popular with patients. (Bailey et al 2005, Brownstein 2007, South, Meah et al 2010) This is echoed by local evaluations in which clients repeatedly said that they found it easier to talk to 'someone like them', someone 'normal' who had time to listen rather than take up the time of a nurse or doctor (see list in references)

The case studies in boxes 1 and 2 provide illustrations of how health trainers are working.

Box 1: North Lincolnshire – establishing the service in disadvantaged areas

In North Lincolnshire, 19% of the population live in areas ranked amongst the poorest fifth in the country and the gap between the rich and poor continues to increase. In 2009/10 additional funding for the Health Trainer Service was targeted at the five poorest wards in Scunthorpe and within these wards, those out of work (especially men) and black, Asian and minority ethnic (BAME) communities previously identified as having poor rates of service uptake. Health Trainers were allocated to a geographical area within the town and engaged with the communities through outreach work such as chatting informally to people at schools, shopping centres, community groups, and by knocking on doors. People were more likely to be interested when they had met the health trainer they would be seeing and could self-refer into the service, so people were recruited who would never have responded to a poster or leaflet.

White et al 2010

Box 2: Portsmouth – group activities as a way of engaging new clients

The Portsmouth Health Trainer Service has been working with the Community Library Service to provide a Healthy Eating on a Budget course consisting of 5 x two-hour sessions. This was identified as a need in the local community and also a means of engaging with possible new clients for both services. The course is based on the Eatwell plate, portion sizes, food labelling / hidden foods and pricing and food hygiene. On the course, everyone completes a food diary each week to assess understanding and learning and highlight those in need of more support.

At the first session 12 people arrived of whom four were visually impaired (one with a hearing impairment too), one had had a stroke in the past six months, one had a mild learning disability and was unable to read any material from the Food Standards Agency while another disclosed an eating disorder. In other words, over half the group had immediate support issues and were offered signposting related to the general health issues that they raised. Two individuals who attended asked if visits could be made to their families to "show them the stuff" as well. By the end of the course, all 12 individuals had decided to work on individual personal health plans.

Mitchell et al 2010

Health trainers need to build relationships with local agencies and professionals as well as establish a good reputation with local people if they are going to be effective in working in the ways described above. In other words they need to work in partnership with a range of agencies and with the local community. Partnership work at the local level is often informal,

but some services have partnership boards which steer the work of the service and ensure it is integrated with what other agencies are doing. In Bradford for example, the health trainer early adopter programme was established by a steering group made up of a wide range of partners and this was found to be crucial to successful implementation. (South et al 2006)

People in Public Health

People in Public Health (PIPH) was a research study funded by the National Institute for Health Research (NIHR) which explored the ways in which people are engaging as volunteers to promote health in their communities. The focus was on the Choosing Health priorities, including reducing obesity and improving diet and nutrition. The study consisted of a literature review, three expert hearings and five in depth case studies. The study found that public are engaging in many and various ways in improving the health of their communities – see Box 3 for some examples.

Box 3: ways in which volunteers are working to support obesity prevention

- Providing health information and simple advice eg chatting to friends, family and neighbours
 - Raising awareness of health issues eg running an information stall at a community event
 - Improving skills eg running cook and eat sessions with parents and grandparents
 - Providing peer support eg befriending new recruits to a green gym
 - Promoting access to services or signposting eg using cultural and language skills to help women from minority ethnic groups get the right help in pregnancy and childbirth (including about diet)
 - Facilitating community groups eg running a breastfeeding support group
 - Supporting professional services eg welcoming people attending screening and weight management services
 - Organising and leading community-based activities eg leading health walks and exercise sessions
- South J et al 2010*

A key focus of the study was on process (what needs to be in place to enable volunteers to successfully engage) and hearing the voice of the volunteers themselves was prioritised - some provided expert testimony at the hearings and others were interviewed for the case studies. A particular effort was made to try and ensure that the study was informed by lay views throughout as is illustrated in Box 4.

Box 4: Engaging lay people in the People in Public Health Study

'To ensure that lay views were genuinely reflected in the study, practitioners from the PCT, who were then based in Bradford District Health Development Partnerships, led the initial public involvement work in the first year of the study. This involved a series of inclusive and interactive workshops with front-line practitioners and volunteers where the research team were able to engage interest in the study and harness ideas. The first workshop was held in December 2007 with staff from both public and voluntary sectors who were working directly with lay workers and volunteers. A further event was held in May 2008, which brought together people who were volunteering in community health activities or were active through patient and public involvement structures, along with some front-line practitioners. A number of geographical and communities of interest were represented, including the South Asian community and people living with long term conditions, all of whom were active in health promotion. Care was taken to organise the workshop in a way which put participants at their ease and enabled them to share their experiences and views in a relaxed setting.'

