WESSEX MAKING EVERY CONTACT COUNT (MECC) PILOT

EVALUATION REPORT

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This is an independent report from the Academic Unit of Primary Care & Population Sciences, University of Southampton, commissioned by the Wessex School of Public Health, Health Education Wessex (HEW), to evaluate the Wessex MECC approach.

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Glossary

MECC	Making Every Contact Count
HCS	Healthy Conversations Skills
SIH	Southampton Initiative for Health
HHFT	Hampshire Hospitals NHS Foundation Trust
PCC	Portsmouth City Council
SHFT	Southern Health NHS Foundation Trust
OAT	Organisational Assessment Tool
PCPS	Primary Care & Population Sciences
ODQ	Open Discovery Questions

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For further information on the Wessex MECC approach contact the Wessex School of Public Health, http://www.wessexdeanery.nhs.uk/public_health.aspx

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EXECUTIVE SUMMARY

Introduction

Making Every Contact Count (MECC) is a long-term national strategy which aims to ensure that NHS staff and staff from other organisations take every opportunity to help patients, carers and members of the public to make informed choices about their health related behaviours, lifestyle and health service utilisation. The approach embraces both developing staff competences in health behaviour change and making organisational changes to support and facilitate behaviour change.

Health Education Wessex identified the requirement for a feasibility study of MECC in NHS and other settings in order to provide learning from introducing and implementing it in different places where the interaction or contact with the public varies.

Recruitment

Three pilot sites in Wessex were recruited and funded to test the Wessex MECC intervention. Different workforces were selected in the two NHS sites, leading to eight distinct teams involved in the implementation:

- Hampshire Hospitals NHS Foundation Trust: 1) Therapy Services (three different teams) 2) Diabetes Services and 3) Occupational Health (Health4Work).
- Southern Health NHS Foundation Trust (SHFT): 1) Minor Injuries Unit and 2) Heart Failure and Respiratory teams. (Several other teams in SHFT also carried out MECC training but they were not included in this evaluation)
- Portsmouth City Council: One local area Housing Office

The Intervention

The intervention was built on and adapted from the Midlands & East MECC model. The Wessex MECC intervention as a whole included a core knowledge and skills training programme, Healthy Conversation Skills (Barker et al, 2011), and organisational changes to embed the change in staff practice into working routines at each site.

The delivery of the pilot aimed to take an organisational development approach to the implementation focusing on:

- Organisational Readiness: Support senior buy-in and board level sign-up to MECC in order to ensure strong leadership
- Staff Readiness: Support managers and service leads to champion and implement MECC by providing them with a development programme which will enable them to understand MECC, their role in implementation and support their staff to deliver MECC
- Training: The delivery of training to frontline staff who will be equipped to help individuals to explore issues and identify solutions and plan for change, give brief advice and signpost to other services where necessary.

The evaluation was designed to assess a practical approach that was feasible within limited resources, and transferable between different implementation contexts. The aim of the evaluation was to inform the development of local guidance - a toolkit, to learn from a number of different sites how to implement it most effectively, and what, if anything, needs to be modified for successful future implementation. The Precede-Proceed model was used as an organising conceptual framework for the evaluation design (Green & Kreuter, 1991).

Healthy Conversation Skills (HCS) training

HCS training helps front-line staff to optimise the time spent with clients by using Open Discovery Questions (ODQs- questions that usually start with 'what' and 'how') rather than make suggestions, give information or tell clients what they should do. At the NHS sites the staff roles, their ability to use their skills to both motivate and support behaviour change and the time they had available with patients were taken into account when selecting the workforces, at these sites the full HCS training was applied. In Portsmouth City Council the roles of the staff to be trained were established initially as being only at Level 1 of the Behaviour Change Framework or 'signposting' (The NHS Yorkshire & Humber, 2010), hence their training was limited to the skills required for that.

HCS Train the Trainer courses were delivered to key staff members, the pilot and service leads from each pilot site, to develop staff knowledge and skills for the intervention. They comprised two 3-hour group sessions and one 6-hour group session, designed to put the training into practice. The aim was for each of the pilot sites and service leads to deliver a training course in their workplaces based on the training received, modified in such a way to suit the particular staff group.

Key evaluation phases

1	•Recruitment of pilot organisations. (2 in March 2013, 1 in 2014)
2	•*Organisation Assessment Tool (OAT)* administration
3	•*Pre-MECC Staff Survey* Sent 2 weeks before training, reminder 1 week before (n=100)
4	•Training evaluation
5	•*Process Interviews* – during MECC implementation (n=14)
6	•*Post-MECC Staff Survey* - 3-4 months after training (n=101)
7	•*OAT* - Reassessment
8	•*Post-MECC Interviews (n=18)*

Key Findings

The study was not powered to detect changes due to the MECC intervention within organisations over time, but there were some positive findings that may be relevant for further research.

From the survey, at least half of the staff responded that they had not received any previous training to enable them to promote healthy lifestyles. Staff knowledge of the importance of their role in discussing healthy lifestyles rose, as did their confidence, but there was little change before and after to the issues that make discussing healthy lifestyles easier or more difficult. These included time, clients' attitudes, service organisation and facilities, for example. The Post- MECC survey showed that the majority of staff thought their lifestyle was healthy with one third reporting that it had improved quite a lot since the introduction of MECC. Some staff expressed disquiet at the dissonance between their own lifestyle and the 'healthy role model' they felt they were expected to demonstrate.

In the training evaluation conducted immediately after the HCS training had been delivered, there were significant increases in confidence and in intention to use the key skills such as ODQs rather than make suggestions or give information. However the peer observations showed evidence of some of the skills demonstrating a good level of competence, but also a need for further encouragement and on-going support.

Themes that emerged from the qualitative evaluation interviews included:

- Challenges to introducing MECC
- Benefits of introducing MECC
- Developing staff knowledge and skills
- Organisational issues
- Recording MECC activity
- Referrals to other services
- Recommendations for the future

Staff at all levels stated finding adequate time for the training was the biggest obstacle. The need to reduce it to achievable chunks, customise it to service needs, and wrap around other important knowledge about health issues and the services available was paramount.

> '…you look at taking a whole day out of somebody's workload at the moment, and that's one day…actually the MECC training would advocate two days….so to cut it down was …was challenging. To get staff to be released for a day…that's a big ask.'

Organisational assessment

The Organisational Assessment Tool (OAT) was the first opportunity to assess some of the key organisational factors important for the successful introduction of MECC. In Southern Health NHS Foundation Trust (SHFT) and Portsmouth City Council (PCC) the 'expectations of benefits beyond helping patients' was seen as high, as was staff involvement and training to sustain the process, and senior and team leadership. There was a very high fit with the organisation's strategic aims and culture, but little in the way of organisational

infrastructure in place for sustainability. Hampshire Hospitals NHS Foundation Trust (HHFT) was more confident in the effectiveness of their systems to monitor progress and felt they had some infrastructure for sustainability. PCC showed a similar pattern except there were lower scores on staff involvement and training and team leadership.

> *'The project is highly relevant to physiotherapy and we currently readily offer advice on exercise levels and discuss smoking/drinking with patients where highly relevant therefore the areas of credibility of the project scored highest'*

The potential difficulties in the system to monitor progress and in on-going sustainability were evident from the OAT before training and delivery of MECC, and subsequently highlighted at later stages of the evaluation. A number of organisational issues were discussed in the qualitative interviews, these included infrastructure issues such as the physical limitations in departments meaning that it was difficult to have private conversations with patients, and lack of regular access to computers.

Recording and referral systems

Recording and referral systems were probably the least satisfactory organisational issues across all sites and settings. The importance of recording a 'MECC conversation', and then following up the patient were seen as vital to be able to evaluate the effect of MECC on patients or client behaviour. This in turn would be fundamental to its sustainability and roll-out to other services.

> *'…we need to look at that, but the whole bit of recording it is a minefield, and how we're going to track it, because every department's got different things.'*

Referrals were described as another 'grey area'. Staff needed to know about the services available in the area and what they provided, and whether they were simply 'signposting' or more formally making a referral to them. In PCC there was a network of health improvement services across the city and a single telephone number and website for information. In HHFT a prompt card and flyer were developed for staff to give to patients with details of local services available and a bespoke webpage was developed for the Diabetes service. Elsewhere there was not always the local knowledge about services to hand, and also whether or not it was possible to refer to them.

> *'We're looking at …having an automated system…, so that's going to be really good, referrals will be a lot easier, and I think that needs to be a separate thing in itself, how can we refer much easier, and make it seamless.'*

Staff views on the introduction and implementing of MECC

The introduction of MECC was reported by staff as improving job satisfaction, increasing professional empathy, providing team bonding, and having a positive effect on organisational culture. It is clear that the key to its successful introduction is having an enthusiastic and experienced health promotion champion whose role is to lead it, provide access to resources and ensure not only senior management buy-in but the engagement of

middle or service management and consultants' involvement from the outset. The inclusion of behaviour change support in staff contracts or through other financial incentives was also noted as important for its sustainability.

> *'I'm certainly more an empathetic professional since Making Every Contact Count. It allows you to speak with residents and their families. They can open, they can talk to you, that gives you some job satisfaction as well…'*

There were practical difficulties with the Train the Trainer model. Some service leads who had received HCS training initially did not feel competent to train their colleagues in their teams. The MECC training was therefore delivered by pilot leads and differed according to the workforce. In all cases the amount of training time was considerably reduced and broken up into shorter sections over a matter of weeks. Modifications included a pre-training video presentation with a brief introduction to specific topics and risk factors including alcohol, smoking, diet and physical activity.

> *'the training has to be quick and easy to implement so that it doesn't take up their staff's time.'*

Overall it was felt that background information on MECC, some behaviour change theory, and healthy lifestyle information (relevant to role) was valuable, but if possible should be delivered in a team setting prior to the delivery of the more intensive skills based training, and should involve administrative and reception staff. In all cases, whatever the mode of delivery of the training, respondents felt that peer support and refresher training would be beneficial.

Recommendations

This pilot has shown that the MECC approach can successfully be delivered in a variety of different settings in both the health and local authority services context. The particular approaches taken, both to introduce and to prepare staff for MECC, and in the way that it was implemented, have shown its ability as an opportunistic intervention to be tailored to the very different circumstances in which staff find themselves in contact with the public. During and since the pilot period further organisations and sites have shown interest in the initiative and begun to implement it. Its importance has been endorsed in the NHS Five Year Forward View (NHS England, 2014). It is hoped that the findings of this study will help to provide clearer mechanisms to sustain and upscale MECC initiatives so that they become embedded in the practice of a wide variety of services and workforces.

Organisational readiness

The Organisational Assessment Tool (OAT) could be a valuable guide to assessing organisational readiness to implement MECC, but it needs substantial simplification and application at an appropriate time in advance of implementation. Organisation-wide communications are necessary to support embedding MECC in the organisational culture, and on an ongoing basis to encourage staff to continue to apply the approach. In addition,

review of the physical layout and space in departments needs to be assessed for their appropriateness for holding healthy conversations.

Management and sustainability

An enthusiastic and experienced health promotion champion is needed to lead the MECC implementation both at initiation and on a continuing basis. Senior management buy-in, the engagement of middle or service management and also consultants' involvement is necessary, and consideration should be given to including behaviour change support in staff contracts or job descriptions for those staff taking on MECC roles.

Referrals and recording

Within organisations the connections for referral between services need to be reviewed and clear protocols developed for referral so that staff are aware of further support available. A system wide approach should be taken so that there is increased capacity for more referrals, and unnecessary administrative barriers to effectively implementing MECC and supporting patients can be removed.

Project leads should review their specific local recording systems and discuss amendments with their IT departments prior to introducing MECC to facilitate the ability to capture both activity and outcome data. A review of the modifications to assessment and recording forms used by the sites in this pilot would be useful to provide examples or templates for other implementers.

Training

Managers should consider how much engagement staff are likely to have with patients or clients following initial contact, and the extent of training needed to be competent. Only staff who are experienced trainers, or who have been prepared adequately and are confident should be responsible for staff training on MECC. Training needs to be delivered in sessions of a length that is acceptable in busy settings. This should include: orientation to MECC, appropriate lifestyle topics, communication skills, information about referrals and services available, and recording methods. Refresher training and support sessions should be built in at regular intervals after initial training.

Introducing information about MECC and the organisational commitment to prevention and health promotion could be provided briefly in induction or other training opportunities such as e-learning, to gain wider understanding and support for MECC, and to reduce training time for future services beginning to implement it. Consideration should also be given to including 'behaviour change' in all professional training as part of widening health promoting organisations and wider workforce training

Evaluation and further research

Further research could be done to explore whether the introduction of MECC has an impact on wider issues such as reducing staff absence and staff's own health, its cost-effectiveness

in different settings, outcomes on behaviour and whether system changes can be put in place to ensure that MECC is sustainable.

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June 2015

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1. BACKGROUND TO MAKING EVERY CONTACT COUNT (MECC)

1.1 The national picture

Making Every Contact Count (MECC) is a long-term national strategy which aims to ensure that NHS staff and staff from other organisations take every opportunity to help patients and visitors make informed choices about their health related behaviours, lifestyle and health service utilisation. The framework was launched in February 2010 and has subsequently been adopted in policy and practice in NHS trusts across England (NHS Yorkshire and the Humber 2011). When public health teams were transferred to Local Authorities in April 2013 this opened up further opportunities for local councils to use MECC to improve the health and well-being of the population. A key aspect of the approach is developing staff competencies and this builds on the Prevention and Lifestyle Behaviour Change Competence Framework (NHS Yorkshire & the Humber & Sheffield Hallam University, 2010) which was designed to enable staff to develop knowledge and skills in addressing the health and wellbeing needs of the local population in the following areas: long term conditions; smoking; falls prevention; alcohol abuse; obesity management; medicines management; physical health; and mental health and emotional wellbeing.

The MECC approach follows other initiatives to promote health in hospitals and other health services, and other settings where staff have contacts with patients and clients. A review of thirty English hospitals which participated in an audit of health promotion provision in 2009 and 2011 using the WHO HPH Standards (WHO, 2004), showed that there was little evidence of co-ordinated health promotion activity at that time. Random samples of 100 patients were surveyed in each hospital each year, (Lee, Knuckey & Cook, 2013). While risk assessment rates for smoking and obesity increased significantly, alcohol assessments remained similar and physical activity assessments decreased significantly. Provision of health promotion support following assessment remained similar for smoking, alcohol and inactivity and actually decreased significantly for obesity. The authors concluded that there is little evidence of health promotion activity in English hospitals, showing much potential for health gain with wider provision with initiatives such as MECC.

The NHS Future Forum (2011) recommended that 'every healthcare professional should "make every contact count", and use every contact with an individual to maintain or improve their mental and physical health and wellbeing where possible, in particular targeting the four main lifestyle risk factors: diet, physical activity, alcohol and tobacco – whatever their specialty or the purpose of the contact.' They called for Health Education England, Public Health England and the NHS Commissioning Board, professional bodies and service managers, to identify where healthcare professionals' skills and knowledge for making every contact count need development, and to work together with education and training partners to deliver this. The Local Government Association has also published guidance and examples of MECC approaches in local authorities (LGA, 2014).

Kislov et al (2012), in their review of the literature relating to work redesign and health promotion in health care organisations, noted that MECC can be viewed as a workforce development intervention operating in the field of health promotion. The literature on work redesign notes a number of organisational factors that are barriers to role redesign

projects including: lack of finance and resources, expectations of pay increase for enhanced roles, and management and accountability changes. They also found, while education and training is widely acknowledged as important, that there is evidence that sufficient training is not always provided, there can be conflicts between in-house and external accredited training provision and that the economic context can limit education and training opportunities. Citing McHugh *et al* (2010) review of the evidence related to implementation of Health Promoting Hospitals (HPH) they noted issues which could also impact on MECC implementation. These include lack of skills and training in health promotion, and the fact that patients themselves have expressed concerns over the knowledge base and the ability of professionals to deliver health education interventions (McBride 2004). In addition to training, a strategic long-term organisational commitment is required to improve attitudes to health promotion practice, and therefore MECC.

