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Lay educators in asthma self management: Reflections on their training and experiences☆

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Abstract

Objective: To capture the experiences and feelings of lay educators in an asthma self-management programme to aid understanding of optimal methods of recruitment, training and retention, and to enhance their value within the programme.

Methods: A multi site randomised controlled equivalence trial of asthma educators and primary care practice based nurses during which the educators were asked to keep a diary of their experience. A qualitative thematic analysis of these diaries was undertaken.

Results: Eight lay educators supplied diaries. From these diaries emerged personal reasons for involvement in the programme, constructive comments on the training programme, a need for preparation for the realities of clinical practice and significant ongoing support and training.

Conclusion: Lay educators are a potential resource for giving self-management education to patients with long-term conditions such as asthma. However, there are some considerations that need to be taken into account regarding contracts, retention and continual support.

Practice implications: Lay educators need a flexible but comprehensive training programme, contracts, on site mentoring and support. They seem most contented when welcomed by health professionals and treated as part of the team.

Keywords: Lay educators; Asthma; Reflections; Self-management

1. Introduction

There are 5.2 million people diagnosed with asthma in the UK [1]. The British Thoracic Society/Scottish Intercollegiate Guideline Network (BTS/SIGN) guidelines on asthma management recommend that those with asthma should receive self-management education [2]. In the UK much routine care of those with asthma is offered by primary care practice based nurses [3] A systematic review of 36 randomised controlled trials of self management education compared with usual care has shown benefit in terms of reduced rate of hospitalisation, need for unscheduled health care, night time waking and time off work or school [4]. Receiving a written personal asthma action plan has been shown to be an important part of such education [4]. Other reviews have determined the optimal content of action plans [5]. Despite this, one study [6] revealed that only 3% of patients had been given an asthma plan and another found 20% of patients had been provided with a plan but that 62% confirmed they would be willing to follow such an action plan [7]. Why such advice is not offered to patients is unclear, but if health professionals are pressurised by time and other constraints there is a need to evaluate alternative methods of delivering this aspect of respiratory care. This led to the hypothesis that a well-trained lay educator could give self-management education as effectively as a nurse.

The results of the overall study, a randomised controlled study involving 567 patients from two centres (London and Manchester), will be reported elsewhere; this report is concerned with the lay educators' reflection on their recruitment, training and work with those with asthma.

2. Methods

The intervention was a disease-specific asthma self-management education programme delivered either by a practice nurse or by a lay person. A total of 15 lay trainers

☆ *Disclaimer*: We confirm that all patient/personal identifiers have been removed or disguised so the patient/person(s) described are not identifiable and cannot be identified through the details of the story.

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were recruited by advertisement from London and Manchester, which were also the areas in which they were to work. Criteria for selection were that the trainer or a close relative had to have asthma. No minimum educational qualifications were stipulated. After recruitment, the lay persons underwent a two-day residential training course at the National Respiratory Training Centre (NRTC, now part of Education for Health) followed by a *6 week* distance learning programme. The learning objectives for training were: (1) to develop lay educators' asthma-related knowledge and experience; (2) to develop lay educators' consultation and practice skills (e.g. record keeping, confidentiality, etc.); (3) to build lay educators' confidence; and (4) to prepare lay educators for the realities of working in practice settings. This was followed by three reinforcing one-day training sessions, conducted locally and separately in the London and Manchester sites, on a group basis by a designated NRTC trainer. The NRTC training programme was followed by regular monthly mentoring meetings, providing opportunities for training, support and the answering of queries from clinicians and researchers involved in the study on both sites.

Recruitment of lay educators began on a rolling basis from July 2003 and their training began in December 2003. Our aim was for them to start working in practices early in 2004. However, owing to the time taken to receive research and clinical governance approvals and honorary contracts, it was not possible for the lay educators to begin working in practices until April 2004 at the earliest, and for some educators and some practices the gap was much longer (in some instances $>$12 months). From first contact regarding the study, the project team maintained regular contact with potential and actual lay educators, by means of phone calls, update letters, mentoring meetings and social events.

The lay educators were paid £8.00 h^{-1} (€11.98/$15.28), from which they paid their own tax, national insurance and travel expenses (this was the maximum sum which it was possible for the project team to negotiate). Each lay educator was allocated to several practices, with patient numbers in each practice ranging from 3 to 21. In London, the practices were all in multi-cultural West London and in Manchester, practices were in North, East, South and Central Manchester, most being in inner city, socially deprived areas. Each educator's involvement was intended to be from recruitment into the project until their last patient had completed follow-up (approximately 3 years). All lay educators were allocated to practices at which the nurses had received an asthma update and study-related training (nurses and lay educators were trained separately). Nurses received asthma-specific training from NRTC trainers and study-related training from project team members). In each practice, a designated contact person for the project team and lay educator was identified. This was usually the practice nurse, but sometimes also the practice manager.

