BN: Excellent. So if you don't mind if we could just start by, if you could explain your role, your organisation and your role within that.

AP13: So I work for (name of location) Healthcare, and I'm part of the Public health team. So my job title is public health manager, so up until very, very recently, I had a small team of health coaches that were part of the public health team and did lifestyle behaviour change across the organization, both inpatient and outpatient. And then the other part of my role was to develop or deliver the MECC program of work across the organization. So we, as a trust, also host the regional post for the ICS. So we've got, that post will (illegible) and then public health trainer. So we, I would say we've probably got quite strong connections with what's going on at a regional level, but also recognize that we're working in a, you know, a slightly different environment within the NHS to say, maybe the voluntary sector or local authorities. So my role with regards to MECC, I came into post two years ago and I picked up the training, it was already being delivered in the organization, for about four or five years. So I guess on a content point of view, nothing has changed massively since the regional programme came underway and we got the train the trainer model last September. But it's more about, I guess, the quality of the content has improved greatly, but also the profile of the work as well, because originally what was happening was, and COVID had a lot to do with this, but when I came into post we had to just do an hour of MECC every week online and hope that staff would drop into that because its not mandatory training. So I inherited some content and you know, you always make tweaks and improvements don't you, over time, modernize it a bit, but essentially my remit was just to, to send it out to the masses across the organization of which there's 12,000 staff, give or take, and hope that people would engage with it. And we did comms around that, but ultimately, coming off the back of COVID, we’re a really time pressured organization, obviously you’ve got staff working in wards etc, and MECC I think, it's still an issue now, but MECC is hard to get up people's agenda in terms of a priority, and you know, it's understandable. So what we felt in the run up to train the trainer was it was very labor intensive doing the core MECC, as its called now the core MECC, 1 1/2 hour sessions online, hoping that people would join, but actually, really, the numbers through that program were very very low.

BN: Right.

AP13: So, at the point in time where the train the trainer model was emerging, that was really positive for us because it just meant that we could adopt that cascade approach in the hopes that we would have more people able to deliver MECC training across the organization, because from a sustainability point of view, really, really challenging with one or two people delivering an hours training every week forevermore. And, you know, we had very loose targets around, you know, we want 80% of the organization MECC trained, but, recognizing that that's going to take different formats and, you know, some of it might have to happen in trust induction or on a pre-existing training programme, like we've got preceptorship and care certificate, health and well-being champions is another one that we've got and we weave MECC into those.

BN: Right.

AP13: So they're, they're quite good because we've got a bit of a captive audience and quite high numbers. But core MECC has always been an issue, and I think that's standard across the different organizations in the region because you put on a lot of training, but your numbers are very, or relatively low, should I say.

BN: Right.

AP13: But we did notice, you know, when we moved to the train the trainer model in the September, we did notice that there was quite a good uptake. So basically, I don't know how much detail you want me to go into now about the experience of that, but we, we advertised everything over the summer period and started it in the September 22. So originally we got (name) the public health trainer for MECC to deliver the first couple of sessions and obviously utilize the regional content. But we put a (name of location) slant on it very, very early on in the process, because when we looked at it, of the five core areas, I think the regional content had covered two of them, but then had the other three as sort of bolt on sessions that you could attend at another time or you could look it up on the NHS futures platform, and we felt as an NHS organization, we couldn't say well, training people on how to have a MECC conversation on smoking is more important than a MECC conversation regarding mental well-being. So, to us the five were very equal. So we, we’ve probably built in too much content to our train the trainer model and our core MECC model, but we wanted people to have information on the five core areas rather than coming back and saying well why, why didn't we discuss anything on alcohol in that session, and, and so we did (name of location)-ise the content of it. But we knew that there was a quality ensurance checklist, so we made sure that we adhered to that, we didn't take anything significant out of the training, we just moved the order of the slides about and, like say added the five core areas, but we also, from memory, took one of the behavior change models out, I think it was the prime behavior change model. And instead of, I guess from a personal perspective and anecdotally, it just felt a bit heavy when I went through the training from a theoretical perspective, I can totally appreciate why that is, you need to set the scene and the context. But I think for our audience, you know, you might have district nurses, you might have ward clerks, porters, healthcare assistants, I mean, it's just, the diversity is immense. So having two or three behavior change models in an hours worth of training just felt a bit heavy for us. So we, we took two of them out and just kept the stages of change.