An evaluation of the Health Promoting Health Service (HPHS) Framework run by NHS Health Scotland (Whitelaw *et al.* 2006) showed that stand-alone frameworks, tools or resources may contribute to the implementation of health promotion interventions in healthcare settings, but where staff knowledge and skills were lacking utilisation of such resources was limited and 'insufficient to precipitate change'. Factors that were seen to be critical for success included: fostering relevant competencies, co-ordination of dissemination activities, and provision of training, support and management. Citing Whitelaw *et al.* (2012), Kislov *et al.* also noted that wider support is unlikely if early adopters 'don't understand the organisation's mechanisms, get a 'buy in' from a critical mass of 'multipliers' and secure an effective leadership to integrate the work into existing structures and procedures'. They state that 'An emerging theme is the importance of coordination, integration and capacity building to embed interventions in the organisational routines and sustain behavioural change even after the health promotion project is completed', and they raised some critical questions for MECC evaluations including the following, some of which have been considered in this Wessex pilot evaluation:

- What are the attitudes of different stakeholders towards the initiative and its (perceived) outcomes?
- What are the perceived (contextual) facilitators and barriers to successful implementation of the MECC projects?
- How are the roles redesigned to enable the implementation of the programme in different contexts?
- What training is provided at the sites to enable the implementation of the programme, and how useful is it considered by its recipients?
- How do perceptions of and approaches to MECC implementation differ across various professional and organisational groups?
- What is the strategy for sustainability and further spread of change that has already been achieved by MECC projects?
- How is the implementation process affected by the current organisational and financial climate?
- What is the role of internal and external facilitation in the process of implementation?

During the course of this pilot NICE (2014) produced a revision of their guidance on behaviour change, and made a number of recommendations for the commissioning, delivery and training for individual behaviour change interventions. In order to commission high quality effective behaviour change interventions it is recommended that: evaluation plans should be built in from the outset, resources should be allocated for independent evaluation, there should be a process to assess intervention fidelity (whether it was delivered as planned), and that a pilot should be done when it is not clear that an effective intervention can be transferred to other settings or populations (Recommendation 4). Commissioners and providers of behaviour change services should encourage health, wellbeing and social care staff in direct contact with the general public to use a very brief or brief intervention to motivate people to change behaviours that may damage their health (Recommendation 9). The requirements for provision of training for behaviour change specify the competencies and skills required including: ensuring behaviour change practitioners have the skills to assess people's behaviour using validated assessment tools and measures; and communicate effectively, for example, by giving people health, wellbeing and other information, by using reflective listening and knowing how to show empathy, develop rapport and relationships with service users, and develop a person's motivation to change by encouraging and enabling them to manage their own behaviour (Recommendation 12).

Prior to the start of the Wessex pilot information was sought from other organisations who had already implemented MECC about their evaluation methods and to find out what worked well, including any information on the potential economic benefits. Informants from Sandwell Metropolitan Borough Council, Derbyshire City Council, and Health Education West Midlands reported some key learning points from their local implementation of MECC. (Brown, Baxter & Heathcote-Elliott, 2013; East Midlands Health Trainer Hub, 2013; Mills, 2013). These included issues around training, organisational commitment, data collection and evaluation. Regarding training it was thought that as many staff as possible should be trained, across all roles, and training itself should be short, adapted for different staff groups, and delivered by experts. The training in these areas included two modules each of about one hour in length. These covered: determinants of health, healthy lifestyle messages, brief advice, local service descriptions and motivational interviewing. From an organisational perspective the importance of the active involvement of management, including at senior levels, was found to be necessary. Staff should get positive feedback and have the opportunity to discuss MECC implementation. Overall there should be cultural change within the organisation to embed prevention into everyday practice, but each organisation is likely to interpret MECC differently. Marketing tools such as posters, and systematising the approach for example by including questions in patient and staff satisfaction surveys were considered helpful. Other practical issues such as simplifying referrals through the use of a single phone number were also mentioned. As far as evaluation was concerned they reported a number of difficulties including lack of mention of MECC by patients attending referral appointments, and that indicators were difficult to measure. The importance of assessing staff confidence, knowledge and competence was also noted.

1.2 The Wessex MECC Approach

1.2.1 Selection of organisations to pilot the MECC implementation

Following a scoping exercise by the School of Public Health of other MECC interventions in England, it was identified that the Wessex MECC approach would need to be piloted in different settings in the NHS and elsewhere in order to provide learning from implementing MECC in different places where the nature of the interaction or contact, with the public varies. The pilot organisations were then identified through the School of Public Health's network. Organisations who were interested in developing MECC were recruited to become part of the Wessex MECC pilot. Selection was pragmatic but each pilot organisation was required to demonstrate commitment to implementing MECC by identifying a MECC Lead and MECC Implementer for each site. Initially there were two pilot organisations identified (one NHS, one LA) who were awarded £15,000 each to support with the implementation of MECC for their organisation. However later on during the pilot a third organisation (NHS) was recruited due to delays with commencement at one of the earlier pilot sites. This then meant that a total of three pilot sites representing different settings were included as part of the Wessex MECC pilot.

For each pilot organisation a funding agreement was drawn up which outlined that the MECC project would be delivered as a pilot in Wessex to test and evaluate the Midlands & East MECC model. The delivery of the pilot aimed to take an organisational development approach to the implementation focusing on:

- Organisational Readiness: Support senior buy-in and board level sign-up to MECC in order to ensure strong leadership at the very top is in place.
- Staff Readiness: Support managers and service leads to champion and implement MECC by providing them with a development programme which will enable them to understand MECC, their role in implementation and supporting their staff to deliver MECC.
- Training: The delivery of training to frontline staff to equip them to support individuals to explore issues and identify solutions and plan for change, give brief advice and signpost to other supportive services where necessary.

The pilot organisations delivered the project by using the adapted Midlands and East MECC model in order to:

1. Assess the organisation's readiness to implement MECC using the Midlands and East MECC Tool
2. Identify the target workforce to deliver MECC. Criteria for choosing workforces were:
   - One to one contact with patients or clients
   - Large numbers in the organisation to demonstrate organisational change/impact
   - Easily accessible to deliver MECC and to follow up for evaluation
3. Use the Midlands and East MECC model to provide a framework for MECC implementation
4. Roll out the Healthy Conversation Skills training to all front line services as the mechanism for meeting the MECC agenda

5. Evaluate the model and its application in Making Every Contact Count
6. Support the Wessex School of Public Health in informing and developing a MECC business case to the Wessex Local Education and Training Board (LETB) for wider roll out

The pilot project was originally planned to be delivered over 12 months, however the project took nearly 24 months to complete. One of the significant factors for this delay was the implementation of the Health and Social Care Act on April 2013 which meant the health system as a whole was in a process of transition. A MECC Steering Group (Appendix I) was set up to oversee this project and there was continuous communication with this group on the progress of the project and agreement for extending due to the system wide factors around transition.

The Wessex MECC intervention as a whole comprised a core knowledge and skills training programme, Healthy Conversation Skills (Barker et al, 2011), (see section 2.1), other training on specific topics and risk factors such as alcohol, smoking, diet and physical activity, and organisational changes to embed the change in staff practice into working routines at each site. For the training element information was sourced from eg NHS Midlands and East e-learning modules, NHS Core Learning Unit modules, NHS Hampshire '60 second project' and RSPH e-learning modules for developing health and well-being knowledge on key public health topics such as alcohol, smoking, and diet. Having considered these options the Healthy Conversation Skills (HCS) training was selected for implementation in this project. (The NICE guidance on behaviour change (2014) was in preparation at this time, but the 2013 update was also referenced). HCS was developed by colleagues from the MRC Lifecourse Epidemiology Unit in the University of Southampton to meet a locally-identified need for practical easy-to-understand skills to support behaviour change that could be accessible and acceptable to a range of staff groups.

As part of the support provided to pilot organisations to enable them to implement MECC within their organisations a planning day was delivered with the pilot site leads (excluding Southern Health as they were not part of the pilot at the time), the evaluation lead and the Hampshire Public Health Development lead. The objectives of this planning day were:

- To identify the implementation process of the MECC project for pilot sites
- To define the quality assurance process for staff training
- To understand the evaluation framework for MECC.

Each pilot organisation was asked to prepare project plans that would outline the particular departments or services within the workplace setting that would be involved, and the numbers and roles of staff within each of these sites that would be trained. These services and the staff within them would therefore would be included in the evaluation. In addition they were also asked to identify methods of recording whether MECC had been delivered, and develop new approaches if required eg modifications to patient record cards or online patient records. In addition referral pathways to services to provide further behaviour change support (eg smoking cessation) would need to be identified and methods of recording referrals developed. Finally sites would need to access or develop MECC communication tools for staff and patients, such as prompt cards for staff, posters, leaflets and webpages. Existing MECC Communication tools, including the 'making the case' presentation for Boards (East Midlands Health Trainer Hub, 2012) were reviewed for their

utility to provide communication strategies for the individual pilot organisations. In addition data capture tools were considered to provide practical examples and realistic methods of recording when MECC has taken place with a client and when referrals are made.

The individual pilot sites and the workforces identified for training are described below from information provided by the pilot site leads.

Hampshire Hospitals NHS Foundation Trust (HHFT)
Three workforces were selected, Therapy Services, Diabetes Services and Occupational Health. Therapy Services are based at Alton, Basingstoke and Winchester Hospitals, and consist mainly of Physiotherapists, Team Managers, Hand therapists, and Allied Health professionals. They were selected as they generally have longer consultation times with patients than other departments, and also have follow up appointments with patients. The Diabetes Services included Specialist Nurses and nurses for diabetes, and dieticians. They were also selected on the basis of longer patient consultations and follow ups compared to other departments, and as it was felt that their patients would get the most benefit from MECC. The Occupational Health service, known as Health4Work, included an Occupational Health consultant, Occupational Health Nurses, Business Manager and administrative team. They were also selected due to longer patient consultations and potential for follow ups with patients. The pilot lead was part of this team

Portsmouth City Council (PCC)
The service selected was the Paulsgrove Area Housing Office, situated in the north of the city of Portsmouth. It is an area of predominantly social housing and high deprivation. This service was chosen because of its location in an area of high deprivation with poor health outcomes, and also the type of service. Although Housing is not traditionally associated with health issues, the officers have a high face to face contact with clients with high needs. In addition the department had had the experience of participating in various examples of public health projects in the past. Those within the team identified for training included: Housing Officers, Estate Manager, Tenancy Support Officers and Customer Service Manager.

Southern Health NHS Foundation Trust (SHFT)
This was the community facing service that provided NHS services. SHFT had identified the opportunity they as an organisation had to supporting the health and wellbeing of their patients and recognised the importance of supporting individuals to self-manage aspects of their health. A Public Health lead was identified who approached the School of Public Health for support. SHFT identified a total of 6 service areas to pilot MECC with, however due to the later addition of Southern Health to the pilot project only two services were included in this evaluation; these were the Minor Injuries Unit, Lymington and the South East Hants Heart Failure and Respiratory teams.

1.2.2 Wessex MECC pilot evaluation framework

The Wessex MECC pilot evaluation was designed to assess a practical approach to evaluation that was feasible within limited resources, and transferable between different implementation contexts. The aim of the evaluation was to inform the development of local guidance, a toolkit, to learn from a number of different sites how to implement it most effectively, and what if anything, from the approaches tested need to be modified for successful future implementation. In addition it also provided for the testing of the feasibility of evaluating the implementation to design potential future larger scale research to assess the longer term impacts. At this stage, in order to focus on what is meaningful to inform future implementation the well-established Precede-Proceed model (Fig. 1) was used as an organising conceptual framework for the evaluation design (Green & Kreuter, 1991).

This model embraces all stages of planning and evaluation of health promotion interventions, and it pays attention to the different stages of intervention development and evaluation, considering organisational and contextual factors, and ways and phasing of measuring process, impact and outcomes. For the purposes of the MECC pilot evaluation, we focused on the phases of 'educational and ecological assessment' looking at issues such as 'predisposing, reinforcing and enabling factors', and 'administrative and policy assessment'. This would examine for example, knowledge, attitudes and beliefs of staff in the services involved in the pilots, the availability of resources, training and management support, and access to other support services. Of equal importance is the organisational context; local policies, attitudes and engagement of senior leadership and management will influence the organisational changes required to support implementation. Thus at the outset it was clear that this pilot was not an outcome evaluation examining the success of MECC in terms of patient satisfaction and behaviour change. The intervention is based on evidence based methods, and the pilot is exploring how it can be integrated into routine practice in a variety of contexts, what helps it to work, or not, and how it works best, addressing many of the questions posed by Kislov *et al* above (2012).

Fig. 1 Precede-Proceed Model

Precede – Proceed Model
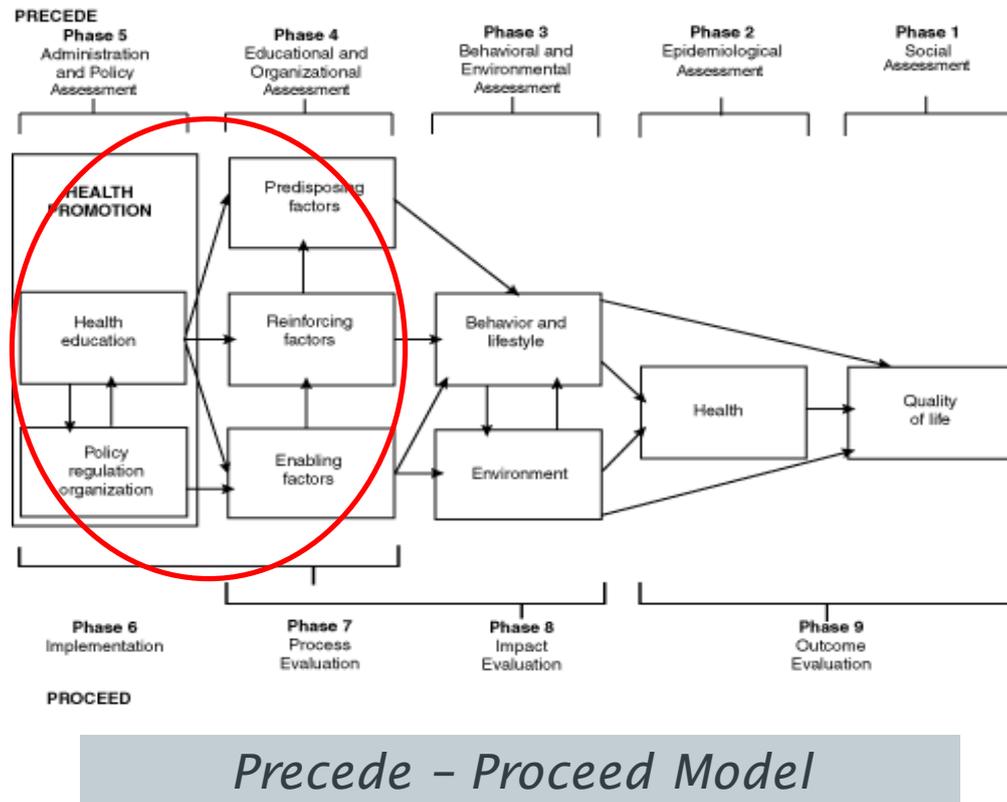
2. WESSEX MECC INTERVENTION TRAINING

Healthy Conversation Skills (HCS) Train the Trainer courses were delivered to key staff members, the pilot and service leads from each pilot site, to develop staff knowledge and skills for the intervention. They comprised two 3-hour group sessions and one 6-hour group session, designed to put the training into practice. The pilot and service leads then took this training back to their workplaces and each delivered a training course based on the training received, modified in various ways to suit the particular staff group. The site specific training is summarised in Table 1 below.

2.1 Healthy Conversation Skills Training

The Southampton Initiative for Health research team were commissioned by Health Education Wessex to deliver Healthy Conversation Skills (HCS) Train the Trainer courses to key staff members as a mechanism of delivery of the MECC initiative. This workforce development training was developed by researchers at the MRC Lifecourse Epidemiology Unit, University of Southampton to empower front-line practitioners to support patients and clients to make lifestyle changes. HCS training aims to improve the self-efficacy and sense of control of individuals, particularly those from disadvantaged backgrounds, in order for them to reflect on their lives and identify ways to improve their lifestyle behaviours, including their diets and levels of physical activity. The training was originally designed to address the barriers to changing health-related behaviours among women with young children in Southampton (Barker *et al*, 2008; Lawrence *et al* 2009 & Lawrence *et al,* 2011), following extensive research and consultation in the city (Lawrence *et al*, 2012). It has subsequently been rolled-out to a wide range of health and social care professionals, both in the UK and internationally. The approach that HCS training is based upon has been shown to improve the health behaviours of individuals with newly diagnosed diabetes, and is grounded in the principle of empowerment (Anderson & Funnell, 2000, 2005).

