**Adapting Making Every Contact Count/Healthy Conversation Skills to pilot online Supportive Conversations training in response to Covid-19**

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ER commissioned the training; PG, ER and WTL adapted the training and its evaluation tools for online delivery; all authors undertook delivery of the training; WTL and DW coded and analysed the data. DW and WTL produced the first draft manuscript; all authors provided input towards the final manuscript.

**Abstract**

***Introduction***

Covid-19 forced frontline workers to change the way they worked almost overnight, from face-to-face to remote methods. In response to this, the Faculty of Healthy Conversation Skills developed online Supportive Conversations training based on the principles of their face-to-face Making Every Contact Count/Healthy Conversation Skills (MECC/HCS) training. This paper describes the development, evaluation and feasibility of this training to support increases in staff confidence and practical skills for having conversations aimed at improving the wellbeing of those affected by the impact of Covid-19.

***Methods***

MECC/HCS training was adapted to create 90-minute Supportive Conversations training to be delivered using the online platform Zoom. The Faculty contacted UK organisations to offer this training to workforces supporting patients and the public. Pre-/post-training questionnaires were completed measuring confidence in having supportive conversations and changes in practice as a result of the training.

***Results***

Nine courses were delivered to 88 staff with 72 responding to the pre-training evaluation and 33 to the post-training evaluation; confidence to support individuals to make positive changes increased significantly from pre- to post-training (p<0.001), and a higher proportion of open discovery questions were provided after training (from 27% to 76%), an indicator of a more empowering conversation style. Feedback was positive and trainees rated the training highly (mean=4.4/5).

***Discussion***

Whilst it cannot replicate face-to-face training, this online version delivers an interactive experience appreciated by attendees. The results of the evaluation confirmed that the online version can provide vital communication skills for staff to have empowering conversations that continue to support vulnerable populations during the pandemic.

***Conclusions***

Embedding MECC/HCS in routine practice can enhance frontline workers’ ability to support individual’s well-being, which if delivered at scale can contribute to population well-being. The imperative is to scale-up delivery of this training to increase reach to include those currently working in acute, pressurised settings.

**Introduction**

In 2019-20 the world experienced an unprecedented pandemic and heard the terms coronavirus and Covid-19 for the first time. Prior to a vaccine and treatments being available, at the time of writing this article, the only effective response option available has been behavioural. A behavioural approach to managing outbreaks and pandemics has been utilised previously by governments such as for the Ebola outbreak and the Swine Flu pandemic, where behavioural science advice was utilised to promote adherence to interventions and messages (Ghio et al, 2020). Population-wide change in behaviours such as frequent and thorough hand-washing, wearing face coverings and staying two meters apart, were required (Cabinet Office, 2020). Behavioural science has been integral to the Covid-19 response, particularly in the development of messaging, interventions, research and policy (Bonell et al, 2020; Michie & West, 2020; Van Bavel et al, 2020; West, Michie, Rubin, & Amlôt, 2020). In the UK, behavioural scientists advised on the Independent Scientific Pandemic Influenza Group on Behaviours (SPI-B) and Scientific Advisory Group for Emergencies (SAGE) committees (Scientific Advisory Group for Emergencies, 2020). They have been instrumental in the development and implementation of nationwide interventions to support public health, education and the economy (Scientific Advisory Group for Emergencies, 2020). New collaborative networks were formed in response to the pandemic (Health Psychology Exchange, 2020), who have conducted psychological research to inform SAGE (Ghio et al, 2020), and supported the implementation of psychological interventions for organisations such as NHS Trusts.

During the pandemic, speedily-produced research and practice outputs highlighted the potential for psychological harm faced by frontline healthcare workers (Greenberg, Docherty, Gnanapragasam, & Wessely, 2020; Holmes et al, 2020; Lai et al, 2020). The British Psychological Society (BPS) published evidence-based guidance outlining principles and practical recommendations for healthcare leaders and managers on how to respond to the psychological needs of healthcare staff, which included having clear communication strategies (British Psychological Society, Covid19 Staff Wellbeing Group, 2020). Published advice on meeting the psychological needs of healthcare workers suggested facilitated interventions could usefully focus on reflective practice, providing online support and effective communication skills (Chen et al, 2020; Cheng et al, 2020; Rimmer & Chatfield, 2020). It was recognised that much face-to-face contact with service-users needed to shift to virtual including telemedicine (Fisk, Livingstone, & Pit, 2020; Ohannessian, Duong, & Odone, 2020); this could result in some service users not receiving the level of support they had previously. Many challenges have been highlighted, including enhancing practitioners’ skills to have effective telephone conversations, technical issues, disruption in patients’ and hosts’ environments, and online privacy (Blandford, Wesson, Amalberti, AlHazme, & Allwihan, 2020; Lerman et al, 2020).