BN: Right, yeah.

AP13: And we also looked at the group activities, because what, what we felt, the royal we of the organization, was that in the original train the trainer that everybody received last autumn, and that probably still goes on across the region, there wasn't the opportunity to do any skills practice. So you're very much talking about the three-A model, how you ask your open questions, how you give information and signposting and obviously have that really positive conversation with somebody, but then there was no opportunity to actually do that in the training or to do any sort of, I hate the words role play, but like we say, skills practice. So we developed our own case studies or scenarios that we gave out in the training and just ask people to, you know, go into pairs and then practice using the three-A approach, so that now takes, I would say 15 to 20 minutes of our training session but, so you do feel like you're trying to cram a lot in, but I felt it was really, really important that people are actually using the, the knowledge and the skills that they're gaining.

BN: Yeah.

AP13: So that was one big change, obviously you’ve got the behavior change models that were changed as well, we looked at the ordering as well of the content because what we found, or certainly when I first went through train the trainer, so it was a bit bizarre because I was delivering MECC training for a good almost year before I did train the trainer.

BN: Oh, wow, yeah.

AP13: Yeah because I came into post, I knew what MECC was, I've worked in public health for years. But there was no train the trainer available at the time. So I just had to run with what the previous post holder had done. And I kind of made it my own and then adopted the regional content when it came into being. But at the point in time where I was going through the train the trainer training, I'd obviously had experience that previous year of delivering MECC anyway. So what I felt as the participant stroke observer in the early days was that there was a lot of information at the front end around health inequalities and obviously your wider determinants and you know, that regional, local data the, the fingertips data, which of course is really important. But then it felt like we were all sat in the training for a good hour or so before MECC was even mentioned. So it was, and other colleagues did say that so what we did was with, we obviously have kept in health inequalities, etc. But we moved to the MECC information a lot earlier on in the training. Just so that people werent getting to sort of an hour plus and thinking, well, this is all really interesting, but where does the making every contact count element come in?

BN: Yeah.

AP13: So we've changed a lot of the ordering, and took out some of the more theoretical information, added a (name of location) slant to it, because for every topic area that we discuss, we advise people what information and signposting is available within the trust. So for example, for stop smoking, we've got a team of tobacco dependency workers in the organization, so instead of just saying, say for example, if you, if you were in a local authority, you would be saying, well, send them to a pharmacy if it's in (name of location) and send them to the proper service, the smoking cessation service, if it's in (name of location). But we added another layer and talked about the internal support that we've got because patients are offered NRT when they're admitted. And then they're also offered the support of the tobacco dependency worker, and then they could be referred outside to the services. So for each of the topics we tried to adapt the 3A model to include what we've got in house for staff, because I guess that's, that's the crook of it, you’re delivering training to staff to, so they know what's available within their own organization as well as externally. And I suppose we're probably a bit unique because we've got, we've got all of those support mechanisms already within the organization. Say, for example, for your mental well-being, we've got a really good set of resources that our staff psychology team have developed. We've also got a staff well-being portal which has got war and peace on there about, you know, where people can signpost patients and friends and family too. So we felt that yes, you've got the MECC gateway which is, you know, we very much promote that and it's important, but we've also got our own internal set of resources that staff aren't always aware of. So we felt that this was a good opportunity to make sure that we raise the profile on those. So after the Train the trainer, we, what we did was we sent out, created a document, trust specific signposting that everybody gets. They obviously get information on the MECC gateway, and we ask staff if they, as part of signing up to the training they've got to deliver four core MECC sessions within a year. So the problem we've had, which I'm guessing, and I know it's not unique, not that I’m guessing it's not unique, people go away, back to their workplaces, and they aren't supported to deliver their training when they get there. So we had lots of feedback around, training was very very useful and enjoyable, but I don't have the capacity when I get back into my team, either the managers not supportive of the extra time it's going to take, or we didn't actually realize what we were signing up to when we came on your programme, even though the clue is kind of in the title a bit, or actually, I've really enjoyed it, but I don't feel confident or comfortable delivering the MECC training. That's not, that's not me, and that's not what I want to do. So I would say, of a cohort of about, I think we managed in the end to get about (number) people through MECC train the trainer. So we were doing it once a month on average between September and April. Of those (number), I would say we're lucky to have maybe 10% of those staff delivering core MECC routinely.

BN: Oh really.