HCS training helps practitioners optimise the time spent with clients by using four key skills. Trainees are trained to ask Open Discovery Questions (ODQs are questions that usually start with 'what' and 'how') rather than make suggestions, give information or tell clients what they should do (Skill 1). By doing this, trainees will be able to explore their clients' worlds in order to support them to identify barriers to change and find their own solutions; thus emphasising the power of listening (Skill 2). They are introduced to the concept of SMARTER planning: supporting someone to make a Specific, Measurable, Action-oriented, Realistic, Timed, Evaluated and Reviewed goal (Skill 3). Using a group work model the training encourages discussion and reflection (Skill 4) on current practice and follows a non-judgemental problem-solving approach, designed to enhance trainees' confidence in supporting behaviour change. In this way they are equipped to deliver the Making Every Contact Count agenda.

The training activities were designed using a theoretical basis (Abraham & Michie, 2008; Michie *et al*, 2013). This taxonomy of behaviour change techniques has been developed and revised by health psychologists in recent years, in order to identify and classify a range of techniques proven to be effective in motivating, encouraging and sustaining positive behaviour change. Healthy Conversation Skills training has been developed with this

taxonomy in mind, so that activities are intended to utilise one or more behaviour change technique.

A 'healthy conversation' supports an individual to explore their own world/context, find the solutions from within and plan to make change. To support others to change their behaviour, professionals working with them may need to change their own behaviour. To achieve this change, this training asks trainers to review their current beliefs about behaviour change; explore their current practice; and reflect on changes in their own behaviour over time. Trainers model what they would like to see in their trainees' every day practice. This training emphasises the importance of reflection, for both trainers and trainees. The purpose behind self-reflection is to improve the outcomes of a person's work by enabling them to reflect or think about what they do and how they can improve what they do. Articles reporting the rationale, development and early outcomes of this training initiative have previously been published (Barker *et al*, 2011; Tinati *et al*, 2012; Black *et al*, 2012; Lawrence *et al*, 2014)

2.2 Training delivered at Hampshire Hospitals NHS Foundation Trust

The training (Table 1) was tailored for each of the different workforces. A pre-course video was available for staff to watch before the face to face training, which covered information on healthy eating, stop smoking, reducing alcohol intake and physical activity (See Appendix J). In Therapy Services only some of the staff saw the 'video presentation' prior to the training. The face to face training was restricted in time. In the Diabetes Services, both teams were trained together in 2x 3 hour sessions which were delivered with 1 week apart, leading to this training being the closest match to the original Healthy Conversation Skills training. In the Health4Work group there were the most diverse range of staff and once again the training had to be tailored to fit the time available and the context of the Health4Work environment. This group also had the longest gap of three weeks between the first and second sessions.

2.3 Training delivered at Paulsgrove Housing Office, Portsmouth City Council

The pilot site lead did not think the HCS training was applicable for this staff group as, using the Yorkshire & Humber framework for MECC, it was agreed locally that staff would be working almost exclusively at Level 1, that is the first level of introducing the idea of changing behaviour and motivating individuals to think more about change, including enabling them to seek more information (see Fig. 7). In the training the use of open questions was taken loosely from the HCS training, but a focus on 'cues to action' was considered necessary with less need to look at SMARTER goal-setting. Some discussion was also had around health topics and knowledge, but the emphasis overall was on sign-posting and referral routes. The learning outcomes for the three hour training session were to:

- Ensure individuals are able to make informed choices to manage their self-care needs.
- Support and enable individuals to access appropriate information to manage their self-care needs.
- Communicate with individuals about promoting their health and wellbeing

- Provide opportunistic advice

In summary the short course aimed to ensure the worker was able to engage with individuals and use basic skills of awareness and communication to introduce the idea of lifestyle behaviour change to motivate individuals to consider or think about making changes to their lifestyle behaviour(s). The HCS evaluation forms were used even though the HCS course was not delivered exactly as planned.

2.4 Training delivered at Southern Health NHS Foundation Trust

Both the Minor Injuries Unit, and Heart Failure & Respiratory teams received the same training. This included a short introduction to MECC, introducing the use of ODQs, followed up by practicing their use through role play and discussion and activities on setting SMARTER goals.

Table 1. Summary of training sessions for each site

SHFT, Minor Injuries Unit, Lymington 30th April 2014 Heart Failure and Respiratory teams, South East Hants 7th May 2014	1 x 6 hr session	Session plan included most HCS activities (apart from those related to Behaviour Change Techniques, & the SMARTER Planning for Change tool); covered all 4 key HCS competencies.
HHFT, Therapy services, Winchester and Alton-18th October 2013 Therapy Services, Basingstoke 8th January 2014 Diabetes and Health4Work November, December 2014 and January 2014	1 x 4hr session (Therapy Services) 2 x 3hr sessions (Diabetes) 2 x 2hr sessions (Health4Work)	Session plans for both modes of delivery included all HCS activities (with some modifications); covered all 4 key HCS competencies.
PCC, Paulsgrove Housing Office 30th January 2014	1 x 3hr session	Session plan indicates no HCS activities; one activity focused on listening for cues, so partially addressed 1 out of 4 of the key HCS competencies.

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3. PILOT EVALUATION METHODS

The design of the evaluation aimed to capture information on the various aspects of the intervention and implementation process from different perspectives. A range of instruments were designed for each phase as in Appendices A – H.
The phasing of the evaluation was as in Fig. 2.

Fig. 2 Evaluation phases

1	• Recruitment of pilot organisations. (2 in March 2013, 1 in 2014)
2	• *Organisation Assessment Tool (OAT)* administration
3	• *Pre-MECC Staff Survey* Sent 2 weeks before training, reminder 1 week before
4	• Training evaluation
5	• *Process Interviews* – during MECC implementation
6	• *Post-MECC Staff Survey* - 3-4 months after training
7	• *OAT* - Reassessment
8	• *Post-MECC Interviews*
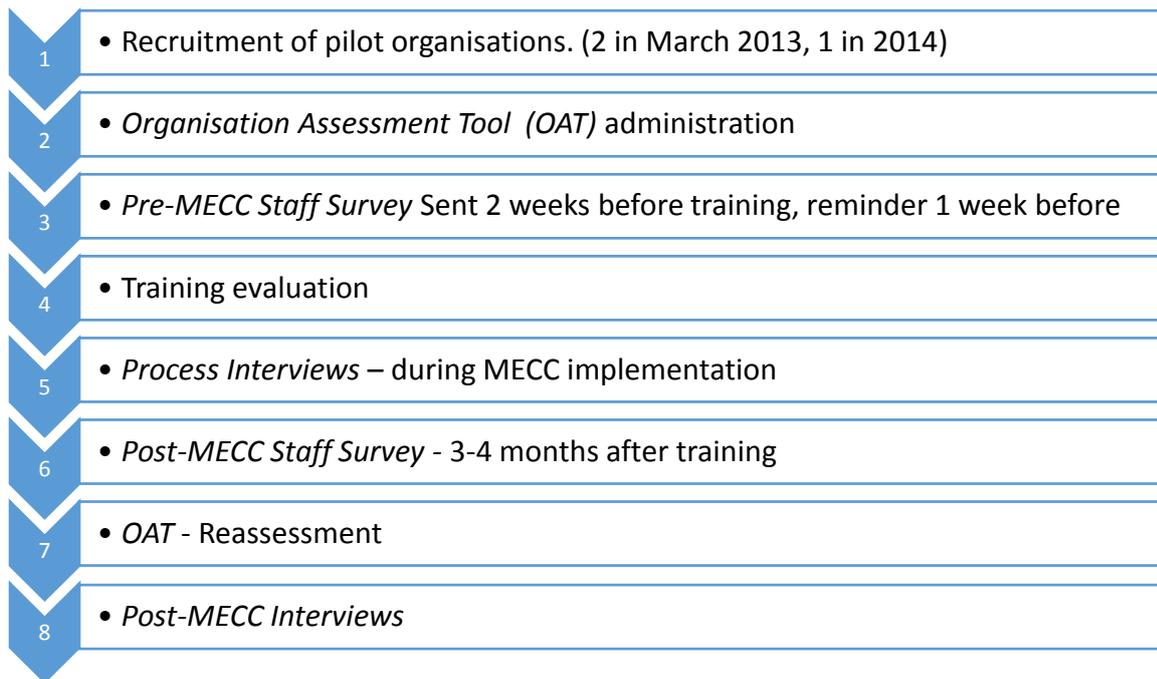
3.1 Organisational Assessment Tool

An Organisational Assessment Tool (OAT) [Appendix A] was adapted to be simpler than the Midlands and East tool for use by pilot site leads with their senior staff and workforce leads, to indicate aspects of the organisation's readiness to implement and embed MECC before and after the intervention. The Pre-MECC OAT aimed to allow organisations to take stock of where they were in terms of readiness for implementing MECC, to identify where support could be provided within the organisation to develop their board level action plan and enable the mobilisation of the implementation of MECC at the front line. At the end of the pilot period the Post-MECC OAT aimed to demonstrate changes in organisational attitudes and policies.

3.2 Staff surveys

Pre- and Post-MECC staff survey questionnaires were designed [Appendices B & C] to provide a method of comparing attitudes, knowledge and self-reported skills of staff before and after the introduction and implementation of MECC to examine any changes in practice of front-line workforce' skills, knowledge and confidence to deliver MECC. All staff who were identified to be invited to attend the training at each site were sent the Pre-MECC

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survey before the training and the Post MECC survey 3-4 months after the training. The Pre-MECC questionnaire was developed in 2013 with input from the Wessex MECC Steering Group and pilot sites at NHS Hampshire Hospitals and Portsmouth City Council to provide insights on staff pre-disposing factors including attitudes, knowledge, beliefs, values and perceptions at the start of the MECC process and before the beginning of any specifically designed 'MECC training' took place.

Pilot sites explored the most appropriate ways for distribution of the questionnaires to all staff at each site eg online by the University 'I-survey', by paper questionnaires, by hand or by post. It was decided to use the University of Southampton 'I-Survey'. The survey was sent to non-University employees by sending an e-mail including a link that has a unique identifier to a particular survey. The list of contacts to whom the survey was to be sent was uploaded from an excel spread-sheet as a 'CSV file', containing respondents' email address, first name and surname. Pilot site leads provided contact details of the relevant staff.

The Post-MECC questionnaire (Appendix C) contains a number of questions that are similar to the Pre-MECC questionnaire in order to help measure changes that may have occurred. Additional questions in the Post-MECC survey would be informed by the outcomes of the Pre-MECC questionnaire and the qualitative process evaluation interviews. The delivery of the Post-MECC questionnaire were scheduled to take place 3 to 4 months after the MECC training and Post-MECC interviews followed afterwards in order to allow sufficient time for staff to put new knowledge and skills into practice, and to be able to reflect on their experience of the delivery of MECC.

3.3 Healthy Conversation Skills Training evaluation

Two members of the Southampton Initiative for Health's (SIH) HCS research training team trained the pilot site leads in order for them to deliver the training to their identified workforces. The training consisted of two 3-hour group sessions followed by a 6-hour group train-the-trainer session. Every person who attended HCS training sessions completed pre- and post-training evaluation sheets at the start and end of the training (Appendix D). This is recommended as the simplest measure of change, assessing Healthy Conversation Skill 1 (use of Open Discovery Questions). It captures changes trainees make in their responses to 4 statements about health behaviours, and changes in perceived confidence, importance and usefulness in having healthy conversations with their clients. A coding matrix for responses to statements has been developed by the SIH training team to code trainees' responses (Appendix E). A "Peer Support and Feedback" tool has been developed to assess use of HCS in practitioners' routine practice (Appendix F). As well as being useful as an evaluation tool, it also encourages trainees to think about the conversations they are having and how they can use more HCS.

3.4 Qualitative interviews and focus group

Qualitative evaluation interviews were conducted in two phases: first following training and during the process of the implementation of MECC (Process evaluation); and second after the formal pilot implementation pilot period (approximately 3-4 months after training) (Post-MECC interviews).

Semi-structured interviews for the Process evaluation [see Appendix G] were held with senior managers, pilot leads and front-line staff at each of the organisations in order to provide an insight on the process of introducing and implementing MECC.

Semi-structured Post-MECC interviews were held with the same senior managers and pilot leads, and mainly with the same front-line staff at each site at the end of the pilot period, to explore the barriers and facilitators to implementing MECC, their views on the communication channels and messages that they received about MECC, the 'Healthy Conversation Skills' training and any other training they received and suggestions for sustainability and future implementation. It had been planned to meet with front-line staff in focus groups but in the event this proved difficult to organise, and only one focus group was conducted in Portsmouth City Council, using the same interview schedule, (Appendix H).

There was a prize draw incentive of £100 per organisation for pre- and post- surveys and interviews. Pilot leads were individually consulted on the preferred type of the prize, which was in the form of vouchers. One winner following the pre-MECC survey was given a £50 'Virgin experience' voucher, some were shared between the whole workforce, for example to provide 'treats' in the form of biscuits and fruit, and in another organisation the Post-MECC prize draw vouchers were used to buy a microwave for the staff kitchen.

4. RESULTS

These results are drawn from the evaluation phases described above and presented in order of: the OAT, the HCS training evaluation, the staff survey, and the interviews.

4.1 Organisational Assessment Tool (OAT)

The OAT (Appendix A) was used by the three organisations in different ways. It was completed by the pilot lead at Portsmouth City Council (PCC) at both Pre- and Post-MECC stage; by the pilot lead and senior manager at Southern Health NHS Foundation Trust (SHFT) at Pre-MECC stage only; and by two frontline workforce leads at Hampshire Hospitals NHS Foundation Trust (HHFT) for the Pre-MECC assessment, and the pilot lead and senior manager Post-MECC. The scoring is described in Appendix A, the respondent(s) in each workforce group considered the questions in the tool, and scored themselves on a scale of 1-12 (low-high) against each. All the scores are subjective, but they are a helpful guide to the impact of the introduction and implementation of MECC on the organisation and within the different workforces especially when seen as a comparison with the Post-MECC organisational assessment tool. Several people found the form difficult to complete and one workforce lead did not complete it at all, hence a review of the tool itself is essential for future implementation.

Table 2 shows the Pre-MECC scores for SHFT; Table 3 Pre- and Post-MECC scores for HHFT, and Table 4 Pre- and Post-MECC scores for PCC. There are considerable intra-organisational differences between some scores for teams in different sites within the same organisation for some aspects, indicating different perceptions of organisational strengths and weaknesses from different viewpoints, but they all score highly against 'Fit with organisation's strategic aims and culture', and (with the exception of one workforce) very low against 'Infrastructure for sustainability'.

Table 2. OAT scores for Southern Health NHS Foundation Trust

SCORES (1 to 12)	Pre-MECC Heart Failure and Respiratory Service, SHFT	Pre-MECC Minor Injuries Unit, SHFT	Post-MECC Overview SHFT
PROCESS			
1. Benefits beyond helping patients	7	7	Not completed
2. Credibility of the evidence	6	4	
3. Adaptability of improved process	7	7	
4. Effectiveness of the system to monitor progress	4	3	
STAFF			
5. Staff involvement and training to sustain the process	9	2	
6. Staff behaviours	4	4	

toward sustaining the change			
7. Senior leadership engagement	10	4	
8. Team leadership engagement	10	4	
ORGANISATION			
9. Fit with organisation's strategic aims and culture	10	10	
10. Infrastructure for sustainability	2	2	

Table 3. OAT scores for Hampshire Hospitals NHS Foundation Trust

SCORES (1 to 12)	Pre-MECC Diabetes Services, HHFT	Pre-MECC Therapy Services, HHFT	Pre-MECC Health4Work, HHFT	Post-MECC Overview HHFT
PROCESS				
1. Benefits beyond helping patients	7	6	Not completed	9
2. Credibility of the evidence	8	11		9
3. Adaptability of improved process	9	8		7
4. Effectiveness of the system to monitor progress	8	8		2
STAFF				
5. Staff involvement and training to sustain the process	7	5		10
6. Staff behaviours toward sustaining the change	10	9		11
7. Senior leadership engagement	11	6		6
8. Team leadership engagement	11	4		9
ORGANISATION				
9. Fit with organisation's strategic aims and culture	10	9		10
10. Infrastructure for sustainability	2	9		5

Table 4. OAT Scores for Portsmouth City Council

SCORES (1 to 12)	Pre-MECC PCC	Post-MECC PCC
PROCESS		
1. Benefits beyond helping patients	9	9
2. Credibility of the evidence	7	7
3. Adaptability of improved process	7	7
4. Effectiveness of the system to monitor progress	3	3
STAFF		
5. Staff involvement and training to sustain the process	3	3
6. Staff behaviours toward sustaining the change	2	2
7. Senior leadership engagement	6	6
8. Team leadership engagement	3	3
ORGANISATION		
9. Fit with organisation's strategic aims and culture	10	10
10. Infrastructure for sustainability	1	1

Those completing the forms were asked to summarise their thoughts emerging from the exercise. Asked 'What have you found from completing the assessment tool?' in the Pre-MECC phase, the following comments were made:

By Hampshire Hospitals NHS Foundation Trust:
'There is a positive feel about health promotion and that as a team and organisation we appear to be motivated'
'Wide variations across different areas of the assessment tool'
'Surprisingly no mention of health promotion in physiotherapist job description yet this is subjectively a large part if the work done and a fair amount of time is spent at University regarding this'
'The project fits very well with Trust and department aims at strategic and operational level'

By Portsmouth City Council:
'We have a very poor data capture system in place and it appears a robust system will be difficult to develop/implement.'