Nurses and lay educators were asked to offer an initial consultation of up to 45 min for each patient, and to follow this with a second face-to-face reinforcing session of up to 30 min duration, three weeks after the first consultation. The lay educators' involvement with each patient was approximately 13 months (from initial face-to-face visit; face-to-face follow-up 3 weeks later then three monthly telephone follow-up for 12 months).

Using semi-structured data sheets, topics addressed during consultations included aetiology of asthma and the long term nature of the disease; asthma medications and their uses; asthma triggers and allergen avoidance; recognition of the signs of worsening asthma and appropriate action to take. A standard written asthma action plan template (adapted from one provided by the national asthma charity Asthma UK and in use in clinical practice at the London site) was provided for all educators in the study and this was individualised for each patient, advising them when to increase their routine preventative therapy, when to start a course of steroid tablets, and when to seek urgent medical attention. All lay educators were observed by a project team member undertaking at least one face-to-face consultation, for training and quality assurance purposes. The initial face-to-face consultations were followed by three monthly telephone follow-up to reinforce messages and to give ongoing advice.

The lay educators were asked to keep reflective diaries of their experiences regarding taking part in the project. They were provided with a blank A5 journal and asked to make regular entries reflecting on their feelings on first joining the programme, their training, commencing work as a lay educator and their experiences when engaging in this role. Written guidance, with exemplars, was also provided and the use of the reflective journals was discussed at mentoring meetings, with excerpts from the journals sometimes being used (subject to the lay educators being amenable to sharing the entries) to prompt or facilitate discussion at these meetings. Qualitative content analysis was undertaken, independently by two researchers. Subsequently, a more in depth thematic analysis, yielding six themes, took place [8].

3. Results

The details of the lay educators and their previous educational attainments are shown in Table 1 and Fig. 1. Of

Table 1
Demographic details of lay educators

Gender	No.
Male	3
Female	12
Ethnicity	**No.**
White British	11
White Other	1
Black African	1
Black Caribbean	1
Other (Filipino)	1
Age	**No.**
To 19	1
20–29	2
30–39	2
40–49	3
50–59	4
50–69	3

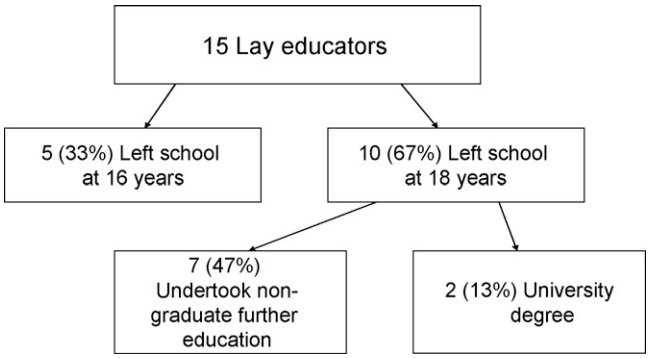

Fig. 1. Educational attainments of the lay educators recruited for the trial.

the 15 lay educators who were recruited, nine dropped out over the subsequent 22 months for health, personal or occupational reasons. Eight lay educators produced diaries, including one lay educator who subsequently withdrew before seeing patients. The major themes identified in the diaries concerned the lay persons' reasons for taking part in the study, their initial feelings on recruitment and during training and their experience with patients, consultations and primary care facilities. These are summarised in Box 1 and some core practical issues reported by the lay educators are shown in Box 2 and further addressed in the discussion. Data extracts have been anonymised using an identification code and demographic details are intentionally not presented to protect respondents' anonymity.

3.1. Reasons for taking part in the project

These were mostly altruistic, e.g.: wanting to 'give something back' especially from those who felt that they had received exemplary care from their hospital, nurses or doctors. Most possessed a desire to learn more about having and coping with asthma in order either to help themselves or their children to cope better with the illness on a daily basis. Some lay educators mentioned that the recruiter's enthusiasm persuaded them to take part. There was also a perception of the role being important.

> 'From my own experience I know how important it is to educate patients and welcomed the opportunity to be part of the project.' LE 8

Although the lay educators were paid a nominal sum, monetary reward was dismissed as an incentive to take part in the project; indeed few educators claimed all that was due to them.