AP13: So it's really, it's been, it's a bit of a shame because, you know, it was very, very labor intensive. Obviously you're putting on a 1/2 day training session each time. People are coming along, you're collecting all this, this lovely list of MECC trainers that the organization's got. But, can, can we call upon them to actually move the training forward in the way that was originally hoped? And, I don't think it's, it's been as successful as what we'd hoped for because in theory, if we'd had (number) trainers delivering 4 times a year across the organization, you know, that's, that's far more MECC sessions than what we as a public health team can deliver. So yeah, we just haven't got that level of capacity in the system. But we did try and, or we, we do still try because we keep in touch with the cohort of trainers. So we've built in a bit of a support package for them after they've done train the trainer, So what we say is do your, do your half day training, try and book in your first core MECC within the first four weeks. And then they are invited to like redeem a peer support group. It probably sounds a lot more fancy than what it really is because again, the turn, like the turn out for the group is low, but once a month we will have a bit of a, like it's an informal, it's just on teams, an informal session where anybody who's done that training can come along and share their experience of delivering the training, or if they've had any difficulties operationally, logistically, or with culture within their team, where can we support them as a public health team? So that would be myself and (name), the trainer. And then also where things have gone really well and how we can share that? Also, we would view the forum as somewhere where we could share updates from the region and make sure that people know how they're using the Futures platform. And, because it is complicated, you go on there, I don't know if you've used it?

BN: Yeah.

AP13: ..but you kind of go on and you’re like oh my god I cant get anything to work, I can't find anything on there and you know, there's always updates of slides and you know, this video, that video. So I do think people find it overwhelming, so we try and, or the idea being we would try and go through any queries people have on that. But again, the problem we have is people don't attend them. They're not mandatory, so they get sent out to everybody on our training list. But we'd be lucky to have three or four people come up to those sessions of the (number).

BN: Oh okay. Uhumm.

AP13: So we've got that and sort of the, that's meant to be a one stop shop, but then we also, we've come together with (name of organisations: healthcare and local authority) so there's four organizations. And what we decided last October was that we were all trying to do the same thing. So we would club together and try and deliver some update training to our cohort of MECC trainers across that patch, and every organization would take responsibility for sourcing a speaker and we would agree the topics six months in advance. And every month we would just open it up to everybody that had done the MECC training. So we recognize that the content of the train the trainer, there's so much to cram in, but actually you're still only getting a whistle stop tour of each of the topic areas. So we felt that by having a more in depth session every month that people could join, then that would tick that box in terms of ongoing learning and development. So we started that process back in January. So we've had sessions on physical activity, healthy weight. We did have one yesterday and it was such a shame. It was financial well-being but, it was delivered by the money and pension service but there was only three people came and I was really disappointed because I thought in the current climate, that would be really well attended even from a personal point of view people would be interested in that but yeah, we had to call it off because we didn't get the uptake.

BN: Ah okay.

AP13: And we’ve had better attended ones on oral health for example, we're going to be getting the drugs and alcohol service to come and talk to us in January. And so we try and align it to the public health campaigns or awareness weeks. So that's another mechanism that we're trying to support our cohort of trainers. But again, it's just trying to get the buy-in from the organization about how to, you know, we need to support the staff that have done this training to deliver it and to keep their knowledge and skills up. So occasionally I will get staff who (ineligible) will contact me and say, you know, I know I should have done this by now, it's been over a year since I've had the training, but I need a refresher, would you mind? So we do that as well and we'll always offer to co-facilitate if people aren't feeling massively confident. So I think, yeah, I would say over the last couple of months I've had three or four staff saying I know I should be doing this and I do want to do it, but I need some additional support, so we offer that. But I would say on the whole, the train the trainer approach, although on paper and in theory it should have worked beautifully, it's just not really had the desired effect. You know, numbers wise I'm sure the region has got lots of MECC trainers now. But I'm not sure what the impact of that is. So that’s phase one, the second, second part, sorry I’m totally just rambing.

BN: No perfect. Perfect.