By Southern Health NHS Foundation Trust:
'A lot of work needs to be done with regards sustainability once the project has finished'
'We need robust processes to measure the effect of MECC'

In response to the question 'Do you think there are specific reasons why you have scored high/low in some areas?', Hampshire Hospital respondents stated:
'Scored low on last question because we have not yet had training'

'Staff morale is relatively low overall due to funding cuts with less funds for training, recent introduction of seven-day working policy with staff sickness meaning staff are being asked to cover weekends/evening on calls short notice, further potential pay freeze etc therefore there is a reluctance when asked to do more with little short term benefit to staff'

'The project is highly relevant to physiotherapy and we currently readily offer advice on exercise levels and discuss smoking/drinking with patients where highly relevant therefore the areas of credibility of the project scored highest'

Portsmouth City Council responded:

'Due to the non-clinical setting and the level of the intervention (sign-posting only) the data collection for impact is always going to be limited. However, we believe that having the sign posting limited to the Health Trainer Service (face-to-face/phone/web) provides the best solution in the circumstances.'

'We have scored low in staff involvement due to the importance of gaining senior management buy-in first and this proved time consuming.'

And Southern Health NHS Foundation Trust commented:

'Due to myself being involved in MECC, scores have been high in some areas. Some staff who will be involved in the project do not know what MECC is at present'

'Because the training has yet to be done so scores are on the low side. There is involvement and commitment from the trust where the scores are higher'

Factors to focus on or develop further included:

Hampshire Hospitals NHS Foundation Trust:

'Systems to help us monitor outcomes'

'Staff morale by rewarding behaviour change/rewards during training to act as motivation. Any audit/feedback tools will need to be kept very simple and not time consuming in order to ensure compliance'

'Support from management to ensure staff are on board with new project'

'Staff involvement with training needs to design training course and therefore improve motivation'

'Potentially look at job descriptions to include health promotion in longer term'

Portsmouth City Council:

'Communication, in particular to the wider workforce.'

Southern Health NHS Foundation Trust:

'Training and education. Work on processes for collection of data '

'Communication'

Finally asked what their organisational aims were for MECC they said:

Hampshire Hospitals NHS Foundation Trust:

'Aim for all staff to have MECC training to improve education and also to ensure appropriate paperwork readily available such as Quit 4 Life to ensure staff feel supported

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in providing information and having difficult conversations once they have received the relevant training'

'Change assessment forms, in medical history section, to include whether the patient is a smoker/non-smoker and how many alcohol units they drink a week to enable staff a way to start more difficult conversations and bring up topics they may otherwise shy away from'

'Aim to have a display board with health promotion education on so patients can get contact details and take own initiative if so wish whilst waiting for appointment

Aim to improve links with staff KSF (NHS Knowledge and Skills Framework) *and job descriptions in longer term so becomes an automatic part of the job role'*

Portsmouth City Council:

'We will roll MECC out across the organisation. Several additional pilots have been identified to assess the range of options regarding full Council integration into the MECC way of working.'

Southern Health NHS Foundation Trust:

'To make MECC part of the culture within the teams'

'To train the staff in Healthy Conversation Skills and evaluate the success'

'To ensure sustainability once the project is completed'

'To work with the Senior Information Analyst and Senior Clinical Change and Benefits Manager to look at capturing data to measure the staff's interventions around MECC'

'To work with communication team to assist staff in sign posting patients to systems and resources, to add MECC to the culture within the trust.'

Insufficient data was collected using the Post-MECC OAT for further consideration.

4.2 Site based training courses

Training courses were run by SHFT, HHFT and PCC for their different workforces on different dates by the pilot leads who had been previously trained in HCS as described earlier. Table 1 (see 2.4 above) summarised the modes of delivery and how they were modified from the original HCS training course.

The following gives information about the evaluation of the three programmes of training at each pilot site. Note, however, that the data from SHFT includes additional workforces that were trained later and who were *not* included in the pilot evaluation, (for the pilot n=22 for SHFT) Table 5. Demographic data on the trainees in HHFT and PCC was not collected at the time of the training, however the profile of the trainees encompassed in the pilot evaluation can be seen in Table 11 from the Pre-MECC staff survey data.

Table 5. Completed evaluations

	SHFT	**HHFT**	**PCC**
Completed pre-training evaluation	65	53	15
Completed post-training evaluation	63	45	15

Pre- & Post-training evaluation of change in staff practice and attitudes following training

At the start and end of the training session(s), all trainees completed pre- and post-training evaluation sheets. They were asked to respond to four statements typically made by clients regarding diet, exercise, alcohol and smoking. One aim of the training is to increase trainees' use of "Open Discovery Questions" (ODQs) in order to empower their clients to identify solutions, set goals and make plans for change, thus decreasing telling, suggesting and information-giving.

They were also asked to rate on a scale of 1-10:
1. How **confident** they felt about supporting individuals to make a lifestyle change;
2. How **important** it was for them to support individuals to make a lifestyle change;
3. How **useful** they felt the conversations they currently have (pre-training) / skills they learnt on the course (post-training) were for supporting individuals to make a lifestyle change.

Post-training they were asked to rate on a scale of 1-10 how valuable they felt the training had been for them and to respond to the following two questions:
1. What could we do to improve this training?
2. What did you find useful or enjoyable?

Figures 3, 4 & 5 show any changes from the predominance of telling/suggesting/information-giving pre-training to the more empowering asking of open discovery questions post-training for each of the three intervention sites, SHFT, HHFT and PCC. In SHFT 63 trainees (note included staff not otherwise included in this pilot study) responded with 134 telling/suggestions to 4 statements at T1, to just 15 at T2, with an opposite shift for ODQs. Figures for the other sites in the Figures below.

Figure 3.   **Number of "telling/suggesting/information-giving" responses & "ODQs" pre- & post-training:**
Southern Health NHS Foundation Trust (P value for change < 0.001) n = 63
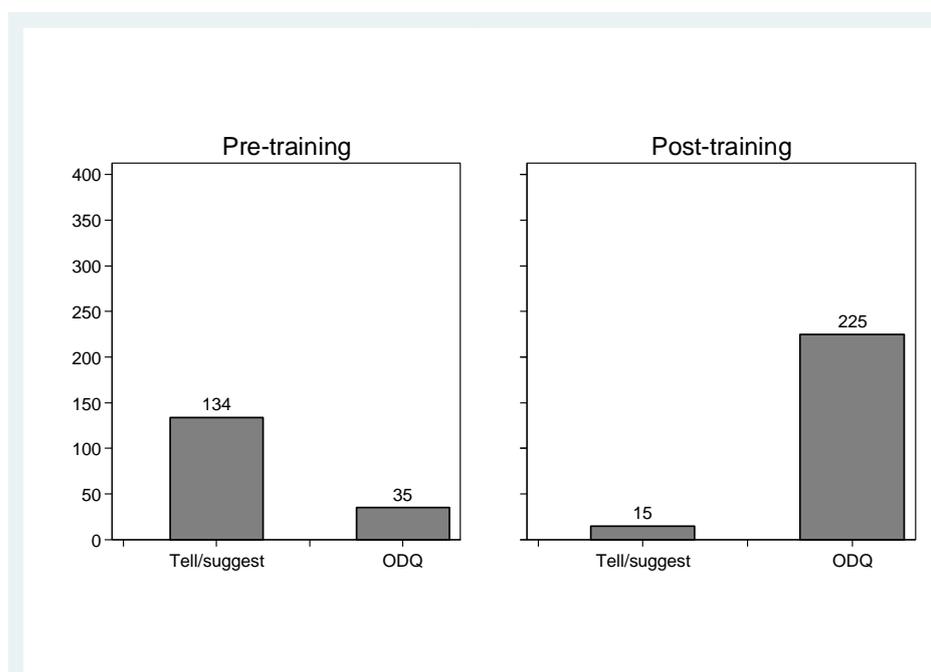
Figure 4. **Number of "telling/suggesting/information-giving" responses & "ODQs" pre- & post-training: Hampshire Hospitals NHS Foundation Trust (P value for change <0.001) n=45**
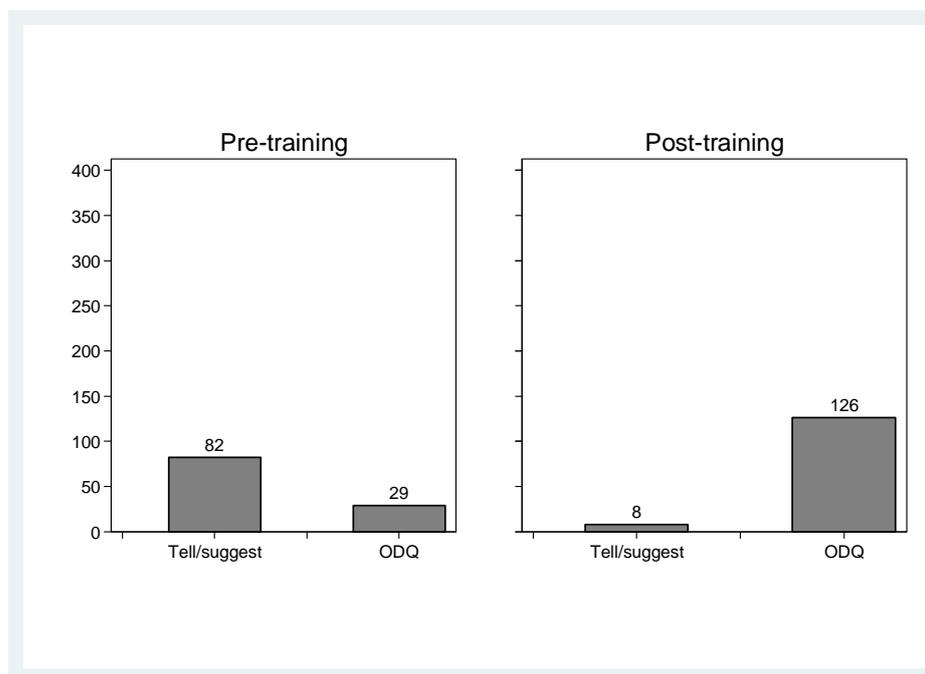
Figure 5. **Number of "telling/suggesting/information-giving" responses & "ODQs" pre- & post-training: Portsmouth City Council (P value for change = 0.5) n = 15**
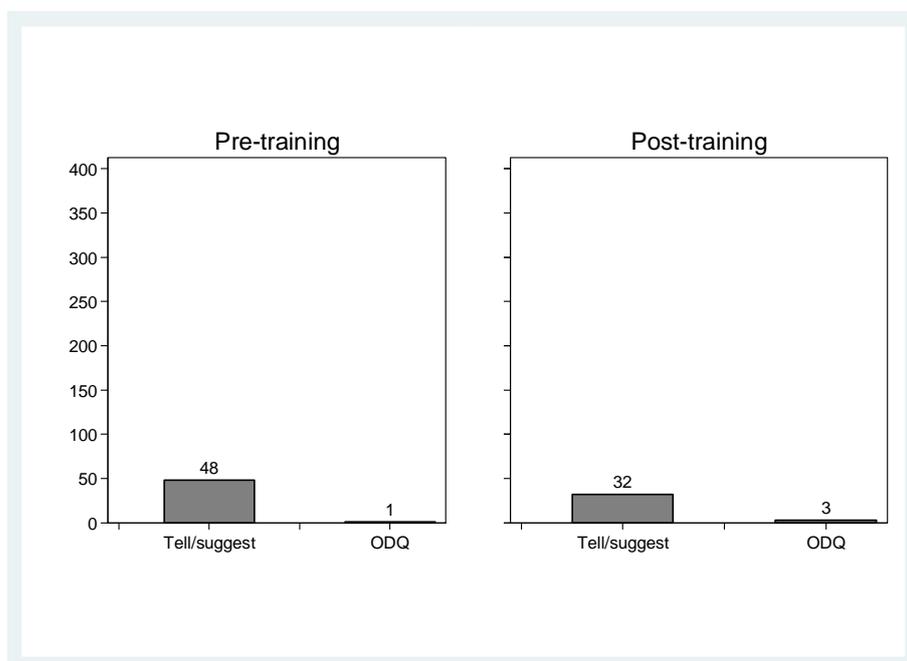
Taking into account that the Portsmouth City Council training session plan included no explicit mention of HCS activities or skills; and that there were no significant differences in use of ODQs pre- and post-training for PCC trainees, the following analysis explored differences between these trainees and those trained by SHFT and HHFT.

Test of difference between Portsmouth City Council and the other two groups:

The total number of possible ODQs used by each participant at each time point was 4, so the total ranged from 0 to 4. A Mann-Whitney two sample statistic test was used to test the difference between the scores for those from Portsmouth and those from the other two groups combined.

Table 6. Total ODQs asked by participants post-training summarised by training group n = 108

Group	Median (IQR)
SHFT	4 (4-4)
HHFT	4 (2.5-4)
PCC	0 (0-0)
All	4 (2-4)

Given that no HCS training was delivered in PCC and the Mann-Whitney test showed that use of ODQs was significantly lower compared to those in the other two groups (P<0.0001), it was decided to remove these participants from the overall calculation of ODQ use (Figure 6).

Figure 6.   **Number of "telling/suggesting/information-giving" responses & "ODQs" pre- & post-training:**
Southern Health NHS Foundation Trust & Hampshire Hospitals NHS Foundation Trust combined (P value for change < 0.001) n = 108
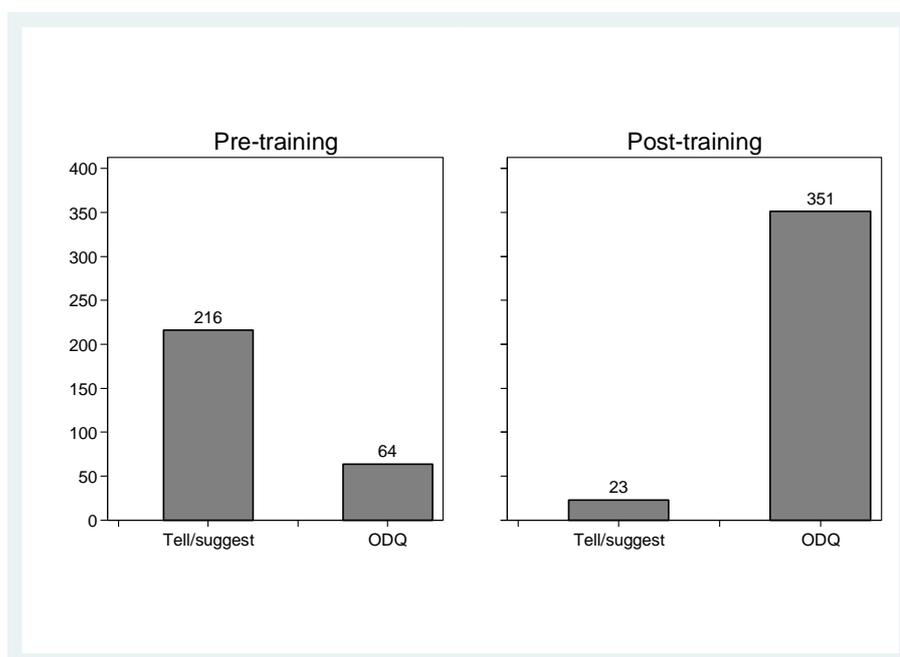
As in the previous analysis, scores for SHFT & HHFT were summated to give an overall total for participants trained in HCS. Paired sample t-tests were used to test the differences between sessions and the results are summarised in Tables 7-9. All participants appeared to have moderate levels of confidence for supporting change pre-training (mean = 6.2), and this increased significantly post training (mean = 8.3) (Table 7).