3.2. Initial feelings on becoming involved with the project

Generally the lay educators thought that the project was an excellent idea. Some held memories of being given their first inhaler with minimal explanation as to how to use it. After the initial excitement, many of the lay educators expressed feelings of nervousness and some apprehension. There were fears over having a lack of knowledge especially regarding the different treatments and the myriad of inhalers available. Various forms of self doubt were expressed by several of the lay educators:

> 'I need to feel competent and confident if I am to be asked to work in a professional context especially one where mistakes and inadequacies could cause harm to patients.' LE 1

> '. . .I am too old. . .I am quite out of the way of things.' LE 7

> 'Will I find enough time to study? Maybe it's too much for me? I am having second thoughts.' LE13

One lay educator expressed a concern that this mode of service delivery would undermine health professionals and was an attempt to 'deliver on the cheap' and thought that this support for patients should be offered professionally.

3.3. On the training

Initially five lay educators reported concerns regarding retaining information. Two commented on the intensity of the course, feeling that they had learnt a lot, but had found it very demanding. Some felt that they learnt more on the local follow up NRTC sessions and would have liked the training to be more spread out. The residential NRTC course seemed to create some fears regarding how much they would be dealing with. Although most reported that they did not enjoy role play in front of the group, they all agreed that it was useful and important, and indeed thought that they should have had more.

Once they had started seeing patients, lay educators reported realising that their training had been very comprehensive, one commenting:

> 'I've even been able to answer nurses' queries.' LE2

Some mentioned that they were not sufficiently prepared regarding the influence of ethnicity on how patients discuss and perceive issues. In the London arm, 32% of patients were from ethnic minority backgrounds. One lay educator found that some of his patients would use the same words that he used, but in a different way.

Several lay educators reported that they wished they had more medical knowledge regarding inhalers and asthma treatments. They felt that additional pharmaceutical knowledge would mitigate personal biases from their own use of medication. There was also a strong desire to be regularly updated on new products. One lay educator mentioned giving advice on 'proper breathing', describing how some people hunch their shoulders and breathe badly. She explained that her physiotherapist had taught her to breathe properly into her stomach and how she had found this beneficial and calming. The lay educator found it strange that this was not covered in training as, for her, it was '*part and parcel of having asthma*' LE8.

Overall the NRTC training was viewed as a positive experience, alongside 'demanding' and 'exhausting' words such as 'interesting', 'excellent' and 'informative' were used to

Box 1. Summary of lay educator diaries—themes and main points

Lay educator	Reasons for taking part	Initial feelings	Feelings regarding NRTC training	Thoughts regarding consultations	Surgeries and practical issues	Comments on project
Female In her 50s	Positive experience of own care	Mixed feelings and self doubts. Concerns re-undermining health professionals and delivering cheaper care	Apprehension, positive perception of NRTC training, demanding		Positive relationships with practice staff increases commitment from lay educators	Long waiting time between recruitment and training and between training and seeing patients – infringes on personal life and increases anxiety. Difficulties with each practice of finding time and space. Withdraws from project
Male In his 40s	To give something back		Apprehension re being involved with patients. Would have liked more role play. Would have liked more information on cultural issues	Felt that patients benefited from their skills	Found GPs more approachable than nurses in one practice	Long waiting time between training and starting. Good support from research team
Female In her 60s	Post retirement altruistic activity	Motivated	Unfortunate timing Exhausting. Apprehension at amount to be learnt	Very nervous/support from practice staff is very reassuring/role satisfaction /travel issues//patients not attending taken personally/rapid increase in confidence	Apprehension prior to visiting first practice/difficulties organising times between themselves, practices (room availability) and patients/reassurance from friendly practice staff	Long waiting time between recruitment and training and between training and seeing patients. Self doubts
Female In her 50s	Appreciative gesture for care received in the past	Excitement	Apprehension at thought of responsibility Reassurance that group shared same feelings. Leaders confidence in ability is reassuring and encouraging	Very nervous/variability in experiences with first contacting patients over phone/adapting to role of being a lay educator/self doubt/ rapid increase in confidence/role satisfaction	Very nervous/variability in reception from different practices/friendly, supportive and enthusiastic staff enhance lay educator's enthusiasm and role adaptation/problems with room availability/nerves at having to use practice computer	Long waiting time between training and seeing patients. Self doubts. Negative effect of letter from other very organised lay educator. Anger at wasted time due to PCT bureaucracy (lost a days pay from other work for unnecessary BCG jab check)
Female In her 60s	Own experience of lack of education	Self doubts but fantastic idea	Self doubts re ability to learn. Realisation of how little she knew. Enjoyed course	Very nervous; empathy with and desire to help patients/practice nurse busy/frustration with patients not attending especially as long travel to surgeries	Self doubts before seeing first patients/practice staff friendly and supportive	Enjoys being a lay educator. Good support research team. Would like more medical or pharmaceutical knowledge re asthma medications and regular updates
Female In her 60s	Importance of role	Confident	Surprised at how much she already knew, but concern re how many different inhalers there are	Perceived benefit of own role to patients/ concern about own memory/experience is interesting and rewarding	Difficulties in arranging appointments due to limited room availability. Practice nurse very busy	Long waiting time between training and seeing patients. Travelling on public transport is time consuming and expensive