AP13: So we class all our train the trainer work as a phase one of the MECC programme so from (date) 22 to the end of (date) this year, that was our phase one. We were trying to roll out train the trainer and offer the support etcetera. Because that's obviously had varying degrees of success we paused that training at the end of April and decided that, and this was done in conjunction with sort of senior level managers in the organization, my manager, one of the public health OSMs had gone to the board and said look, this is what we said we'd do, this is what you agreed to do but actually it's not had the desired outcome. So it's, we need to get MECC embedded in the organization it sits within our public health strategy and it's part of the wider organizations’ sort of preventative approach. But actually people aren't doing it on the ground. So what would you recommend we do? So theyve decided that there would be a more targeted approach to the training, so we would work with engaged teams and say yes we’ll do your train the trainer. So we absolutely need to embrace this and move it forward within your service. And we'll also support you with helping embed MECC within your teams because that's the crux of it you know, it's not about the training, it’s about what people are doing with that every day. So our public health team sits within the Community business unit so it was felt like that was a natural fit we would work with four or five services across the business unit to look at their day-to-day work, when we could capture MECC approaches or knowledge or opportunities to develop it. So from September this year, we kind of did a bit of a call to action over the summer and we've ended up with a team of district nurses, (name of service) which is a relatively new service within the organizations so it's all domiciliary carers provided by (name of location). So in a really good position going into people’s homes all the time, (name of service) which is just like a rehabilitation service in the community, we've also got cardiac rehab and (illegible), and possibly sexual health but we won't know that until the new year.

BN: Right.

AP13: So we've started some preliminary work with these services to say actually, what is it you are doing already? Because MECC’s not a new concept, it's not something that we necessarily need to teach people, particularly got the likes of district nursing and therapists going into people’s homes, carers, they are already doing these or having these conversations and doing signposting. But, you know, where can we support you to make sure that that's being evidenced, so for a case study being produced or that we can offer all of these opportunities where you're asking a lifestyle behavior change question and then nothing's been done with that. Where can we look to support, and of course remembering that MECC isn't just public health domains, you know, we're going to be getting a lot on carers or finances, housing etcetera, social isolation. So we developed a bit of a MECC gold standard checklist. So we're going into these teams saying what's your assessment and paperwork documentation like, have you got these types of questions in there, do you know what to do if you’re getting information to say this person is drinking to excess, what would you do as a result of that and is it being recorded? And we’re asking them to document best practice, and we're asking them to if they haven't already been trained, to go through the training and sort of commit to having that role out across their service. So I would say that it is still very early days, and we met with the district nurses on Monday, and they totally get it but at the same time, because it's so ingrained, that's their job to be having a, like going into somebody’s home and having a conversation about all the holistic elements that might impact on their health and well-being, it's not about you need to be trained in MECC it's about how can we evidence that this is going on and, so its that end of things. The thing with sort term support service, they are actually the most engaged teams that I have come across in the whole organization because they're already flying with their own training they've got, across the locality they’ve got four or five people who are doing it routinely, they don't need us to sort of bang on about the importance they just, we just need to work with them to see where we can document all the good work that's going on. So this is the approach we're taking that, that more targeted MECC approach, how do we embed it? How do we evidence it? In the hope that by sort of April time we can have built up, I guess a remit of good practice that other teams across the organization will go actually you know we can feed into that as well and we want to, so, oh and the other thing to mention aswell, we're looking at other people aswell, people (illegible) in the environment that patients are coming into. So we're hoping to work with ambulatory care as well, so when they’re sitting up at the waiting areas in (name of location) hospital, you know, what is it that they see on the screens, what is it, you know, that might engage them towards a conversation that they might have or a behaviour that they could engage in, so that's slightly different because you’ve got quite a fast turn around of patients coming through that department, but we delivered MECC training to their team a couple weeks ago, so hopefully we can get some amendment in that service. But I would say on the whole, which, we've done a lot of comms, we've done a lot of promotion. So there's no end of requests to be MECC trained, you know, we get them from HR, we get them from the governors, we get them from a whole range of clinical teams across the organization, dietetics, physios, you name it. And we always still do a monthly core MECC session for anybody to drop into.

BN: Right.

AP13: So we've always got some MECC training going on that people can attend, but it does sometimes feel a bit like you’re banging the drum and hoping people will sit up and take notice. I mean in terms of the capacity within our team there is also a clinical educator who’s supporting this piece of work. So we've got (name) public health clinical educator. So she'll go and, she’ll go onto wards and advise them you know, be MECC trained, these are the resources that you can have, this is where we can help. So she's just sort of another person on the ground, trying to sort of infiltrate more of the acute settings. And then I mentioned right at the beginning that we also have MECC training built into other training programs, so what we do again on a monthly basis is have a MECC session, a core MECC session in the preceptorship program. So that's all your new allied health professionals, nursing staff, etcetera, have to go through their preceptorship. I think it's for the first year or so of being employed. So there's particular training days and public health have a full training day, of which MECC is part of that. So that's capturing, I would say, between 30 to 50 newly qualified staff every month, and then we have it in our care certificates. So again, very similar, you know, if you've got nursing assistants and any sort of technical instructors, so, from memory, I don't think they are the qualified staff, but they still go through the care certificate program. And we deliver MECC on that.