Table 7. Mean scores (95%CI) and differences between times for "confidence"

Group	Session 1	Session 2	Difference	P-value
SHFT (n=62)	6.2 (5.7 to 6.6)	8.3 (8.0 to 8.6)	2.1 (1.7 to 2.5)	<0.0001
HHFT (n=35)	6.3 (5.7 to 6.8)	8.2 (7.9 to 8.5)	1.9 (1.4 to 2.5)	<0.0001
PCC (n=15)	5.7 (4.5 to 6.9)	8.5 (7.8 to 9.1)	2.7 (1.7 to 3.7)	<0.0001
SHFT & HHFT (n=97)	6.2 (5.9 to 6.6)	8.3 (1.7 to 3.4)	2.1 (1.7 to 2.4)	<0.0001
All (n=112)	6.1 (5.8 to 6.5)	8.3 (8.1 to 8.5)	2.1 (1.8 to 2.4)	<0.0001

Participants rated their role in supporting change as important pre- and post-training (mean = 8.3 and 8.9 respectively). Only SHFT showed a significant increase post-training (mean = 8.2 to 8.9) (Table 8).

Table 8. Mean scores (95%CI) and differences between times for "importance"

Group	Session 1	Session 2	Difference	P-value
SHFT (n=62)	8.2 (7.8 to 8.6)	8.9 (8.6 to 9.2)	0.7 (0.4 to 1.0)	<0.0001
HHFT (n=35)	8.5 (8.1 to 9.0)	8.8 (8.4 to 9.2)	0.2 (-0.2 to 0.7)	0.3
PCC (n=15)	7.9 (6.7 to 9.1)	8.3 (7.5 to 9.2)	0.5 (-0.6 to 1.5)	0.4
SHFT & HHFT (n=97)	8.3 (8.0 to 8.6)	8.9 (8.6 to 9.1)	0.5 (0.3 to 7.7)	<0.0001
All (n=112)	8.3 (8.0 to 8.6)	8.8 (8.6 to 9.0)	0.5 (0.3 to 0.8)	0.0001

Pre-training all participants felt that the conversations they were currently having were reasonably useful in supporting change (mean = 6.4), and this increased significantly post-training (mean = 8.6), indicating that they felt the skills they learned were going to bring additional value to these conversations (Table 9).

Table 9. Mean scores (95%CI) and differences between times for "usefulness"

Group	Session 1	Session 2	Difference	P-value
SHFT (n=62)	6.5 (5.9 to 7.1)	9.0 (8.8 to 9.3)	2.5 (1.9 to 3.1)	<0.0001
HHFT (n=35)	6.3 (5.7 to 6.9)	7.9 (7.4 to 8.5)	1.7 (0.8 to 2.5)	0.0003
PCC (n=15)	5.7 (4.1 to 7.2)	8.3 (7.5 to 9.0)	2.6 (0.9 to 4.3)	0.005
SHFT & HHFT (n=97)	6.4 (6.0 to 6.9)	8.6 (8.3 to 8.9)	2.2 (1.7 to 2.7)	<0.0001
All (n=112)	6.3 (5.9 to 6.8)	8.6 (8.3 to 8.8)	2.2 (1.8 to 2.7)	<0.0001

Trainees rated the value of the training highly with a median score of 9 (Table 10).

Table 10. Scores in answer to the question "How valuable do you think the training has been?" (n = 102)
(Score range from 1 to 10, with 10 being the most valuable)

Group	N	Median (IQR)
SHFT	63	10 (9-10)
HHFT	39	8 (6-9)
PCC	0*	-
All	102	9 (8-10)

*Note that staff in PCC were not given the post-training course feedback sheet to complete

Some examples of participants' responses to questions about the training are provided below. These indicate that trainees were happy with the training experience and had little to suggest by way of improvements. This provides the organisation with confidence that this training is acceptable to staff and therefore could be rolled-out more widely. Suggestions for improvement included providing:

> 'More scenarios', 'offering refresher/review sessions once a year (or after a certain time)', and 'Have the two parts closer together, ie in same week if possible'.

Trainees found much of the training useful and enjoyable, for example:

> 'This training has been very useful and valuable learning, some great top tips and questioning techniques to use in practice'; 'Good to put techniques/questioning skills into practice and observe others'; 'Good use of recording in a non-threatening way. Made us realise our questioning technique'.

Peer support and feedback worksheet – completed at Hampshire Hospitals NHS Foundation Trust

Between November 2013 and June 2014 the HHFT trainer and another member of staff trained in HCS, observed trained HCS staff to capture use of HCS in their practice setting by completing the "Peer support and feedback" sheet (Appendix F). A total of 18 peer observations were completed (median observation duration = 35 minutes). A range of sessions were observed including initial assessments and diabetes check-ups. Issues discussed included insulin use and shoulder, knee, hip, lower back, neck, arm and wrist pain. Action-planning and goal-setting mainly focused on exercise. The "Peer support and feedback" sheet allowed the observer to capture use of ODQs, time spent listening and SMARTER goal-setting.

All practitioners (n=18) asked at least 2 ODQs in their conversations with clients, demonstrating an exploratory, empowering style of communication. 12/18 spent most or half the time asking ODQs, with 6 using them less than half the time.   Whilst this is encouraging, it indicates a need for practitioners to continue to practise their new skills and to be supported to do so, in order for them to all spend more time asking ODQs. 8/18 practitioners spent the same amount of time talking as their client; 5 spoke less and 5 spoke more. Overall this indicates a good level of listening, one of the 4 key HCS competencies.

On-going support to increase listening time would be beneficial for many. Developing the skill of asking more ODQs is likely to enhance listening skills. However, as found with previous HCS follow-up observations (unpublished data), practitioners were less successful in supporting SMARTER planning than they were in incorporating the other skills; four people showed a good level of competence, three attempted to support planning, but 11 did not demonstrate this skill during the observation period. This indicates a need for further follow-up and support for staff to be able to work on this challenging skill and ultimately embed all the HCS into routine practice.

Healthy Conversation Skills Evaluation Summary

Healthy Conversation Skills training was delivered to practitioners within SHFT and HHFT. Analysis of the evaluation data shows that they were significantly more likely to ask open discovery questions post-training than make suggestions or give information. This demonstrates a more empowering style of conversation, aimed at supporting people to identify solutions to their problems, set goals and make plans for change. This approach has been to be shown to be more effective at supporting change and managing chronic conditions (Anderson & Funnell, 2000 & 2005).

Participants were more confident in having conversations to support lifestyle changes post-training, and we know from earlier evaluation of practitioners trained in HCS, that the more confident they were, the more competent they were in using HCS (Black et al, 2012). Pre- and post-training, participants felt that it was important to support individuals to make lifestyle changes, but in SHFT they felt it was more important post-training.

Post-training participants rated the usefulness of the skills learnt during HCS training higher than pre-training, when asked how useful they felt their current conversations were at supporting individuals to make lifestyle changes. So whilst they felt their conversations were moderately useful at supporting change pre-training, they clearly felt that their new skills were going to improve the usefulness of such conversations.

Post-training observations undertaken by HHFT provides further evidence of the use of three of the four HCS competencies: asking open discovery questions, listening and supporting SMARTER planning. Whilst these observations highlight a need for on-going support to encourage increased use of the skills, practitioners demonstrated a good level of competence for the three skills.

1.3 Pre- and Post-MECC Surveys

All the Pre- and Post-MECC survey data from HHFT, PCC and SHFT was collected then modified in Excel before being converted to SPSS for data analysis. The overall response rate for the Pre-MECC survey was 72%, (73/101). For the Post-MECC survey the response rate was 63%, (63/100). Only fully completed questionnaires were included in the analysis, making the response rate 56% (57/101) and 54% (54/100). The data from the three sites has been combined in the analysis owing to small numbers of respondents.

As there was no method to link pre and post scores due to the anonymous nature of the responses comparisons between pre and post responses were made using Mann-Whitney U tests. P values less than 0.05 have been considered as statistically significant.

The respondents were mostly female (84 or 87%, Pre- and Post-) and aged between 25-54 years (82 or 87%). 60% had an undergraduate degree or higher. Over 40% had worked in their current role for 1-5 years, with a similar proportion having been in their current role for between 5 and 20 years. (Table 11)

Table 11		Pre	Post
Gender	**Male**	9 (16%)	7 (13%)
	Female	48 (84%)	47 (87%)
Age	**Under 25**	2 (3%)	3 (5%)
	25 to 34	12 (20%)	11 (19%)
	35 to 44	15 (25%)	22 (37%)
	45 to 54	22 (37%)	18 (31%)
	55 to 64	9 (15%)	5 (9%)
	65+	0 (0%)	0 (0%)
Highest Qualification	**PhD**	0 (0%)	0 (0%)
	Master's degree	5 (8%)	7 (12%)
	Undergraduate degree	31 (52%)	28 (48%)
	HND/HNC/Teaching Qualification	8 (13%)	3 (5%)
	A levels/BTEC/NVQ 4	7 (12%)	7 (12%)
	CSE 1/GCE O levels/GCSE A-C/NVQ 3	4 (7%)	6 (10%)
	CSE 2-5/GCSE D-G/NVQ 1&2	0 (0%)	0 (0%)
	No Qualifications	0 (0%)	0 (0%)
	Other	5 (8%)	7 (12%)
Length of time in current role	**New/Less than 1 month**	1 (2%)	0 (0%)
	1 to 6 months	2 (3%)	2 (3%)
	6 months to 1 year	5 (8%)	2 (3%)
	1 to <5 years	24 (40%)	28 (48%)
	5 to <10 years	17 (28%)	11 (19%)
	10 to 20 years	11 (18%)	15 (26%)
	>20 years	0 (0%)	0 (0%)

Less than a half (44%) of the respondents across all the sites indicated that they had received training to enable them to promote healthy lifestyles before the MECC intervention. This increased to 84% in the post-MECC questionnaire, all the respondents should have received the MECC training, so this response may indicate that the question

was misinterpreted by some, or that not all of the targeted respondents had indeed received the required training as indicated by the 95% response to having had MECC Healthy Conversation Skills training in the post pilot survey (Table 12). Site specific responses showed previous training to promote healthy lifestyles as similar (HHFT (16/34 47%); PCC (3/10 30%); SHFT (5/11 46%)), the lower figure from PCC might be expected from a non-health organisation. Both PCC and SHFT reported 100% receiving MECC training, with HHFT 93%.

Despite the potential misinterpretation of this question in the post-MECC survey as evidenced by the reduction in reporting of some specific areas of training, it is however notable that the majority had neither received training in skills (motivational interviewing (25%)), or on risk factors and health issues (healthy eating and physical activity (50%); smoking (42%); alcohol (38%); mental health (29%); drugs (25%) and sexual health (21%)) prior to the intervention.

Table 12		Pre	Post
Previous training to promote healthy lifestyles?	**Yes**	24 (44%)	42 (84%)
	No	31 (56%)	8 (16%)
Specific areas of training	**Alcohol**	9 (38%)	11 (26%)
	Smoking	10 (42%)	14 (33%)
	Drugs	6 (25%)	1 (2%)
	Sexual health	5 (21%)	1 (2%)
	Healthy eating	12 (50%)	11 (26%)
	Physical activity	12 (50%)	14 (33%)
	Mental health	7 (29%)	2 (5%)
	Motivational interviewing	6 (25%)	9 (21%)
	MECC healthy conversations training	-	40 (95%)
	MECC video presentation training	-	18 (43%)
	Other	2 (8%)	6 (14%)

Slightly more than half (53%) of the respondents had received information or were already aware of MECC before completing the survey (Table 13). This had come from colleagues, either other staff or their manager, or formally in a staff briefing. Only a few (9%) had already received MECC training.

Table 13		Pre
Received information or already aware of MECC?	**Yes**	29 (53%)
	No	26 (47%)
Source of information	**Newsletter**	2 (7%)
	Communications department	0 (0%)
	Manager	10 (34%)
	Staff briefing	10 (34%)
	Other staff	13 (45%)
	Previous job	0 (0%)
	Other	2 (7%)
Have you received MECC training on how to discuss healthy lifestyles?	**Yes, in previous job**	1 (2%)
	Yes, recently in current job	4 (7%)
	No not yet, but planned	37 (67%)
	No, not planned	13 (24%)

Table 14					
How important do you think it is for YOU to discuss healthy lifestyles with:					
	Time	**Not Important**			**Very Important**
Service Users	Pre	1 (2%)	5 (9%)	6 (11%)	8 (15%)	34 (63%)
	Post	0 (0%)	1 (2%)	4 (8%)	14 (29%)	30 (61%)
Carers	Pre	0 (0%)	6 (11%)	5 (9%)	15 (28%)	27 (51%)
	Post	2 (4%)	1 (2%)	7 (14%)	21 (43%)	18 (37%)
Colleagues	Pre	1 (2%)	5 (9%)	14 (26%)	17 (32%)	17 (32%)
	Post	3 (6%)	2 (4%)	12 (24%)	20 (40%)	13 (26%)
Family and friends	Pre	1 (2%)	4 (7%)	7 (13%)	11 (20%)	31 (57%)
	Post	0 (0%)	3 (6%)	5 (10%)	23 (46%)	19 (38%)

When asked to consider how important they thought it was to discuss healthy lifestyles with service users, carers, colleagues and family and friends there were some changes between the pre- and post-MECC surveys, however none of these reached statistical significance (Table 14). For service users the proportion indicating it was 'very important' was high and much the same (63%; 61%) while the numbers of those indicating it was 'important' rose after the intervention (15%; 29%). The pattern was downwards towards less importance for carers (very important (51%; 37%); important (28%; 43%); neither (9%; 14%)), perhaps indicating recognition in some roles that contact with carers was less feasible. This effect was more marked for family and friends (very important (57%; 38%); important (20%; 46%)), perhaps raising questions about any anticipated wider impact of training, but this finding would require further investigation.

The proportion of respondents who felt they knew a lot about the factors that influence healthy lifestyles rose marginally, but not significantly following the intervention. However there was a greater movement towards more knowledge of the importance of their role in

discussing healthy lifestyles (A lot (23%; 31%); Quite a lot (43%; 53%) and neither (26%; 14%), (Table 15).

Confidence in raising the subject of healthy lifestyles also rose slightly for service users (very confident (24%; 29%); confident (44%; 49%)) and there was a similar downward pattern as seen above for carers, colleagues and family and friends (Table 15).

Table 15						
How much do you feel you know about:						
	Time	**Nothing**				**A lot**
The factors that influence healthy lifestyles	Pre	0 (0%)	0 (0%)	14 (26%)	28 (52%)	12 (22%)
	Post	0 (0%)	0 (0%)	8 (16%)	28 (56%)	14 (28%)
The importance of your role in discussing healthy lifestyles	Pre	1 (2%)	3 (6%)	14 (26%)	23 (43%)	12 (23%)
	Post	0 (0%)	1 (2%)	7 (14%)	26 (53%)	15 (31%)

Table 16						
How confident do you feel about raising the subject of healthy lifestyles with:						
	Time	**Not at all confident**				**Very confident**
Service Users	Pre	1 (2%)	3 (6%)	12 (24%)	22 (44%)	12 (24%)
	Post	0 (0%)	2 (4%)	9 (18%)	24 (49%)	14 (29%)
Carers	Pre	4 (7%)	4 (7%)	15 (28%)	20 (37%)	11 (20%)
	Post	1 (2%)	2 (4%)	14 (28%)	26 (52%)	7 (14%)
Colleagues	Pre	3 (6%)	5 (9%)	18 (34%)	14 (26%)	13 (25%)
	Post	1 (2%)	3 (6 %)	13 (26%)	25 (50%)	8 (16%)
Family and friends	Pre	1 (2%)	4 (7%)	8 (15%)	18 (33%)	23 (43%)
	Post	0 (0%)	1 (2%)	9 (18%)	27 (54%)	13 (26%)

Motivation to raise the subject of healthy lifestyles does not appear to have been particularly affected by the MECC intervention (Table 17), with around 70% indicating they were motivated or very motivated to address this with service users both pre- and 80% post-, and less so for other categories, all findings were non-significant.