'Throughout the study, the research partnership has pioneered different ways of lay engagement in research, through the expert hearings, websites and registers, workshops and other participatory methods. This involvement has enriched the study and will hopefully influence dissemination of findings into practice.'

South et al 2010: 207 and 231

The study concluded that involving members of the public in the delivery of health improvement programmes is potentially a low cost way of increasing service capacity, but a level of investment is needed to build and sustain lay engagement. This should not be about imposing top-heavy organisational structures on grassroots activity. It should be about developing systems that are flexible and supportive. It should also be about having a wider infrastructure that actively addresses rather than erects barriers to lay engagement as is all too often the case. (South et al 2011) The study made several recommendations about how to successfully engage lay people:

1. **People should be at the heart of the system** – not an ‘add on’. Action needs to take place at all levels that values what people offer and puts this at the heart of planning, commissioning and service delivery. Lay people are a source of invaluable ‘community intelligence’, can act as a ‘bridge’ between professionals and people in disadvantaged communities, and provide input into service redesign.
2. **Barriers to recruitment need to be minimised**, particularly when working with groups that may experience social exclusion. Participants reported a range of barriers including lack of formal education, language and literacy barriers, extensive bureaucracy, CRB checks and fear of stigma, financial concerns and worry about the impact on welfare benefits. Informal recruitment methods, using community networks and word-of-mouth contacts, are likely to be more effective than formal recruitment processes. Critically for new recruits having a contact person who is able to give clear verbal information and support will help in navigating any barriers.
3. **A wide range of training and development opportunities should be offered.** Provider organisations need to create opportunities for people to ‘dip their toes in’; for example, through running taster courses on health. At the same time, training and development opportunities should be made available that allow people to extend and deepen their involvement. These actions will help ensure growth and sustainability by investing in both new and experienced volunteers.
4. **Training can increase confidence and enhance skills.** Training courses should be designed to enhance the confidence and natural helping skills of volunteers and lay health workers, as well as preparing them for their roles in delivering specific interventions. The value of life experience and the social, communication and language skills that people bring to the roles should be acknowledged. Finally if public services want to increase the scale and depth of participation, they should ensure that people get enjoyment and can benefit personally, as well as providing good support.
5. **It is critical to provide adequate and accessible support for people in these roles.** Provider organisations have important roles in supporting active citizens and need to have the capacity and skills to work effectively with the local community, along with expertise in managing volunteers or lay workers. Support and supervision by practitioners within local programmes was found to be essential for implementation. Access to ‘light touch’ support helps lay health workers and volunteers feel valued and offers a way to talk through problems as they arise.
6. **Services should decide on the best option for payment and rewards.** Consideration needs to be given to the pros and cons of different options around payment. Use of sessional payment was found to support engagement, particularly where people are facing financial hardship and it can help boost retention and aid service reliability. On the other hand, payment has costs, there may be equity issues as people take on different levels of responsibility, and it can potentially undermine

the ethos of volunteering. Receiving payment and expenses can be a worry for those on welfare benefits and this issue needs active management within local services.

7. **Risk can be managed through training and good support systems.** There are risks in handing over delivery to members of the public, just as there are risks leaving it in the hands of health professionals. It was found that risks can be successfully managed through providing induction and continuing development opportunities that equip people with the right knowledge and skills, and through having good support systems (including appropriate practice protocols) that involve both peers and practitioners.
8. **Commissioning should include funding the infrastructure to support people.** Commissioning should not be limited to funding a specific intervention but instead commissioning organisations should be prepared to fund training, development and support systems within provider organisations. This will result in members of the public who are well equipped and supported to do the tasks in hand, better retention and active management of any issues around role boundaries and quality assurance.