Female In her 30s	To help others with asthma	Nervous, but looking forward to it		Self doubts/satisfaction and enjoyment with consultations/travelling is time consuming/role satisfaction/frustration of patients who did not attend appointments as arranged	Difficulties contacting nurse, liaising between practice re room availability, patients and self	Face to face contact enjoyable and rewarding. Travelling to and from practices extremely time consuming
Female In her 30s	Extra knowledge and benefit of this to own children and subsequent quality of life	Self doubts and apprehension	Reassurance of group sharing same feelings. A lot of information to learn Concern re all the inhalers, would appreciate placebos to keep. Self doubts	Variability in interest from patients/phoning patients is time consuming/self doubts		Good support from research team.

Box 2. Practical issues encountered by lay educators:

- Patients not attending appointments/cancellations/ non response from patients.
- Travel.
- How to address the patient.
- Practice nurse busy/difficulties getting hold of practice nurse.
- Phone calls and preparation time consuming.
- Inaccessibility to office facilities, e.g. photocopy machine.
- Lack of support from practice nurse/practice nurse perceived to be not helpful/practice nurse on long term sick leave.
- Study violations (e.g. practice nurse seeing lay educators patients).

describe their experience. Through the diaries the importance of a positive learning experience, coupled with the reassurance gained from the group of sharing similar feelings in increasing their confidence and reducing their anxiety emerged. It also emerged that the NRTC trainers' and project leaders' confidence in the lay educators, helped their own self beliefs about their ability to carry out their role as a lay educator.

3.4. On being a lay educator

Of the seven lay educators who went on to undertake patient consultations, five reported feelings of nervousness and self doubt. However, after seeing a few patients, their confidence increased rapidly and they later reported feeling comfortable switching into the role.

> "The most peculiar feeling, to be on the other side of the doctor's desk and in his room." LE 4

> "...so I have been sitting **on the doctor's leather chair** [educators' emphasis], welcoming the patient in and sitting them down where I would normally be sitting. That took a bit of getting used to, that really was weird." LE5

Most of the lay educators felt that there was a definite need for their services and were convinced of making a difference, citing lack of knowledge amongst patients regarding their medications, how they work and how to take their inhalers. Nearly all of the lay educators had their favourite example of a patient's inadequate inhaler technique and as one of them exclaimed:

> 'That's why we're doing this job!' LE 7

Visual aids such as large diagrams of airways were considered to be extremely useful in aiding patient education. They liked the document they were given which contained pictures of all the main inhalers, as did many of the nurses in the study. They also reported that patients needed to talk about their having asthma. Many reported spending much time

listening to their patients on asthma issues. One lay educator, however, felt that many of her patients were already well controlled and worried that she was not helping them that much.

The lay educators did express strong sentiments about wanting to help their patients, who they felt wanted to know more about their asthma and how to deal with it. Most reported receiving positive feedback from their patients, who expressed an appreciation of the time spent with them. The lay educators did tend to spend much longer with their patients than their nursing counterparts, often over one hour, and were also available for patients to contact for advice and support between consultations.

The lay educators described the actual face to face contact with patients as being very enjoyable and rewarding, however they described as demoralising the continuing frustration of patients not turning up for, or constantly cancelling, their appointments. The lay educators reported feeling rejected when patients dropped out of the study, especially when this was done by not turning up to a scheduled appointment followed by not returning phone calls or correspondence. This happened mostly on the second face-to-face consultations and whilst they realised that they should not take this as a personal affront, emotionally they found it frustrating and difficult to deal with.