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Table 17

How motivated are you to raise the subject of healthy lifestyles with:

	Time	Not at all motivated				Very motivated
Service Users	Pre	0 (0%)	4 (8%)	11 (21%)	22 (42%)	16 (30%)
	Post	0 (0%)	3 (6%)	7 (14%)	24 (49%)	15 (31%)
Carers	Pre	1 (2%)	4 (8%)	12 (23%)	24 (45%)	12 (23%)
	Post	2 (4%)	3 (6%)	13 (26%)	22 (44%)	10 (20%)
Colleagues	Pre	1 (2%)	5 (9%)	17 (32%)	24 (45%)	6 (11%)
	Post	2 (4%)	8 (16%)	16 (33%)	17 (35%)	6 (12%)
Family and friends	Pre	1 (2%)	5 (9%)	11 (21%)	19 (36%)	17 (32%)
	Post	0 (0%)	3 (6%)	12 (25%)	21 (43%)	13 (27%)

Table 18 shows a non-significant pattern in the expected direction for how often staff currently raise the subject of healthy lifestyles with service users (at every contact (10%; 15%); at most contacts (29%; 41%); never (12%; 2%)). For carers and family and friends the pattern is of less often raising the subject currently.

Table 18

How often CURRENTLY do you raise the subject of healthy lifestyles with:

	Time	Never				At every contact
Service Users	Pre	6 (12%)	6 (12%)	19 (37%)	15 (29%)	5 (10%)
	Post	1 (2%)	5 (11%)	14 (30%)	19 (41%)	7 (15%)
Carers	Pre	10 (20%)	8 (16%)	18 (36%)	10 (20%)	4 (8%)
	Post	11 (24%)	9 (20%)	18 (39%)	7 (15%)	1 (2%)
Colleagues	Pre	7 (14%)	12 (24%)	21 (41%)	10 (20%)	1 (2%)
	Post	8 (17%)	11 (23%)	21 (44%)	7 (15%)	1 (2%)
Family and friends	Pre	3 (6%)	11 (22%)	23 (45%)	13 (26%)	1 (2%)
	Post	5 (11%)	10 (21%)	22 (47%)	10 (21%)	0 (0%)

These effects reach significance when the respondents were asked how often they expected to be able to raise the subject of healthy lifestyles in the future (Table 19). For service users the pattern is towards raising the subject at most contacts, however there are significant moves away from expectations of being able to raise the subject of healthy lifestyles for carers (P = 0.001), and family and friends, again perhaps indicating a greater awareness of when to have these conversations. Very few respondents thought that they would never expect to raise the topic in the future with these groups, but the figure for carers rose (4%; 11%).

Table 19

How often do you EXPECT to be able to raise the subject of healthy lifestyles (in the future) with:

	Time	Never				At every contact	P value
Service Users	Pre	2 (4%)	5 (9%)	13 (25%)	20 (38%)	13 (25%)	0.323
	Post	0 (0%)	4 (9%)	17 (36%)	21 (45%)	5 (11%)	
Carers	Pre	2 (4%)	5 (10%)	16 (31%)	20 (39%)	9 (17%)	0.001
	Post	5 (11%)	12 (26%)	16 (35%)	12 (26%)	1 (2%)	
Colleagues	Pre	2 (4%)	10 (19%)	19 (37%)	17 (33%)	4 (8%)	0.006
	Post	2 (4%)	18 (38%)	21 (44%)	6 (13%)	1 (2%)	
Family and friends	Pre	1 (2%)	7 (13%)	17 (32%)	23 (43%)	5 (9%)	0.001
	Post	1 (2%)	13 (27%)	25 (52%)	9 (19%)	0 (0%)	

Issues that impact on raising and discussing the subject of healthy lifestyles by making it easier or more difficult are shown in Table 20. There is little change pre- and post-MECC, and some possible problems with interpretation ie whether questions have been answered negatively or positively. However it is notable that the predominant elements are to do with the client (interest; knowledge; attitude to sustaining change), staff confidence and knowledge, and time. Issues to do with service organisation and work facilities appear to have a lesser influence overall.

Table 20

Elements that impact on raising and discussing the subject of healthy lifestyles	Make it easier		Make it more difficult	
	Pre	Post	Pre	Post
Service organisation	15 (21%)	10 (17%)	11 (15%)	8 (14%)
Time	16 (22%)	9 (15%)	37 (51%)	34 (58%)
Clients' interest	33 (45%)	27 (46%)	30 (41%)	26 (44%)
Clients' knowledge	26 (36%)	18 (31%)	20 (27%)	12 (20%)
Clients' attitude to sustaining change	30 (41%)	25 (43%)	35 (48%)	28 (48%)
Work facilities	14 (19%)	8 (14%)	12 (16%)	11 (19%)
Work environment	21 (29%)	14 (24%)	19 (26%)	12 (20%)
My own confidence	34 (47%)	26 (44%)	14 (19%)	10 (17%)
My own knowledge	33 (45%)	26 (44%)	16 (22%)	6 (10%)
Training I have received	26 (36%)	27 (46%)	9 (12%)	4 (7%)
Other	1 (1%)	2 (3%)	2 (3%)	1 (2%)

When asked about the relationships with colleagues and the likelihood that 'the people I work with have a positive impact', on own health and well-being, there is an increase in 'quite agree' (31%; 59%)); similarly for confidence in carrying out my role as a health promoter (quite agree (33%; 52%)); and morale (agree (36%; 54%), (Table 21).

Table 21

The people that I work with have a positive impact on	Time	Strongly disagree				Strongly agree
My health and well-being	Pre	1 (2%)	5 (9%)	20 (36%)	17 (31%)	12 (22%)
	Post	0 (0%)	2 (4%)	13 (28%)	27 (59%)	4 (9%)
My confidence in carrying out my role as a health promoter	Pre	0 (0%)	4 (7%)	19 (35%)	18 (33%)	14 (26%)
	Post	0 (0%)	0 (0%)	14 (30%)	24 (52%)	8 (17%)
My morale	Pre	0 (0%)	4 (7%)	14 (26%)	20 (36%)	17 (31%)
	Post	0 (0%)	1 (2%)	6 (13%)	25 (54%)	14 (30%)

The MECC intervention had no significant impact on staff's feelings about the support given to them to address healthy lifestyles by their line manager, or how they feel that their organisation values the way it interacts with the public (Table 22).

Table 22

Staff feeling about line management / organisation interaction	Time	Strongly disagree				Strongly agree
I feel that my line manager is supportive of me raising the subject of healthy lifestyles with service users / patients / clients	Pre	0 (0%)	3 (6%)	9 (17%)	16 (30%)	25 (47%)
	Post	0 (0%)	0 (0%)	8 (17%)	17 (37%)	21 (46%)
I feel that my organisation values the way it interacts with the public	Pre	0 (0%)	1 (2%)	10 (18%)	22 (40%)	22 (40%)
	Post	0 (0%)	1 (2%)	6 (13%)	26 (57%)	13 (28%)

Finally the impact on staff's own health was assessed in the Post-MECC survey (Table 23). The majority of staff thought their own current lifestyle was quite or very healthy (73%) and 31% thought it had improved quite a lot since doing MECC.

Table 23					
Staff feeling about the healthiness of their own lifestyle					
	Time	**Very Unhealthy**			**Very Healthy**
Healthiness of current lifestyle	Post	1 (2%)	6 (13%)	6 (13%)	30 (63%)	5 (10%)
		Got a lot worse			**Has improved a lot**
Own lifestyle change since MECC	Post	0 (0%)	1 (2%)	33 (67%)	15 (31%)	0 (0%)

4.4 Process and Post-MECC interviews

Overall a total of 29 Process and Post-MECC Interviews were carried out. These were recorded using a digital recorder and transcribed verbatim. The data was analysed iteratively and thematically (Braun & Clarke, 2006). Initially the coding was carried out by theoretical (or deductive) analysis following the order of questioning used in the interview schedule or topic guide. The initial themes and sub themes (or codes) were generated in Nvivo 10 (a computer software tool for supporting the analysis of qualitative data). Both researchers read all the transcripts. The transcripts were then re-read, several times if necessary, and re-coded according to the emerging list of themes which were regularly reviewed and modified. Each version of Nvivo was saved by date to ensure a trail of evidence. The number of themes and sub themes were gradually reduced by merging some of them when there was some overlap, such as the sub themes within the themes 'challenges' and 'benefits'.

4.4.1 Process evaluation interviews

A total of 14 process evaluation interviews were completed, one with each of the pilot leads, one with a senior manager in each organisation and the rest with frontline staff. These included: a total of 7 from Hampshire Hospitals NHS Foundation Trust (HHFT) between November 2013 and March 2014, including representatives from Health4Work (Occupational Health department), Therapy services, and Diabetes services; 3 from Portsmouth City Council (PCC), including the local Housing office manager, between March 2014 and April 2014; 4 from Southern Health NHS Foundation Trust (SHFT), including nursing staff from the Heart Failure and Respiratory teams, between June and July 2014. Table 24 lists the themes and sub-themes for the process evaluation interviews. These interviews were conducted after the selection of sites, the completion of the Pre-MECC staff survey, and after training, but during the early stages of the implementation phase. As the sites joined the pilot in sequence, information from these process interviews was fed into the Steering Group as appropriate to help to inform implementation in later sites where relevant. The themes and sub-themes have been combined in appropriate sections for reporting.

Table 24. Themes and sub-themes for process evaluation interviews

Theme	Sub Themes	Section headings
Staff roles and experiences	Initial feelings	Staff roles, experiences and training: initial feelings
	Previous training	Staff roles, experiences and training: previous training, MECC training
	Role in the organisation	
Barriers to Introducing MECC	Challenges for the department	Challenges and benefits for staff and departments
	Challenges for the organisation	Challenges and benefits to the organisation
	Challenges for staff	Challenges and benefits for staff and departments
	Challenges for patients/ clients	Challenges and benefits for the patients/clients
Benefits of introducing MECC	Benefits for the department	Challenges and benefits for staff and departments
	Benefits for the organisation	Challenges and benefits to the organisation
	Benefits for the staff	Challenges and benefits for staff and departments
	Benefits for the patients/ clients	Challenges and benefits for the patients/clients
	Facilitators	Facilitators
Future Roll Out		
Background and experience		
Progress with implementation		
Workforce selection		
Organisational issues	Communication across the organisation	Organisational issues and recommendations: Communication, leadership and engagement
	Communication to front line staff	Organisational issues and recommendations: Communication, leadership and engagement
	Future implementation	
	How to get senior level engagement	Organisational issues and recommendations: Communication, leadership and engagement
	Leadership	Organisational issues and recommendations: Communication, leadership and engagement
	Local context	
	Recording MECC	Organisational issues and recommendations: referrals and recording
	Referrals and signposting	
	Service connections	Organisational issues and recommendations: System changes and service connections
	System changes	
	Workforce type and selection	
Staff training and evaluation	Future training	Staff roles, experiences and training: previous training, MECC training
	Health knowledge and online training	
	Healthy conversations (in house)	
	Other evaluation	
	Other training	
	Peer reviews	
	Pre-MECC survey	
	Train the Trainer (HCS)	

4.4.1.1 Challenges and benefits of introducing MECC

Interviewees were asked initially about the benefits and challenges of introducing MECC to their organisation, the staff and departments involved, and to the recipients, whether they were patients in the NHS or clients of the City Council housing office.

Challenges and benefits to the organisation

Within the staff from the NHS there was a clear view that prevention ought to be part of their role:

> *"…there is definitely a view within senior clinical people that part of the role of a provider organisation is to promote health, it's not just about the reactive element…I think they see their role as wider than that." [HHFT]*

> *"I think to the NHS it's just fundamental to focus on health, ill health prevention and health promotion to keep people out of hospitals, to be able to afford health care…" [SHFT]*

In the local authority there was also recognition that prevention was a Government priority,

> *"…and you know it's all the Government initiative about doing more for less at the moment, so we're trying to be as proactive as we can rather than be reactive to customer's needs…" [PCC]*

Cost savings were also recognised in the NHS, as were improvements in workforce health which themselves could lead to organisational benefits:

> *"…we make our own lives easier as healthcare professionals if we are treating a healthier population, and therefore are less numbers, so the cost implications…are obviously apparent…" [HHFT]*

> *"…we know that a fitter healthier workforce, they are more productive [and] more likely to have positive interactions with patients….There's quite a lot of research now linking staff wellbeing with a positive patient experience. Positive outcomes in terms of…lower MRSA rates…better sickness absence…" [HHFT]*

Challenges for the organisation were mostly to do with staff attitudes, and limitations and pressures on time and facilities. In the NHS some staff viewed MECC as another passing initiative,

> *"…some of the staff that have been here a long time, they've seen projects come and go and they don't…think things are going to work…" [HHFT]*

Physical limitations of departmental size *"which means you can hear any conversation that's going"* [HHFT], and limited access to emails by frontline staff were constraints to successful implementation.

"…I didn't quite realise until fairly recently that some of our frontline staff just do not access computers on a daily…or even weekly basis….we all have computers but we may only log onto a very specific patient bit to enter certain data…we do need to be sure that we are understanding their world and able to work within it…not what we perceive to be their world." [SHFT]

Commissioning was seen as having the potential to disrupt the introduction of new ways of doing things.

"..you're commissioned to deliver X. That's not about delivering MECC…so how can you deliver it, or build that into your work, without any additional funding stream…" [SHFT]

This also impacted upon the ability to release staff for training for MECC.

"…however high they value it, unless it's mandatory, and even then you're going to struggle to get the Board to agree to a whole day's mandatory training…" [SHFT]

"the training has to be quick and easy to implement so that it doesn't take up their staff's time." [HHFT]

In Portsmouth City Council, with the exception of training, few challenges were seen at organisational level:

"To be honest very little. They all buy in to the concept…operationally there's a time element, particularly around the training, that is causing the biggest, they're not even problems, they're slight barriers, slight hurdles to jump over." [PCC]

Challenges and benefits for staff and departments

Benefits for staff were immediately seen in their own communications with and perceptions of patients:

"Definitely it did open my eyes…I'm a typical medic and I do 'tell' and I was 'suggesting' a lot, so it really did open my eyes." [HHFT]

"I think it makes you stand back and realise that people do have their own solutions and you do need to get to know their world…" [HHFT]

"So we step outside the boundaries to help them, because we know that if we don't…they will be back…asking for help again." [PCC]

Also their professional roles and connections with other services improved:

"Benefits, almost I suppose job satisfaction…it's not just when you've done your job…the thanks you get from patients are the ones where you've done something a bit different or a bit over and above that…" [HHFT]

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> *"…we have got a Healthy Living Centre downstairs…So it was useful for staff to know what was out there, where it was going on and what the contact details were."* [PCC]

Relationships within their team also improved following training and introduction of MECC.

> *"…we did come out of it feeling really good, you know as a team, yes we can work together with this…"* [HHFT]

> *"…it was really good team bonding…"* [HHFT]

> *"…we really benefitted from having a few hours together, and you know really gelling."* [HHFT]

In addition some staff reflected on the benefits to their own and families' lifestyle and the potential benefits that might have on patient care.

> *"…we're trying to be or promote our staff as being healthy role models for patients, so of course we want to try and influence them or encourage them to have healthy lifestyles."* [HHFT]

> *"…aside from using it at work, I use it with my children…instead of sort of being quite prescriptive …helping them to explore with …the safe questioning, it's just been quite an eye opener on a personal as well as a professional level really."* [HHFT]

The main challenges to introducing MECC were staff attitudes and the problems of lack of time, seen across all sites.

> *"The barrier is time and people's perception that this will take longer…"* [HHFT]

> *"…if we are asking them to embark on assisting people…then they won't be getting through their caseload and the workload…"* [PCC]

> *"We're trying to squeeze it all in in the end, so the barrier is, it's just prioritisation."* [PCC]

And with regard to the time for the training:

> *"…you look at taking a whole day out of somebody's workload at the moment, and that's one day…actually the MECC training would advocate two days….so to cut it down was …was challenging. To get staff to be released for a day…that's a big ask."* [SHFT]

Staff attitudes were also a challenge, feelings of lack of confidence, perceptions that it was extra work, and fear:

> *"…first of all I thought, oh no, more work, what do they want us to do now…"* [SHFT]

"…there is still a fear factor around it ie 'I can't raise that issue, it's not my place to do that'…" [HHFT]

Challenges and benefits for the patients / clients

Few challenges regarding patients or clients were noted, except for recognising that they may have concerns other than lifestyle issues at the time, and whether or not they actually wanted to make changes.

"…you know a lot of them we are dealing with are perhaps stressed at work or have issues at home…" [HHFT]

"…it's just really the patients, if they want to change…" [SHFT]

"…for example with smoking, they enjoy it they just don't want to give up…you just have to respect that and go with that." [SHFT]

As staff had generally had not had a lot of time to actually implement MECC at the time of these interviews, the benefits considered were mostly theoretical, although a few had already seen successes with individuals.