One established behaviour change communication intervention is Healthy Conversations Skills (HCS), which provides an empowerment approach (Rappaport, 2002) to support individuals to explore their world, identify their own solutions to current issues and to plan first steps to change (Black et al, 2014; Lawrence et al, 2016). Since 2013, Health Education England (HEE) in Wessex have used HCS as the mechanism for delivering the government initiative ‘Making Every Contact Count’ (MECC). MECC posits that health and social care practitioners in the UK have millions of contacts with patients and clients which represent opportunities to support people to adopt healthier behaviours and thus make every contact count (Field, 2012). Evaluations demonstrate that HCS-trained practitioners show improved confidence in supporting behaviour change, and up to one year post-training sustained use of the skills (Black et al, 2014; Lawrence et al, 2016; Tinati et al, 2012). HCS are practical and simple to learn and can be used opportunistically by practitioners working in any setting, with any population, in any time frame (Barker et al, 2011). Study participants who have engaged in healthy conversations with trained dietitians or midwives have appreciated the approach, changed their health behaviours and set more goals than those who did not have healthy conversations (Adam et al, 2020; Jarman, Adam, Lawrence, Barker, & Bell, 2019; Lawrence et al, 2020a; Lawrence et al, 2020b). Whilst the focus is on supporting changes to improve health and well-being, the skills are invaluable for having a person-centred, empowering conversation even where change is not the main priority. HCS training is interactive, and before the pandemic, was exclusively delivered face-to-face over two half-days. Due to lockdown restrictions on movement and gatherings resulting from the pandemic, there was an urgent need to adapt the training for online delivery.

In response to the pandemic, the Faculty of Healthy Conversation Skills was conceived by health psychologists at the University of Southampton and NIHR Southampton Biomedical Research Centre, and public health educators from HEE(Wessex) to explore opportunities to support the Covid-19 response. The Faculty of HCS realised that the MECC/HCS training met the call for developing reflective practice approaches to support the workforce and adapting communication skills to the challenges of the pandemic (Chen et al, 2020; Cheng et al, 2020; Rimmer & Chatfield, 2020); they just had to convert what they had into an online version. The Faculty thus developed Supportive Conversations training for a virtual platform based on the principles of the MECC/HCS training, but specifically designed to upskill frontline/volunteer workforces to support the public via remote technologies during the pandemic. Whilst the initial focus of the literature published during Covid-19 has been on the over-stretched, hardworking NHS workers (Greenberg et al, 2020; Holmes et al, 2020), it was recognised that whilst they were working at capacity to respond to the crisis they were unlikely to be freed-up for training. Hence the Faculty of HCS took the pragmatic decision to pilot the new training programme with the equally dedicated community workforce. This group had to rapidly switch their valuable face-to-face services for some of the most vulnerable, to a telephone service. They were not necessarily equipped with the skills to provide effective remote support, and their organisations were keen to take up the Supportive Conversations training. Hence our population rather self-selected for the pilot, which in a climate of urgency, was extremely welcome.

This paper aims to describe the development, evaluation and feasibility of the 90-minute online Supportive Conversations training in order to answer the question “How does a short online adapted HCS training session support changes in staff communication skills and confidence?”

**Intervention development**

***Setting and participants***

The Faculty of HCS contacted national and local organisations to offer the Supportive Conversations training to their workforces. The national organisations did not take up the offer, but local charities and voluntary/community services responded positively to the open letter (appendix A) sent to leads for wellbeing, human resources and MECC via Wessex Public Health networks. These included MECC Trainers, Public Health Practitioners, and Voluntary Sector Organisations who were asked to cascade to their networks.