BN: Right.

AP13: And that's once a month and then we have a program for staff, which is health and well-being champions. So that's delivered by myself and the staff health and well-being lead. So anybody can be a health and well-being champion. It's sort of a voluntary thing. You just need manager sign up and you're meant to be the conduit for anything health related from our team into your own team. So you would be responsible for campaigns., you would be responsible for making sure that people have the up-to-date information, just generally being that port of call for anything to do with staff health and well-being, and we deliver on that program as well.

BN: Right.

AP13: So, and then there's always conversations about where else could MECC be delivered, you know, we've got lots of apprenticeship schemes in the trust and lots of business development schemes coming in that, and manager training. So there's lots of forums. So essentially that's spreading the word, but it's not, they're not then gonna go on to train people. That's just about getting more staff trained in MECC. And then at the moment, we've got a public health fellow who's working into our team for a year, who's evaluating everything that we've done since September last year, and the journey that we've been on and kind of doing a few focus groups, because we have, we've gone out to the trainers to get their views on what, what some of the stumbling blocks are, we know, we can make an educated guest but we've done formal questionnaires with them and focus groups and she’s kind of pulling all of that together to talk about the journey that we've been on. There's always lots of little offshots of, you know, we've got a MECC portal being developed at the moment where we signpost people to our training, but also the elearning for healthcare training if they're not able to attend ours, train the trainer if they feel that they’re passionate enough about it, we've got things on there from the region and different best practice case studies on there, videos of, you know, saying we’ve gpt a member of staff who’s stopped smoking as a result of coming to the MECC training and those sorts of things go on there, and then where we go out and do any sort of comms and promotions. So because we're in the Community business unit, we, we've worked closely with the management team there and they decided they want 50% of staff within the Community to be trained in MECC. As fabulous as that that’s probably about 700 staff there and they want that done by the end of March or April.

BN: Oh, wow.

AP13: So I'm not, I'm not convinced that's going to happen, but it's, I suppose we’ve got to try and get some numbers to, you know, hold people to account as well and try and get that buy in. So we are trying, it's very like, it always feels very busy in terms of lots of people are interested in MECC, I think there's been lots of good profile raising gone on across the organization. But at the same time I do think there'll be lots of this work going on tht we just don't capture, that we're not aware of. That there's no real way of saying yes by having MECC training that would definitely have that outcome. I think that's the difficulty, but, you know, I suppose you could say that for a lot of things even, you've got to try. I always describe MECC as one tool in like, a little box of prevention, isngt it, it's about, you know, having those positive, very brief interactions about health and well-being and then hoping that that person takes the information away and feels motivated enough to make a change. It's not, It's not necessarily going to happen, but all you can do is try. So yeah, I think a lot of the time, you know, the powers that be are looking for definitives. So right you’ve trained 75 people so what's happened as a result of that, and that can be hard to quantify. But yes, we are, I think you know, we'll work through phase two probably for the next 6 or 7 months and then look to evaluate that. Longer term, I'm not sure whether the grand plan would be just to continue having training opportunities, you know, forever more, or whether, I'm not sure, I really dont know, because you've got to reach a tipping point haven't you where you think there’s so many people trained so when does it, when does it end? I’m not sure, I might be doing this for 20 years or, I hope not!

BN: It's amazing what you've done so far. Its a real journey.

AP13: Its a lot. Sometimes I think, what are we doing, like all of this, the emailing, the patrolling, the putting on the sessions, all the admin behind it, all the number crunching, because the other thing I should mention is we started off using the, so I call it the app, the regional app to book onto the training, the ICS one, but very very quickly realized that we couldn't expect staff to set their own training up on that because it was just, there were, I think there were lots of glitches in the system at the time. And then it just felt like we were asking them too much. So what we do now is, anybody who is delivering core MECC, obviously it's not huge numbers, but we would just ask them to arrange it in house and then just send us the registers and evaluations and then we update them onto the staff’s record automatically. So we have that organizational view of who's done the training rather than it sitting on regional app and then not, it sounds awful but that’s not doing us any favors from an organizational point of view, what we need it on is like the electronic staff record, so there's quite a lot of admin goes on. So we have got a lady in the team who supports that. And we’ve had MECC competencies created by our learning and development team and that’ll link, as soon as they've gone through the preceptorship program and it's updated on their record, that will automatically ping to say they've been MECC trained as well.