"We work in a way where we're looking to put people in a better place. It's not just about housing to us, it's about health, it's about their lifestyle, it's about the area that they live in…" [PCC]

"…I've seen it work really well with some…who previously I would have a lot of difficulty getting to stick to an exercise regime…but because I've found out specifically what they want to do…it's worked really really well…" [SHFT]

"…I did something on smoking cessation with a patient…and they were like…actually I didn't realise that…and they're happy to now let me refer them on…that was just from one contact yesterday…" [SHFT]

Facilitators

Some particular facilitators for the introduction of MECC were noted, others will follow in sections below. However at this point there were comments about: keeping the scale of introduction manageable;

"…what we didn't want to do is jump in with all seven area offices piloting it…we wanted to keep it small scale…" [PCC]

And that it should fit with staff roles and natural conversational flow;

"So it kind of naturally fitted into their role…and it's not too intrusive on our part, because it's flowing in the conversation." [PCC]

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> *"…they're pertinent to what we're treating. So…with knee pain …often their weight is the cause of the problem…" [HHFT]*

At this stage support and motivation, and access to resources were also facilitators in its introduction.

> *"…we need the support and the motivation, and without it I think it would have gone by the board to be honest…" [HHFT]*

Having reminders was seen to be very useful initially, but it was also felt that a more comprehensive package around available resources would have been helpful, although it was recognised that as a pilot this might not yet be available.

> *"I think the one thing that people would have liked more, it to have a bit more of a show around the resources…available…and in retrospect some clearer guidelines about what was expected of us…" [HHFT]*

4.4.1.2 Staff roles, experiences and training

Initial feelings

Staff's initial feelings were mixed, some excited about introducing a new role, others reluctant or *"a little bit anxious, because it's the unknown…" [HHFT]*. To some extent this may have depended on their previous knowledge and skills.

> *"I think they either don't feel confident and therefore feel reluctant to do it, or…people pretty much in the therapy setting feel that it is their job role." [HHFT]*

> *"So there were some staff who feel like this is what they'd do anyway and they don't necessarily need it, know or want to know about anything else, and there perhaps are the more newly trained staff…who are used to this and this is part of university degrees now in terms of health education, and [they] are therefore very open-minded to it." [HHFT]*

Again the importance of fit with current service provision was evident.

> *"So in our new way of working…we're quite happy to signpost people in the right direction if we feel that's going to add value. So the housing officers were chosen purely on the basis that it was a conversation that they could easily lead into without being too intrusive on people's lifestyles." [PCC]*

> *"…so I think it's been really good for my nurses just to re-evaluate how they, you know how they go out and speak to our patients." [SHFT]*

Previous training

Mostly staff reported little previous knowledge of MECC, but some NHS staff had had previous training in behaviour change in their university courses:

> *"…I qualified from Southampton University in…and…we'd already done kind of healthy lifestyles, health promotion modules, and actually quite a bit on…behaviour change cycles and communication skills…"* [HHFT]

But other staff had had little specific training since their pre-registration courses:

> *"…only kind of general stuff when you do your nurse training, but nothing really specific during my nursing career. Other than I did attend a smoking cessation study day, and that's it."* [SHFT]

Other previous organisational initiatives had however led to some systemic workforce development:

> *"…about two and a half years ago, the Health and Wellbeing Champions, so looking at the Health Trainer concept and bringing that into the workplace…and that's culminated in us having around 70 staff health and wellbeing champions who've been through the Level 2 Health Improvement Course."* [HHFT]

In the council one of the managers had previously had the experience of working on a neighbourhood management project in a deprived area of the city, whose purpose was:

> *"…to look at the overall effects of a deprived community and what could be done to improve the deprivation scores…and we developed into a number of areas…[including health]…the usual you know high blood pressure, heart attacks, obesity, diets …and we promoted a lot of resident learning and doing things for themselves…"* [PCC]

MECC training

Organisations approached preparing staff for the MECC training in different ways. All the pilot leads and the front line staff leads from each of the three organisations first attended the Healthy Conversation Skills (HCS) Train the Trainer training delivered by the MRC LEU team to enable further roll-out of the HCS training. The MECC training for front line staff in one organisation (HHFT) consisted of a 'health knowledge' video and online training, followed by the adapted Healthy Conversations Skills (HCS) training.

There was felt to be a need to provide some background to MECC, theory about behaviour change, and messages around key areas of health behaviour. However the timing, access and demand this placed on staff varied across the sites. Half an hour was scheduled in work diaries to view a video, but it was felt that where this was viewed in a staff meeting prior to the HCS training that this worked best.

> *"…when we did the x training, they watched the video all together and it was much more evident from the training that they'd grasped that, more than when people at y had watched it on their own…"* [HHFT]

Not all staff managed to view it before the HCS training:

> *"Some of them hadn't had time to look at it before the MECC training…the people that did I felt were more engaged than those that hadn't…The second week, from those that hadn't looked at it there wasn't enough engagement."* [HHFT]

Elsewhere 'healthy knowledge' training was felt either not to be necessary for the level of interaction anticipated from introducing MECC, or had not been successful.

> *"…we asked them…what health knowledge have you got and what do you actually need in order to do this. And it turns out that most of them had more health knowledge than they need to perform MECC at this level."* [PCC]

> *"We took the national MECC eLearning programme and put it on our system. A few people have accessed it…and we did all feel that…it was possibly too involved, too detailed to get into…it was perhaps off-putting to some people…So we're looking for something simpler, as a sort of opening into Making Every Contact Count."* [SHFT]

For the Healthy Conversation Skills part of the MECC training, key staff who would be involved in rolling out the training at their worksites were initially trained by the MRC LEU training team. This training was then modified differently for each pilot site according to local needs and opportunity. Two members of front line staff reflected on the difference between the MRC and local training courses:

> *"I've sat in on both trainings…there are bits from both that I'd probably amalgamate a bit more and there are bits from Southampton that I'd leave out. [the local training] had a bit more behavioural change theory in it…which made more sense, I didn't have that from the Southampton training so I was a bit in the dark about what was going on. The actual training at S, how to do the 'How' and 'Whats'…and all the games we played were very pertinent…The SMARTER goals…I really struggled with…but the SMARTER goals in the session with [the local training] were more focussed on our area so…that helped…"* [HHFT]

> *"…I've been on both lots of training, the condensed and the full lot…I had a much better understanding once I'd been on the full training than I did from the shorter training. I think a little bit of…the specific direction…got a little bit lost…because it was a combination of giving us the background, teaching us the skill, and then asking us to go and do something, all within a very short period of time…"* [HHFT]

In Hampshire Hospitals NHS Foundation Trust the training for the different teams varied from one four hour session to two sessions of between 2.5 – 3 hours. There was some thought that mixed groups may work better as with a single perspective there could be cynicism.

> *"…if you're in a mixed group with people who are using behaviour change a lot that breaks down that cynicism and it is more of an eye opener."* [HHFT]

In Southern Health NHS Foundation Trust the training was delivered in half day sessions after the experience of the first one, and was not further adapted to the team setting,

> *"…the first time I did it I booked it for the day…but I realised that I could compact it quite easily…and that worked out really well because it meant that it wasn't taking up much time, but it still had that wow, you know that impact…"* [SHFT]

> *"I didn't adjust it to the setting I was in…I felt that if it was something that could be picked off the shelf and used, it needed to be the same."* [SHFT]

In Portsmouth City Council the three hour training sessions did not include the specific HCS training as these sessions were developed to suit the level of engagement and signposting to other services expected of the housing office staff:

> *"…the level of training time that was allocated was appropriate…it was kind of to the point and it was purposeful for the team. I don't think any of them had any extra queries following the training, so they all came away equipped, knowing what they needed to do…"* [PCC]

> *"…a lot of it was around building confidence and reassurance around what they were doing, so looking at some of the general models, tools and skills around behaviour change, lots of stuff around communication, how to engage, and then really the signposting elements of it, which was a big part of the confidence element, knowing they were able to refer on. So it's not opening a can of worms and having to deal with it."* [PCC]

The 'Train the Trainer' element of the initial training was not viewed that positively by front-line staff, and a number of sessions were cancelled due to insufficient numbers. Pilot leads went on to deliver the local training rather than the front line staff as originally intended:

> *"…what I didn't enjoy was the third day, when you were trained to be a trainer. There's no way I could train people I'm afraid at that stage…there's no way you can expect a nurse who hasn't got that background…I felt I needed to consolidate my practise first."* [HHFT]

> *"…it was covering stuff we already knew…I was a little bit surprised there was no assessment done at the end of the 'Train the Trainers' because how do you know people are trained to deliver, how do you quality assure their competency?...It was useful as a refresher.* [PCC]

It was thought that with time further training could be provided for staff to take forward MECC with other teams, *"…someone who would be the right person, a super-user…or a trainer."* [PCC]

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4.4.1.3 Organisational issues and recommendations

Communication, leadership and engagement

The instigation of MECC was usually led from an informed and enthusiastic individual at a relatively senior management level within the organisation. Every site described the importance of communications upwards to more senior management and the Board to get approval to begin to introduce MECC and outwards to staff and teams to gain commitment to deliver it.

A senior manager in Southern Health NHS Foundation Trust described the process of getting it approved and setting up mechanisms to implement it.

> *"…I found myself doing a presentation…with our whole Board…they said yes, we'll do that. Can you go off and do it, make it happen…So I set up a Steering Group of senior managers…that was clinicians, communications, training leads…across the Trust."* [SHFT]

In Portsmouth City Council:

> *"It kind of snowballed quite rapidly, the initial conversation I had was with one of our public health consultants. That then led to it going to our operational management team…then…to the directorate management team…I then escalated from there to include our elected member with the health portfolio, without whose endorsement nothing goes anywhere…"* [PCC]

After senior level buy-in the challenge was to get middle managers and team leaders on board.

> *"I think there needs to be more time to do …maybe more pre-briefing with the staff to get some of their objections out of the way and some of their attitudes around it."* [HHFT]

In order to get engagement at this level it was vital to meet with people face to face to explain what MECC is and the potential impact it might have.

> *"Face to face, so what we did…I was then invited along to team meetings and I …introduced the concept of MECC to the team managers, directly, who were then to cascade that to their individual staff members."* [PCC]

> *"It was mainly face to face, [we] worked out a plan of who we were going to target…she got me the contacts and arranged for me to meet with the heads."* [HHFT]

> *"I went and did a few engagement meetings with a few teams and…practically demonstrated…role playing…and the logistics and reality of bringing it in."* [SHFT]

While there were concerns about *"keep[ing] a tight lid on it"[PCC]* during the pilot phase, as capacity to deliver support to increasing numbers of teams was limited, there was also a need to keep the information about MECC in front of staff.

> *"…we are developing a page for our internal website. But we haven't actually wanted to highly publicise this, because we wouldn't have had the capacity to deal with any expectations that staff were saying…" [SHFT]*

> *"…the health promotion specialist within the hospital…she's emailed us updates…sort of summaries of how it's gone in other areas…the evaluations and things, so …she just keeps us up to date." [HHFT]*

> *"I don't think that people who aren't in the pilot scheme really know it's going on, at all….it has been difficult in some ways to keep the enthusiasm for continuing…so I've tried to send regular email to encourage people, and I've mentioned it at staff meetings and then I'll get a little influx where …people will do a little bit more and then it will tail off again…" [HHFT]*

Referrals and recording

The distinction between referrals and signposting or directing someone to another service was approached in different ways by different teams, and in some cases this was constrained by contractual arrangements between services.

> *"…we are limited as to who we can refer to. We can refer to physio…to dieticians, but there's …a strict criteria about that. " [HHFT]*

> *"…we'd talk about it and we'd sort of signpost them onto the agencies that they can do, because at the hospital, we've got a smoking cessation [service] but it's not something that we refer." [HHFT]* and from another service, *"we were told that it wasn't about us making referrals to other services, so it was more just signposting in the direction of the resource." [HHFT]*

In Portsmouth City Council and Southern Health NHS Foundation Trust:

> *"We deliberately kept the referral group down to something we had a vague control over. So predominately it's the Health Trainer Service which we commission…there was the Healthy Pompey phone line, which is manned by the Health Trainer service…" [PCC]*

> *"…the smoking cessation we can directly refer. There are schemes such as Slimming World that we can refer directly our patients to if they meet certain criteria as well if they're overweight. And…some of the GP practices can refer patients onto gyms and things to get fitness programmes." [SHFT]*

Conversely some services received referrals from GPs and were surprised that:

> *"…you'd talk to people and you think an issue might have been covered and it's the first they've ever heard about the fact that their weight might be causing the problem…" [HHFT]*

Recording MECC contacts and having any chance to see what impact they might have had further down the line, was difficult and inconsistent across and between the sites.

In Hampshire Hospitals NHS Foundation Trust:

> *"…it's a bit more tricky because we don't follow up the same patients and nurses change…it depends on the next person reading back the notes or getting it out of the patient and then recording whether the action has been done." [HH]* However for referrals this was not a problem, *"Referrals can be pulled off our database…so that audit trail is fine…" [HHFT]*

> *"…we are using an outcome measure…called the PFSF…and…an audit tool, where you write the patient number and…their score at the beginning and…end…so…we just added another form, so that people…do the two side by side." [HHFT]*

> *""we have an audit sheet…and …we'll tick whether we've had a healthy conversation, and…which area…and that we've followed it up and any comments." [HHFT]*

In Southern Health NHS Foundation Trust:

> *"…we've got a computer system called RiO and all of our patient records go onto that, so every time I've contacted a patient…they all go on RiO…so whether we now do smoking cessation advice, obesity, all those have been put on RiO." [SHFT]*

The pilot lead reported the changes made to this system by adding a 'pick-list' of lifestyle behaviours. However RiO is not used across all the SHFT sites, in another department:

> *"…we do document in our progress notes if we've had sort of a MECC interaction…and …we then document the outcomes of that discussion…And there's nothing, I don't think, in RiO what we use to record the activity…" [SHFT]*

In Portsmouth City Council they developed a worksheet to record activity and be able to evaluate impact that:

> *"…just had peoples name, address, date, who was referred, topic, brief description and who was signposted to and the likelihood of it being taken up and how long the conversation has lasted on the specific subject." [PCC]*

However there was some doubt that staff would remember to consistently fill it in as,

> *"…there's no real great incentive that they remember to do it…it's not a tool that we measure their performance on."[PCC]*

System changes and service connections

In addition to the changes made to the RiO recording system above, another service in Hampshire Hospitals NHS Foundation Trust changed their assessment forms to include more lifestyle issues, as staff were not confident in raising topics such as smoking or alcohol.

> *"…we've changed our assessment forms, so…as part of medical history, we now ask how many alcohol units do you drink a week and are you a smoker, so it gives you a very easy way in." [HHFT]*

In Portsmouth City Council the local connections with the Healthy Living Centre were seen as very valuable for the implementation of the pilot but could be developed further city-wide.

> *"we've got fairly close relationships with HIDS [Health Improvement & Development Service]…we've all done sort of little projects together…but there isn't a formal sort of link-up between us, and that's the one thing we've really been looking for from Public Health…and we're still really waiting to have a defined, not exactly a service level, agreement between us…" [PCC]*

In Hampshire Hospitals NHS Foundation Trust there was also thinking about formalizing the MECC approaches in service contracts in some way.

> *"I guess I'd want to try and link it somehow to some of our monitoring mechanisms, so you know CQC…or our contracts that we have with the new CCGs…it's possible that the CCGs are writing some of this into their requirements of us…" [HHFT]*

4.4.2 Post-MECC evaluation interviews

As far as possible the same people were interviewed for the Post MECC interviews who were interviewed for the process evaluation, including the pilot leads and the front-line staff. Only one of the senior managers from Southern Health NHS Foundation Trust was available for interview during that time and senior managers from Hampshire Hospitals NHS Foundation Trust and Portsmouth City Council, Housing department were unavailable. A total of 15 interviews were conducted, including 7 with Hampshire Hospitals NHS Foundation Trust from July to September 2014 with representatives from each of the 3 workforces; 3 from Portsmouth City Council from June to July 2014 and 5 from Southern Health NHS Foundation Trust, including each of the different workforces during September 2014. There were 3 front-line staff from the Portsmouth City Council, local housing office who were interviewed as part of a focus group, using the same interview schedule and included in the Post MECC evaluation qualitative data. It was not possible to arrange focus groups in any other organisation due to capacity, geographical and time constraints. Table 25 lists the themes and subthemes for the Post-MECC evaluation interviews and the section headings under which the issues have been reported.