***Design***

Activities from the six-hour face-to-face MECC/HCS training were adapted to create the 90-minute Supportive Conversations training to be delivered using the online platform Zoom, using annotation and chat features. It was developed as a proof of concept to see how highly interactive and experiential face-to-face training can be delivered online whilst maintaining fidelity to this approach. The training content was adjusted to reflect the current situation of providing remote support and addressing priority issues such as increased anxiety and isolation. To accompany the online training, a toolkit drawing on existing MECC/HCS resources was developed. This contained information about the context of MECC, its relevance to Public Health, the HCS approach, and tools aiding reflective practice and structured goal-setting. The digital aspects of the training followed the BPS digital intervention guidance (British Psychological Society, 2020), with particular consideration given to creating a safe, confidential and non-judgemental virtual environment where attendees could explore their beliefs and professional approaches, practise their new skills and reflect on their practice. Before each training session, an email containing the pre-training evaluation questionnaire and information on how to access and use Zoom was sent to the lead contact to disseminate to all attendees. During the session participants were asked to respond to typical quotes that service users say; these were developed in collaboration with the Learning and Development Services Coordinator from a charity providing a telephone befriending service to vulnerable people.

**Methods**

**Study design**

Pre-/post-training evaluation tools were adapted from those used to evaluate the full face-to-face MECC/HCS training. The pre-training evaluation was completed before the training and trainees were asked to complete the post-training evaluation as soon as possible after the training. These assessed trainees’ confidence in their ability to have supportive conversations (measured on a ten-point Likert scale with end points ranging from 1 not confident to 10 very confident) and their ability to form open discovery questions; trainees were presented with two quotes and their responses were coded in accordance with an established coding rubric to code to six different types of responses including telling/suggesting (the least empowering) and open discovery questions (the most empowering) (Black et al, 2014; Lawrence et al, 2016; Lawrence et al, 2020b). The primary aim of the MECC/HCS training is to shift to a more empowering style of communication, illustrated by asking open discovery questions (those beginning ‘what’ or ‘how’). Asking these questions promotes understanding of the issues and needs of service users whilst supporting them to identify their own solutions, enabling a person-centred conversation. Post-training only, the value of the training was scored out of five ranging from 1 not at all valuable to 5 extremely valuable.

Analysis strategy

The confidence data were analysed using a Mann Whitney U test. The total numbers and percentages of each response to the two statements pre-/post-training, and the mean value score were calculated. Trainees were invited to provide qualitative feedback in free-text boxes on what they had enjoyed and what could be improved in the training in order to inform future development of the training. Some of these quotes are reported below to illustrate the most common responses.

**Results**

A total of nine courses were delivered to 88 trainees from charities, community and voluntary organisations and allied health services. Results from the pre-/post-training evaluations showed a significant increase in trainees’ confidence to support individuals to make a lifestyle change from pre- (mean=6.4, n=72) to post-training (mean=7.8, n=33; p<0.001). The pre-/post-training evaluations showed that trainees were able to use more open discovery questions than any other type of response after training compared to before training, from 27% to 76% of all responses made (see Figure 1).

**Figure 1. Total responses to two quotes, pre-/post-training**

Pre-training n=69 trainees; 138 responses to the 2 statements

Post-training n=25 trainees; 50 responses to the 2 statements

Trainees highly valued the training (mean = 4.4/5, n=25), and 14 trainees also provided largely positive qualitative feedback in the free-text boxes. They enjoyed the interactive nature of the training, found it interesting, learnt new skills, and found the online platform easy to use following a short induction.

*“I found it really useful and great to reflect on how we speak to patients and how we can improve communication to make it more patient-centred and effective … we don't tend to have those meaningful conversations that we would like.”*

*“Really impressed with the transition from face-to-face to virtual and thought it worked really well.”*

Trainees’ feedback showed understanding of the MECC/HCS philosophy of empowerment and the key skills of listening, asking open discovery questions and reflecting on practice (Lawrence et al., 2016).

*“The things that have stood out to me have been the way open questioning helps to guide the conversation rather than a big list of suggestions. I’ve definitely been guilty of that before!”*

Trainees suggested some improvements, largely in relation to the technology and length of training.

*“My only minor change would be (and this possibly happened and I missed it!) to ask everyone to mute throughout unless they were wanting to speak. There were a few times when I missed what others were saying because of background noises.”*

**Discussion**

This paper describes the adaptation of an existing face-to-face training programme to a shorter online intervention to enhance communication skills of community volunteers working remotely with members of the public affected by the impact of Covid-19. The evaluation of this pilot study showed that trainees’ confidence to have supportive conversations increased, they used more open discovery questions, and valued the training highly. Post-training feedback was largely positive indicating that the training was well-received and could be acceptable to other workforces and organisations. It was helpful to hear what improvements trainees felt could be made, some of which have already been taken on board by the training team following this pilot.