BN: Right. Okay.

AP13: So, just so that we can get to the point where we can run a report on how many people have had it in the organization. So yeah, there's a lot of sort of adminny type of things and number crunching going on as well. But it is, it is busy and I think the word is getting out it is just trying to keep on top of it all the time so.

BN: Yeah definitely.

AP13: So yeah that's where we’re at. Probably missed some crucial bit of information, but I'm looking at the call and I’ve spoked for literally, I've not stopped talking for half an hour.

BN: Oh no that's fab because you've really taken me right through, so just to check, when you mentioned about the ICS app, so that data at (name of trust) doesn't go on there at all?

AP13: No. So all of the, all of the train the trainer sessions that we did between September and April are on the app and were bookable on the app. But when, but I think the idea was that then all of those staff who would deliver core MECC would also use the app to set up with their own trainers. And I just think that that for our, I mean there would have been some I'm sure, who would have managed, but we just felt it was another barrier to our staff to navigate that system and then you know, set up that training and then keep tabs on who was signing up and whatnot, whereas it's far easier just to say do your MECC training in a team meeting, take a paper register, scan it through to us and we'll update it on that staff members records. Whereas what the regional team would have to do, and I don't think they have done this yet but they could do, they would have to come to us and say how many core MECC sessions has your organization delivered as a result of the train the trainer program, and we could give them that information, but to my knowledge we’ve not been asked for it yet.

BN: So that would be a better way of collecting the data from you?

AP13: Okay, okay that's interesting. And so, and another question. So it sounds like in phase two the train the trainer has been abandoned completely, is that right?

AP13: So in phase two, we will deliver train the trainer, and we are doing that, so for example, next, two weeks time I'm delivering it to our new cohort of public health fellows with a view to base it within medical education. So again, they are our conduits out to the junior doctors and medical staff so they will take that forward, and that won't be an issue because that's part of their work within the team, so we'll do it for them. And we'll also do it for any team signing up under phase two that wants that training. So for example, in December we’re delivering train the trainer to (name of organisation) so their management team are coming along, they're quite keen, and then they will develop, they'll deliver Core MECC to their staff over time.

BN: Right.

AP13: So we are still offering it, but it's just not going to be offered trust wide. So I wouldn't advertise a 1/2 day train the trainer session on our staff portal because at the minute it's not deemed to be a good use of time because we might get 5 people signed up, but then based on past experience, we know those five people probably won't do anything with it. So at least if we're working in a more targeted way with these particular teams under phase two, then we've got a bit more leverage to actually say we delivered train the trainer on the 8th of December to your management team and they’ve not done anything with it, what's going on? And I imagine, oh god we will do something about it, whereas if you've got some, you know, it sounds awful but some random healthcare assistant who came on train the trainer last January, there's only a limit to how much we can get them to do anything with that. You know we can send them emails but we've got no sort of authority over them, whereas working more closely with these services should hopefully mean that we can give them a bit more of a nudge if they’re not rolling that training out.

BN: Yeah.

AP13: Yes, so that sort of train the trainer does exist and it will still be used, but not as, sort of freely as it was.

BN: Yeah. The only approach, yeah. And so, obviously you haven't done the full evaluation of phase two yet, but what are your sort of comparisons so far between phase one and phase two?