> 'I did feel that maybe it was because of me. . .but when I tried to contact her she just didn't reply. . .I felt I had been rejected.' LE 5

Some of the lay educators also mentioned that travelling to and from several different practices was extremely time consuming, especially as it was not always possible to book a block of patients, so they were often making the journey for one or two patients only.

Overall, there was a huge variability in their experiences of contacting and seeing patients. Some patients were very friendly and enthusiastic, while others were reported to be rude. Later on, as the lay educators became more experienced in seeing patients there was a realisation of the frequency of patient non-disclosure of symptoms and non-compliance with medications.

> 'I suspect that some patients are non-compliant even though they say they are.' LE 8

One lay educator stated that they felt there was a difference between the theory they were asked to teach and every day practice, including their own practice. Many patients would seemingly assume that the lay educator was a nurse or doctor and they would often volunteer information on non-asthma related issues.

The Manchester lay educators also reported some discomfort and also sadness in saying 'goodbye' to people at the end of the study.

> ''The fourth and last telephone follow-up consultations made with my (name of surgery) patients. Will miss speaking to them. My gentleman expressed his thanks for all I had done for him – felt very close to tears – he has become a friend.'' LE 4

> ''Now that the project is coming to an end with just a few telephone follow-ups to do, I feel quite sad.'' LE 3

The London educators did not make such comments. They had larger patient lists and therefore possibly the bond between themselves and their patients was less.

3.5. Working in a healthcare setting

There was mixed feedback regarding the experience of working in a practice setting. Some were concerned about this before visiting the practices:

> ''Will the doctors and nurses at the practices be hostile?'' LE 3

Most found their first visit daunting, even though they were always accompanied by a project team member for this visit. Negative experiences included not feeling comfortable, feeling that they were seen as an intruder by the nurse, or feeling that the practice was hostile to them.

> ''Plus the fact that one surgery was very hostile, the nurse was very hostile.'' Later she elaborates: ''not hostile to me but hostile to the study. She went ranting on, that's something that sticks in my mind as well.'' LE 5

> ''I felt they regarded me as a bit of an intruder.'' LE 4

However, more positive experiences were also reported:

> ''. . .Made very welcome at the surgery by nurse and staff.'' LE 3

> ''Dr . . . is lovely and friendly – he's the only doctor I have seen so far. . .the practice nurse was friendly and welcoming. I felt comfortable about my role.'' LE 4

What did emerge from the lay educators' diaries was the importance to them of the practice being friendly and supportive. Despite the fact that all practices had been briefed on the study and a ''link person'' identified, the lay educators reported that some practices did not seem to know what was happening regarding the study, who the lay educator was and what they were doing, which left the lay educator feeling uncertain about their role. This may in part have reflected the high level of nurse turnover, which occurred within the practices throughout the study. It emerged that working in a busy practice as a temporary outsider, with very little interaction with the permanent staff can be lonely. This sense of isolation was lessened when the lay educator was treated as staff and made to feel at home (for example felt free to use staff areas such as the kitchen and reception areas, as opposed to having to sit in the patient area waiting for staff to give permission or felt free to use a photocopier). This helped the lay educators adapt to their new role of, in their words, 'being on the other side'.

> ''Made a preliminary visit to (practice name). What a difference from my other two practices! Everyone very friendly, shown the kitchen & introduced to all the staff. They seem happy to have me there and are very interested in the study. Felt more confident.'' LE 4

There was a general consensus that most nurses seemed 'rushed off their feet' and 'pressed for time' and were therefore difficult to approach. Some lay educators reported frustration at having to constantly chase up nurses, e.g. for prescription requests, whereas others expressed surprise at nurses and GPs calling them back to discuss notes left for them. However, all agreed that having an efficient contact point within the surgery was vital. This could be a nurse, a doctor, a practice manager or a receptionist, but as one educator noted:

> 'If she is not efficient or not available, then you come to a dead end.' LE 5

Some lay educators expressed a preference for approaching GPs directly to write a prescription and where they had not been introduced to a GP, reported that they would have preferred this; knowing that the GPs were happy with the study would have given them more confidence. Five of the lay educators reported difficulties with room availability at the surgeries.

3.6. On the project as a whole

Most of the lay educators who returned diaries wrote that they were happy to be involved with this project and that they hoped it continued. They mentioned that they had good project and clinical support from the research team. They complained about the long waiting times, both between recruitment and training, and between completing their NRTC training and seeing their first patients. Delays were caused by having to seek research and clinical governance approvals (including Criminal Records Bureau checks, medicals, honorary contracts) and requirements varying in different sites. The longest time taken to provide approval for the study was 2 years and 3 months in one primary care trust (PCT). These delays did appear to contribute to drop out, with educators' health, personal and work circumstances changing during the time that approvals were awaited. Initial high levels of enthusiasm decreased as time passed. Long waiting times increased anxiety and they worried about the loss of knowledge and skill that they had accrued. For some lay educators, being kept waiting meant that the project interfered with their personal life.