Supportive Conversations training was adapted from the full MECC/HCS face-to-face training in order to meet the need to deliver remote training during a pandemic “lockdown”. This had its challenges, for both trainees and trainers, in adjusting to new technology and recreating the interactive nature of the face-to-face training (Blandford et al, 2020; Lerman et al, 2020). It is vital that our community and voluntary services feel confident in supporting the most vulnerable populations in order to prevent the widening of health inequalities. This training equips individuals with effective communication strategies, whether used face-to-face or by telephone (Blandford et al, 2020; Lerman et al, 2020), in order to respond to the psychological needs of service users. The transferable nature of the skills means that this approach can also be used to respond to the psychological needs of staff as called for by the BPS (British Psychological Society, Covid19 Staff Wellbeing Group, 2020). What we have found from this work is that online training has its place; it may not exactly replicate face-to-face methods, but with determination and creative ideas we can deliver an interactive experience which is appreciated by the workforce. It led to important changes that have previously been seen in evaluations of the face-to-face training (Lawrence et al, 2020a; Lawrence et al, 2016; Black et al, 2014).

Thus, there is an imperative to consider how to upscale this online training and there are two principle ways to do this: firstly to deliver the training to larger groups; and secondly to increase the number of trainers delivering the training. Both these options are being piloted by the Faculty of HCS.

***Strengths and Limitations***

This pilot study has some limitations, not least the small number of participants, particularly those completing the post-training evaluation (only 33 out of 88 trainees). It is possible that this evaluation is biased in that those participants who enjoyed the training or felt more confident afterwards may have been more likely to have completed the evaluation forms post-training. We were unable to collect any demographic details, so only know in the broadest sense about the trainees in relation to the organisations for whom they work. However, in the current circumstances where restrictions and changes to how people work are happening so quickly and so frequently, it was decided that these evaluation findings should be made available as soon as possible as evidence that this type of training can be adapted for online. There has been no follow-up of those trained, which means we cannot report on how this online training has promoted the use of new skills Cane, O’Connor and Michie (2012) found that implementation and maintenance of newly learned skills after training remained variable across studies, possibly due to a variety of individual and environmental factors needing to change simultaneously. Recognising this, we plan to follow-up staff that receive this training over the next few months. Findings from previous published work on the face-to-face HCS training consistently demonstrate that skills can be readily adopted into routine practice and sustained over time, so for now we can only speculate that this is the case following the online training. Many trainees complimented the training for its interactivity, which suggests that the underpinning principles have been maintained. As with much of the previous evaluation work, there has not been an opportunity to engage with service users to find out their views on the support received from staff trained in Supportive Conversations. This is clearly an area to address in our future plans. It is of note that the national organisations contacted did not take up the training offer, so our focus switched to smaller, local groups. This may not in itself be a limitation of this work but is worth considering when looking to scale-up the training delivery.

***Conclusions and Implications***

The main strength of this work is the proof of concept that it is possible to adapt a highly interactive, experiential face-to-face training programme onto an online platform thus maintaining its integrity. As we continue to face a great deal of uncertainty about living with Covid-19, and the ever-present threat of further “waves”, the Supportive Conversations training can help trainees develop basic skills which should be a core skillset for all workforces engaging with the public. It can only be of benefit to both staff and the public to have a workforce that feels confident in supporting those affected by the crisis.

The Faculty of Healthy Conversation Skills plans to upscale the offer of training to a wider range of organisations, particularly as we move into further critical phases or ultimately the recovery phase of the pandemic. In the periods between or after significant outbreaks of the disease, the aim would be to contact organisations who employ staff working on the front-line. They arguably have been exposed to significant stress and thus may be struggling with their mental health. Next steps are therefore to reach out to NHS trusts and similar employers. Training those who manage and mentor the front-line workforce could be one effective route to improving the health and well-being of those under the most pressure. Undoubtedly, a healthy workforce provides better care for patients which ultimately improves patient outcomes. To achieve this end, we need to ensure that the skills are being embedded in routine practice following online training, and in turn that those in receipt of Supportive Conversations feel this approach is helpful in maintaining their well-being. It is therefore important to carry out follow-up research activities with trainees and the individuals they are supporting. The Faculty of HCS is ready for the challenge and will seek opportunities to collaborate with researchers and practitioners alike to pursue this agenda – both within the current Covid-19 climate and beyond.

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**Appendix A – Open Letter**