AP13: I think, if I sort of bunch all the services together that have, I put signed up in inverted commas because it's all just, it's all very informal, but I think we will be able to demonstrate a higher level or a level of patient outcomes that we weren't capturing under the train the trainer, all we were capturing under the train the trainer was numbers through and this pool of staff that we thought would spread the word, whereas we can get a lot more qualitative outcomes from this piece of work, I would hope, because we've developed a case study template that they, you know, they are filling in at the minute, we've got examples of where MECC questions are asked in their assessments. So we can, you know, demonstrate that, where there's not MECC information we can, we can have a conversation with the digital teams to say is there the possibility to build these questions or these signpost options onto the digital, digital systems that these services use, and then we can also get staff feedback on how it feels and the knowledge base and all of those sorts of things will come, I hope. I mean things like can we influence readmission rates or length of stay at this stage I think are a lot harder. Theoretically yes, you could say if you, you know, if you’ve supported somebody to stop smoking then they're not going to have as many complications after a hospital stay. But I don't know that you'll ever be able to attribute that to MECC necessarily do you know what I mean, so I think that's a bit harder, but yes, we should hopefully have, and certainly in terms of the environment that people are working in, if we can make that a lot more conducive to having these conversations, you know, if we can say the particular door openers or environmental nudges you can use to start these discussions, you know, could you put a particularl poster or QR code etcetera on the wall, like for example, we're trying to get that done in the emergency department. So hopefully you've never had to go, but when you do go, there's a huge wall of QR codes to different patient information. So we're trying to get the MECC gateway on there. Nothing’s ever is straightforward you’d think that was a really quick thing to do, but it's got to go through different channels because one needs to be removed in order to put another one on and its all this what’s more important. But we are, yeah, trying to influence the environments that patients and staff are in to make it more health promoting.

BN: Yeah.

AP13: But that's, I guess that's a whole different, that’s a wide piece of work entirely isn't it, work looking at, you know, step by step how you can health improve your environment, it is huge and again, MECC’s just one part of that. So yeah, we've not, I'm not sure about what the plan is for evaluating the second phase of work, but I think we will have to get to a point, probably summer next year when we say this is, this is the comparison between the two. This is what we've tried over the last 18 months. These are obviously the successes, but now what? Do we have, because I think probably what's lacking at the minute is like a, maybe a steering group around MECC, like a specific project plan, so is it about, we have a group of key stakeholders that sort of disseminate this work rather than it just coming from, from sort of one or two staff within the public health team, which is still how it is at the minute it's about public health going in and saying this is what we can support you with, but ultimately again, how much leverage does that have when they're already very busy? That's, I think that's the difficulty because it's not a formal, it's not a formal project with a plan. We've got an implementation as with everybody across the region, so we use that documentation but It's not, It's only I guess us, so I say like myself, the clinical educator and our OSM (nae), and then we've got the public health fellow who's doing the evaluation, we're kind of that small little group, whereas we don't have I guess a more formal structure across the organization. That might be something that could assist in future.

BN: Yeah. No, that makes sense. And, I'm just sort of going back to phase one, when you said only about 10% were going onto cascade routinely, did you have any sort of comparisons between that 10% and the other 90% in terms of what, what would, what helps them to become routine cascaders?

AP13: Yeah so we had, of that smaller group we had two staff who were sort of at arms length in the public health team so they were public health fellows with medical education, so they have to do that and it was part of their role and they had, I would say they had more opportunities to do that in their day-to-day, they didn't have to go and hunt for, you know, a training session or a group of staff because they were always training the junior doctors. Then we also had, we've got a public health midwife in our wider team and so then she was MECC trained and would deliver on maternity education days. So that was inbuilt. Then we had clinical educators who were MECC trained. And again, lots of opportunities within their role to deliver MECC, but also interestingly a lot of them were going to do their teaching qualification at the time. So wanted to do the MECC training in order to build up the hours of teaching and learning they needed for their qualification.

BN: Right.

AP13: So I think there was like, there was, maybe if you could build in, sort if you do this then there will be opportunities for it to feed into, if you’re doing a formal qualification or if you need hours of teaching and all of that sort of thing. That might be one approach to encourage people, you know, if you’re doing your practice education or practice development qualifications then I guess deliverign MECC sessions routinely would I suppose tick a box for certain people. And then we also had, we also had a group from the short term support service, a couple of physios and technical instructors who for whatever reason, and we are working with them closely, were just really keen and invested and were just doing it. There was no need to nudge or do anything, they were just doing it. And I don't know whether that's because they had, or they have a manager who is very interested and passionate about it, or whether, I don't know, I think just some groups of staff get the benefits and understand the merits and you know, if I was on the other side and I've been set on a train the trainer program, I think I would probably feel like I had to do something with it. Because why else have I spent half a day of my life doing it? But then I suppose it depends what kind of team you’re working in, if your managers not going to support that, then you're not going to be able to move that forward. Whereas if your manager, if you’ve got a manager who’s saying come on, there's three or four of you from the team have gone off and spent half an hour, half an hour, half a day, doing your training, we need some movement on it. So I guess there’s that element as well. I’m trying to think who else has also been doing it routinely for us. I mean, our health coaches, they've all done MECC train the trainer, so they would, as part of their role they would be delivering on the care certificate or they might co-deliver a session. So it's, yeah, it's probably the ones where there's opportunities within their job already to deliver education, and if they're part of the public health team as well, then the expectation is that they would be, they would be doing MECC routinely.