One lay educator thought there should have been much more pressure for people to turn up to consultations. Some were worried about the amount of responsibility they had towards the patients:

> 'One doctor frightened me because he said. . .you could kill this patient.' LE 3

(re-giving the patient oral steroids, although the patient had had these many times before).

Overall, the lay educators were able to empathise well with their patients due to their own experience of living and coping with asthma. There were some issues surrounding health problems, with some lay educators having long stretches of sickness and/or hospitalisation, and some dropped out due to illness (although this happened to our nurses too). Amongst those lay educators who had not been in professional employment, some dealt with our requests to return completed data sheets, etc. by a strategy of disappearing, not returning calls and not turning up to meetings. However, again, similar problems were also encountered amongst some nurses. Whilst it is not possible to generalise from so small a number of individuals, it did appear that those who had less experience of regular employment (e.g. were long term sick or unemployed) had more difficulty in meeting their commitments as lay educators and hence more commonly withdrew from the programme.

For some lay educators this was the first time they came across people who had led different and very difficult lives compared to their own, which was described as '*a bit of a shock really*' LE5. However, there was an overriding positive feeling that they were empowering patients to help themselves in managing their asthma. They listed qualities to look for in other lay educators as; determination to carry on, persistence, ability to keep records, organisation, ability to empathise, people skills, assertiveness, reliability and conscientiousness.

4. Discussion and conclusion

4.1. Discussion

Our lay educators' reflections have highlighted some important considerations for those seeking to undertake comparable work. Lay educators need support and reassurance, especially at the beginning, on recruitment, throughout the training and during the initial phase of first seeing patients. Educators did undertake at least one consultation with a trainer present (though this was mainly for quality assurance purposes). For future programmes, it is suggested that lay educators have the option of observing an actual consultation and of doing several consultations with a trainer present. After seeing a few patients their confidence and ability to work independently increased rapidly.

It is important that among the patients assigned to lay educators, there are people who clearly benefit from the consultations. Having patients who benefited from their skills enforced the perception of their role being worthwhile, thereby enhancing satisfaction. There is a need to address the lay educators' feelings of frustration and self reproach at patients not attending appointments within their training and at follow up mentoring sessions.

There are a number of limitations of the study which must be borne in mind when interpreting the findings reported here. The study occurred within an English healthcare setting; providing lay-led asthma self-management education may not be feasible or acceptable in all healthcare systems, particularly those with a high level of medical dominance and/or where patients expect to receive care from a medically trained practitioner. The number of lay educators recruited was small ($N = 15$) and drop-out was high—although this is of interest in itself. It is

disappointing that reflective diaries were available from so few of those who withdrew from the study, as these individuals may have had useful insights and perspectives.

4.2. Conclusion

Lay educators are a potential resource for giving self-management education to patients with long-term conditions such as asthma. However there are some considerations that need to be taken into account regarding contracts, retention and continual support. The reflective diaries are a particular strength of the study, since comtemporaneous reflections gathered over time are very powerful, in terms of the unique insights they provide.

4.3. Practice implications

- Keep the time period between recruiting, training and seeing first patients to a minimum. This would involve finding a faster, more efficient way of obtaining honorary contracts from the Primary Care Trusts.
- More comprehensive support and monitoring at the beginning of the study, including allowing the lay educators to sit in on a consultation, and being shadowed whilst doing their first few consultations.
- Increase the amount of role playing during training (although with caution as for some this is an anxiety evoking process).
- Forewarn the lay educators as part of their training, of the realities of working in a primary care surgery (i.e. how busy health professional staff can be, difficulties in getting prescriptions written, how scarce room availability may be, patients not attending) and how best to work within a busy practice setting.
- Lay educators to be tied into a formalised contract.
- Inform lay educators during their training of basic professional conduct and this to be set out as rules in their contract.
- Increase medical/pharmaceutical information including updates on new products.
- Provide a less intense training course over a longer period.
- Brief practices on how to support and include lay educators within the practice as well as maintaining channels of communication, and having one designated contact within the practice.
- All practice staff (practice managers, receptionists, nurses, GPs) should be introduced to the lay educator and informed of their role within the practice.

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