Altogether Better: a community health champion programme

Altogether Better is a five-year programme funded through the BIG Lottery that aims to empower people across the Yorkshire and Humber region to improve their own health and that of their families and their communities. The regional programme is made up of a learning network and sixteen projects with an emphasis on three themes: physical activity, healthy eating and mental health & well-being – all highly relevant to reducing obesity at a local level. Altogether Better is based on an empowerment approach (Woodall et al 2010)– equipping members of the public with the knowledge, confidence and skills to make a difference in their communities and workplaces. The Centre for Health Promotion Research conducted a thematic evaluation of the community health champion role and empowerment in 2010 (White et al 2010). The evaluation found that community health champions were involved in a huge range of activities relevant to obesity reduction, including: leading organised health walks, working in allotment and food growing initiatives, setting up social clubs and sports activities, delivering health awareness presentations on chronic conditions, signposting people to local services, establishing fruit ‘tuck shops’ in local schools and administering healthy heart check questionnaires. Although the focus of Altogether Better was on physical and mental health outcomes the evaluation found that champions were connecting people to groups and services and to support from other community members, helping, slowly and over time, to build healthy and cohesive communities. These wider benefits can be missed if evaluation focuses just on behavioural change outcomes. The evaluation concluded that there is a need to:

1. **Recognise the wider benefits of engaging champions** as outlined above
2. **Build opportunities for long-term support and networking-** vital if the benefits of projects are to be maintained after the initial training & support period has ended.
3. **Ensure training adequately supports roles.** Training needs to adequately prepare champions for their role but also enable them to progress and develop additional skills as those roles develop. It is at the heart of effective lay engagement as illustrated by the case story in Box 5.
4. **Commit to the long term.** Empowerment approaches may take a long time to lead to sustainable changes in communities which in turn lead to improvements in health.
5. **Consider the ‘business case’ for empowered communities.** Motivated, informed and skilled champions are a resource which the public sector as a whole could do more to support and harness as it seeks to explore different ways of delivering services. This is about co production, not volunteers replacing professionals.

Box 5: Training course to become a community health educator

Community health educators in Leeds do a 14 day course (10 – 2.30) for one day per week before getting involved in work in the community. 'The students can elect the health topics which have validity and meaning in their everyday lives. Ideas and experiences are shared and there are no text books. The course is designed to raise consciousness, increase confidence levels, health and employability. The course is informal, arts based and interactive. On the course students learn

- to be an effective health promoter, making people aware of the potential risks to their health and how to improve their health.
 - how to organise and run group activities.
 - about the health issues in their areas and how they can be improved.
 - how to examine issues about inclusion and how race, religion and culture influence people's attitudes.
 - how to find out what resources, services and networks are available to help them.'
- The course is accredited by the Open College Network and students can achieve up to 15 credits at level two. Most CHES go on to do further training and get involved in a wide variety of volunteer and paid work.

Hindley 2011

Essential elements of a local, community-wide approach to preventing obesity

The three programmes outlined above illustrate how to engage lay people and communities effectively – an essential element of a local community wide approach to preventing obesity.

The PIPH study recommendations set out what organisations need to do if they are serious about lay engagement – build engagement into the way their organisation operates, resource the infrastructure needed and provide high level support and leadership. All programmes which seek to engage lay people need this high level of organisational commitment if they are to be scaled up and effective.

The outline above of the way health trainers work in and with communities, illustrates the ways of working and skills that are needed to engage communities, plus the importance of local partnerships. The Altogether Better evaluation illustrates that if they are to engage effectively, individuals and communities need to be empowered which is a long term endeavour that can have much wider benefits than single issue programmes.

The motivation and commitment of programme staff, champions and volunteers is vital to effective lay engagement, but individuals will always be limited in what they can achieve if they do not have a supportive leadership and infrastructure. Programmes which involve people are often pioneered by highly driven individuals, but to really make a difference there also needs to be a 'whole system' approach with all parts of the system working in partnership towards agreed goals. So for example, if volunteers, champions and health trainers are motivating people to lose weight and/to be more active, then the environment they live in needs to make this possible – ie there need to be safe, green spaces to exercise in, accessible and affordable outlets to buy healthy food, courses which teach basic cookery skills, and healthy meals in schools, workplaces and hospitals. Health promotion evidence consistently supports the need for this sort of 'joined up' approach (Tones and Tilford 2001)

Unfortunately organisational upheaval and reductions in public spending are leading to some successful health improvement programmes being reduced or decommissioned plus

partnership work is often set back as people leave, or change positions - relationships suffer and organisational history and experience is lost. Lay health workers are making a difference to health outcomes (people are changing their behaviour) and people are being reached who would not normally access an obesity management programme. Plus through building community and organisational capacity, there is the potential to create supportive environments and cultural shifts which mean improvements in health can be sustained in the long term. In conclusion, there is a lot of good practice around community engagement which needs to be built on in order to ensure interventions to reduce obesity at a community level are as effective as possible.

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Useful Links

Health Trainers England: <http://www.healthtrainersengland.com>

People in Public Health: [People In Public Health final report](#)

Altogether Better: <http://www.altogetherbetter.org.uk>