BN: Yeah, OK, that's interesting. So very much kind of their, being part of their role and support from their managers and leadership. So, then do you think there is any way the train the trainer training can be amended that would improve cascade or is it more about those organizational factors?

AP13: I think it is more about the org-, well, yes and no, because I think the feedback I get from staff around the content is that it can be quite overwhelming, I think within public health you take in the health inequalities information, the policy information, the wider determinants, they’re all, you get used to talking through that. But I think if you're expecting, and this is no disrespect to anybody else, but I'm just pulling it out of thin air, say if we get a porter or a ward clerk or, you know, training is open to everybody. Say somebody who hasn't got that insight or foundations in public health or health improvement, I do think it can be hard for them to know how to deliver the information on, say the wider determinants, say the bit around, you know, social gradient of health and Marmot, and you know, some of the policy documents around the long term plan and then talking through the health inequalities I think can be quite difficult if you're not doing it all the time, you know, how do you, how do you describe that and, and you know, if you're not hugely familiar with the signposting options in the trust, how do you get to a place where you think I can talk through hat service confidently, and I guess a lot of it is practice over time, isn't it? But you've still got to have that little bit of insight I think in terms of, you know, how to put it forward, how to present that information. You know, if you think about the fingertips data, you might be able to, you would be able to identify your outliers and you know, we’re above the england average, but you might not have the back story in terms of why that might be. And so again, talking through the behaviour change model I don’t think that's the easiest thing to do if you've never come across that before, we take these things for granted dont we.

BN: Yeah

AP13: So sometimes yeah, I think on the face of it, it's not technical training, but I think there's elements to it which can be hard for people to deliver confidently.

BN: Right. Yeah. So do you think the answer is to take those bits out or like you said, kind of talk more through how they can present that information?

AP13: I think so, I think so. Because that is manageable because that is sort of part of the second-half of the train the trainer. But again, one of the differences we made was, I know in the regional it's all about, they do an exercise, I think it's called the Diamond 9 where they're asking, are you familiar, asking people about the qualities needed for the trainer, which I think is, it is important, but ultimately I think we're not there to teach people how to present, I think if you if you are, if you are signing up to deliver some training, the hope would be that you've got the fundamentals of how to, how to present, you know, a slide deck and you know, you would have some of the attributes already, you're going to be personable, you're going to be welcoming, you're going to you know, let people talk and ask questions and all that sort of thing. So sometimes I think that you know, that part of the training might be better spent saying actually, and we do try and do this, if we reflect back on the slides then what are the areas where you feel you might struggle to present that, and how can we, you know, what are some of the key things that you could say you know, if we are talking about the wider determinants, you know, pick three or four key points that you want to make for that slide. But I think ultimately there is a lot of, when you’re doing these sort of things, you have got to take a little bit of ownership about, you go away and you familiarize yourself with the content and then you know, if there is something where you think oh I just don't know how to put this across, then I guess you could come back to one of us. But yeah, I certainly felt doing the train the trainer way back in October last year, it was a case of I don't really feel the need to do an exercise on what kind of person I need to be to do this. I feel like we need to do something about how I present the content.

BN: Yeah.

AP13: Because everybody knows, you know, if you're nervous about presenting, you know, you know you need to prep, you know you need to build in that time before, you know you need to check your technology and your room bookings and all those sorts of things. I don't necessarily think you need to tell people how to, maybe a nod to it. But I think more, more influence or more information on how do you actually deliver this? That would be helpful.

BN: Yeah. No, that makes, definitely makes sense. Yeah, well that was everything I had to aslk you, I don't want to keep you over, past 11 as well so. Thank you so much (AP13). I really appreciate it, it's been great.

AP13: That’s alright, no problem, Do you know I feel like I’ve been, had a right therapy session. Think well actually I’ve not been sitting twiddling my thumbs for the last (illegible).

BN: Offload! Oh, no, it's amazing what's you've achieved. That's. Yeah, it's great to hear. But yeah, thank you so much.