Table 25. Themes and sub-themes for post-MECC evaluation interviews

Themes	Subthemes	Section headings
Challenges to introducing MECC	Challenges for the organisation	Challenges and benefits to introducing MECC: to the organisation
	Challenges for staff	Challenges and benefits to introducing MECC: for staff and departments
	Challenges for patients/clients	Challenges and benefits to introducing MECC: for patients / clients
Benefits of introducing MECC	Benefits for the organisation	Challenges and benefits to introducing MECC: to the organisation
	Benefits for staff and department	Challenges and benefits to introducing MECC: for staff and departments
	Benefits for patients/clients	Challenges and benefits to introducing MECC: for patients / clients
	Benefits for the local community	
Developing **staff knowledge and skills**	Developing staff confidence	Developing staff knowledge and skills: views on MECC training received
	Initial feelings	
	MECC training	
	Roles, professional background and experience	
	Future training	Developing staff knowledge and skills: views about future training
Organisational issues and recommendations for the **future**	Communication and staff engagement	Organisational issues and recommendations: leadership
	Senior level engagement	
	Leadership	
	Future roll out	Organisational issues and recommendations: recording, referrals and future roll out
	Future resources	
	Local context	
	Recording MECC	
	Referrals and signposting	
	Service connections	Organisational issues and recommendations: leadership
	System changes	
Views on **evaluation**	Organisational Assessment Tool	
	Survey	
	Other evaluation	

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4.4.2.1 Challenges and benefits of introducing MECC

The challenges and benefits of introducing and implementing MECC were discussed in relation to the organisation, for staff and departments, and for patients/clients.

Challenges and benefits to the organisation

The three groups of staff represented a number of departments from two health care organisations, and one housing office from a city council. Not surprisingly benefits to the organisation or department varied dependant of the nature of the work of the department, and the type of contacts with patients/clients. Benefits for the health service were seen in terms of cost savings due to fewer patients admitted to hospital, improved healing rates and earlier discharges:

> *"if they're healthier then they're not going to stay in hospital so long, they could be treated easier, … eg if they had COPD, if they can help to give up smoking…there'll be less patients for the Trust. …for those in beds so it is getting them to be a bit healthier, they can leave hospital because their wounds will be healing.'* [HHFT]

Also there were possible benefits to staff health,

> *'if it's making staff think about their own health and well-being, which is vital because we know that links into sickness absence.'* [HHFT]

For the housing office the financial benefits were more immediate:

> *'as a business it's helped us with ….understanding people's financial position, which then in turn helps us to collect rent'; and, 'we are able to project and manage our accounts better because we've got a better idea of their finances based on Making Every Contact Count…'* [PCC]

At an organisational level there was a sense that MECC had contributed to changing cultures and had had a positive impact on service and organisational changes.

> *'I think the Council as a whole is changing… they're always talking about health in Portsmouth,'* [PCC]

Specifically the MECC pilot was seen as *'influencing our new Holistic Lifestyle Service'*, and across the council;

> *'it's in the overall strategic plan that we, as a City Council, we want to make every contact count, so it's been brought in at a very high level, and on the ground people can see the benefit of a very simple client-centred approach'.* [PCC]

Staff feedback was similar in the health service:

'…one of the things that has come back from all of them is that it's an easy skill to have these healthy conversations. It's made them think about actually the impact that one person can have within the NHS, within our organisation.' [SHFT]

Conversely there were organisational barriers, for example lack of support from middle management:

'it's middle management will be the challenge…because they're somehow managing the additional demands of having to release staff and monitor staff with MECC versus delivering their own work and their workloads…the challenges are often around…convincing them that's it's worthwhile...to invest at this early stage to get gains further on.' [PCC]

Similarly managing MECC along with 'the reality of the day job' was evident in the health service:

'We've got CQC coming in a couple of weeks, and that diverts minds and attention you know to other things…every Trust is under huge financial pressures…it's as much the climate we are in, both nationally and locally, makes it very difficult for senior managers to be able to prioritise something like this.' [SHFT]

Changes in management also impacted on organisational support for implementing MECC:

'To be honest they've [senior management] had very little involvement at all…we had somebody temporary come in, and really we've been left to our own devices…' [HHFT]

Connections between services within an organisation for referral to provide more support to patients were also sometimes problematic, it was suggested that *'…these links definitely need to be stronger and seamless.'* [HHFT]

'…it was a bit of a hike to try and get the referral through…a lot of it is political, it's felt that you know we haven't got a budget to refer to dietetics, so who's going to pick up that budget, you know the cost of that referral. They're sort of grey areas.' [HHFT]

Other challenges around referral, recording MECC and training will be considered further below, but a final comment on organisational culture, where the organisation and its staff start from at the initiation of the intervention could also impact on the success of its adoption. NHS staff reflected that:

'…the Council seem to be embracing Making Every Contact Count in a way that is perhaps more positive than the NHS have…' and that in the health setting,
'…there were so many people saying well I've done that already, we do that already, we're doing that…I think that has been hard…they may be doing bits of it already,

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they may be doing lots of it already, but they're not quite doing it in the whole package of MECC.' [SHFT]

Challenges and benefits for staff and departments

Challenges for staff ranged across a number of themes: issues to do with their own personal views, their confidence in their knowledge and skills to initiate healthy conversations, time to include MECC in routine practice and timing ie when it is appropriate and perhaps when not. Also conflicting views on the value of MECC within their team or department, changes to working practices, being able to access further support for patients or clients, training and recording contacts were also challenges. From a personal perspective some found that they reflected on their own lifestyle and felt uncomfortable giving advice to clients when their own health behaviour wasn't perfect:

'I felt I was being hypocritical, because my lifestyle isn't healthy, I don't eat healthily, I don't smoke, but it was kind of me not telling them how to change their lives, but understanding that it isn't about me and it's about them, and that for me was the biggest challenge…' [PCC]

'I think we still struggle with alcohol purely because…the limits are so low a lot of people aren't aware that you actually have to give advice to people on the amount of alcohol they are drinking, when in fact it's the amount of alcohol you may well be drinking yourself at home, so that's definitely harder…' [HHFT]

'…if you're feeling pretty stressed yourself, you know it's a really busy shift, sometimes you just don't want to go there' [SHFT]

Having the confidence to initiate healthy conversations, often a considerable change in routine practice, knowing when to do it and being concerned about how the patient or client would react were all barriers, at least initially for some staff:

'I think it's initially having the confidence to actually use the open discovery questions and introduce the topics…' [HHFT]

''I think it's to do with confidence…they're asking and doing something new and the change in their practice, particularly for people who've being doing it a long time, that's quite a hard ask… they don't see it as their role to talk about healthy lifestyles.' [HHFT]

''I think they're worried about…how the patient's going to react. You know I think they're just projecting their anxieties onto the patient, and so worried that the patient's going to be upset with them raising that issue…' [HHFT]

'And what we struggled with most…you're suddenly asking them about how much they are smoking or…drinking, is where does that fit into our role and are people going to take offence to that?' [HHFT]

Lack of time or time pressures were widely stated as a barrier to implementing MECC across the range of services, whether they were quick opportunistic contacts or longer scheduled appointments with patients or clients, time was frequently an issue.

> *'I'd love to speak to every tenant about how they could change their lives and their lifestyles and how that could have a knock-on effect for their children and their finances, but I don't have time to do it.'* [PCC]

Even where longer appointments were booked with patients, in some services they were also juggling with urgent referrals from the consultant, or the priority for the interview was different:

> *'…we've only got an hour to see clients, which maybe to some sounds like a lot of time…you really have got to utilise the time…to answer the questions the manager needs to know about…when this person is going to be fit to come and carry out the duties they are employed to do, so that becomes our priority.'* [HHFT]

However as one of the pilot leads said,

> *'…one of the concerns were around the time it would take to have those brief conversations, but actually practising and using the skills they have found that actually it doesn't take as long as they first feared.'* [SHFT]

Related to this was the development of understanding that sometimes it was inappropriate to raise healthy lifestyle issues, and getting the timing right was the best and most efficient way to have healthy conversations.

> *'I think there is only so much information that somebody can take on board in one go and I think if they're coming in because the bailiffs are at their door and things like that…you really have to gauge at what point you're going to bring it [MECC] in and it isn't always at the first stage.'* [PCC]

> *'I've made it, I'm in their house, and then that's your one opportunity…and then you start opening questions about their lifestyle…and they kind of close down…'* [PCC]

In the health service timing is also an issue, and for some not having an ongoing relationship with a patient is a problem for implementing MECC.

> *'…a lot of the MECC principles I think are better placed out in Primary Care, where people have got long-term ongoing contact so that they've got the follow-up. Because a lot of our care is when it's an emergency…or…urgent situation and because it's for a short sharp period it's not quite so easy to apply…'* [HHFT]

> *'…we potentially have got a sick patient going into hospital and having those conversations can be inappropriate and difficult.'* [SHFT]

'So the biggest place that it is discussed is the gym…it's more of an environment where you do get chatting to the patients week on week…so it's definitely that environment lends itself more to the advice and the types of conversations you want to be having.' [HHFT]

The views of other team members who may not have been trained or whose attitudes and experience differed from that of the interviewees also impacted on their ability to implement MECC. In the housing office there was a service organisation change underway which ultimately would mean that all Housing Officers would be expected to take a more holistic approach to their clients, but in the transition phase workloads and roles differed making it more or less easy to encompass healthy lifestyles in their contacts with clients. These differences also impacted on the way staff were perceived by clients.

'…either you are on board with Making Every Contact Count and you believe in its purpose, or you don't. And sometimes negativity from other colleagues can affect…the way that MECC is perceived and is accepted into our tenants' communities and homes. So if one housing officer is really proactive with MECC and then another isn't, and they talk, you've got conflicting information…and opinions, and that was a challenge.' [PCC]

Another factor impinging on the success of MECC often cited was access to other support services and information. Once staff had initiated a healthy conversation and elicited a positive response from the patient or client the process was helped or hindered by how readily they could refer people onto more intensive or sustained support. In the case of HHFT a prompt card was developed for staff to give to patients with contact details of services. Access to services might also be limited by lack of access to the internet or travel costs.

'…a high percentage of my clients don't have internet, or they're on pay as you go telephones with no credit, and or they live four miles away, so although you want to make every contact count, giving them that card to the website is sometimes pointless because they can't access it.' [PCC]

'…we would have to be mindful that there are some people who don't have easy access to computers and if that's the case we need to print off relevant information for them…' [HHFT]

In the housing office staff were able to use the local Healthy Living Centre to provide more support and sometimes could help make that first contact,

'…when they say I've just about had enough, I can't cope anymore, and it's getting to that point where you think, right, okay, why don't we just take a walk down there and have a chat to someone and see what we can do.' [PCC]

'…so to be able to say here are the services available to you, do you think you'd like to speak to anybody…and then dialling the number, handing them the phone, leaving the room and letting them take the steps forward…' [PCC]

The impact of community networks could also be beneficial, or a challenge:

> '…a good experience will be shared between the neighbours, a bad experience will be shared between the whole patch.' [PCC]

The other users of the Healthy Living Centre could also put people off accessing the services available and was seen as a barrier.

> 'And so they don't want to be seen going into a building where heroin users or methadone users are going in, they don't want to be seen as one of those clients.' [PCC]

Challenges and benefits for the patients / clients

Generally many fewer challenges were described for patients/clients than benefits. Many echoed the comments above around difficulties of access to services and ongoing support.

> '…we're on low incomes, we're talking about healthy eating, improving your finances, but if you want to do and engage with Making Every Contact Count…you have to come to the Healthy Living Centre, and to come up on a bus from my patch is four pound fifty.' [PCC]

Family and peer pressure were often seen as a considerable barrier to changing healthy lifestyles.

> 'But the families are also likely to be near to each other, in social housing you are likely to have families within walking distance of each other…so if there's drug abuse going on from grandparents, that will be going on in all properties…' [PCC]

> 'And then another patient said to me again, his wife continues to smoke, so it's very, very hard, that's kind of a barrier…' [SHFT]

Interviewees mentioned many advantages and benefits that they perceived for their clients and patients, from debt management to improved health, increasing access to support by signposting to local services, and the provision of supportive relationships.

By undertaking income/expenditure reviews with clients, personal life choices were revealed and 'MECC kind of almost naturally dropped in the conversation'. [PCC]

> '…and we see people smoking forty cigarettes a day, we don't say to them well here's an area you need to cut down, that's their choice, that's the conclusion that they may come to…well okay, so how do you think you can cut down? Do you need help? Do you need support? Did you know that there is this service out there that could help you reduce, cut down, you know stop smoking? [PCC]

'…when you actually realise at the end of the week what that totals up to…that's when…its; the right time to say well are you happy with that? No I want to cut down actually, I didn't realise, I can save for a holiday if I'm not smoking…' [PCC]

One housing officer mentioned two customers that had benefitted from being able to talk about their health, one with their confidence and another with overcoming their drug addiction, which *'wasn't necessarily a conversation I'd have had with them previously'.*

Understanding the complexity of all the impacts on people's lives was also a substantial benefit.

'…one of the main benefits was really focussed around seeing people beyond the issue they're there for…recognising that other things impact on someone's life, it's not just what they present with. It's probably the benefit I think, seeing people in a much more rounded, holistic viewpoint.' [PCC]

In the health service it was felt that the patient experience was improved by MECC, particularly where patients were seen on more than one occasion.

'…hopefully they go away feeling that they've been listened to and that people are genuinely interested in their health…and that they've been able to get support to perhaps overcome some perceived barriers…and maybe feel a little bit more positive about making some changes because it's been broken down into smaller, bite size chunks.' [HHFT]

'I think well a) it brings the health agenda forward for the individuals themselves, b) it helps them start to take ownership…and often move then from potentially either not thinking about it pre-contemplation or from pre-contemplation to contemplation or ultimately to action. So although on one occasion you might not get from the whole journey, we do sometimes see people for follow-ups, that is useful as well to help them on their journey.' [HHFT]

However even where contacts were brief

'…within that small time that they've been with us, you know it's a little, little seed that might sprout' [SHFT].

In general it was thought that patients

'…are getting more aware of how healthy lifestyles impact on their conditions', and that *'they are getting more used to [MECC] and they're responding well'* [HHFT].

For patients with chronic conditions and even advanced disease

'…if they can make small changes it can actually improve the quality of life.' [SHFT]

The particular technique of healthy conversation skills was a direct benefit to the quality of consultations.

> *'…rather than if we were to ask them closed questions it would go through very quickly and obviously [we] don't explore things. By doing MECC, if we say what and how, it just gives them an opportunity really to answer the questions and kind of explore things in more detail about their lifestyles and things we could help them with and address.'* [SHFT]

Increasing access to supportive services and improving the connections between services was seen as a benefit. In the Portsmouth housing office links with the local Healthy Living Centre were improved by the introduction of MECC, and it was particularly welcomed

> *'…that they came in and just made us aware of the current sorts of things that they were offering, [it] just puts it to the forefront of your mind…'* [PCC].

Having the services so near to the housing office was important in being able to act when the opportunity arose.

> *'…and this immediacy has, this is a big factor…because well, if you've got to make a referral to another service and they've got to wait however many weeks for it…the oomph has gone then.'* [PCC]

Other suggestions were made for increasing the network of support and referral services such as the food banks and how to cook with the foods provided.

Positive changes in the relationships between clients and staff were also seen as a result of MECC.

> *'…it opens up a trust and a relationship with your tenant …a more personal relationship as its about health…and that encourages them to come into the housing office and not see it as an authority figure , but a place of help.'* [PCC]

> *'I'm certainly more an empathetic professional since Making Every Contact Count. It allows you to speak with residents and their families. They can open, they can talk to you, that gives you some job satisfaction as well…'* [PCC]

> *'I think they're a lot happier, and just their attitude towards you is a lot better if they've got some control over what they're doing then I think they're a lot more compliant…if it's something they've said they can fit in, and I think I've probably become a bit less militant about how often people are doing things.'* [HHFT]

4.4.2.2 Developing staff knowledge and skills

Views on the MECC training received

Interviewees were asked about the training they had received and what they thought about it. In Hampshire Hospitals NHS Foundation Trust the initial training was well received by staff, but follow up support was *'disorganised at times'* and could have been improved.

> *'…the main aims of MECC could have been a little bit clearer in the beginning but …in general the training was really, really good…and it was very interactive and people enjoyed that…'* [HHFT]

> *'I think the initial set-up and organisation of the training was fine. I think for me…it's been about sustaining it afterwards. And although we've had somebody come in and sit in…and observe us in practice and give feedback, perhaps we could have done with a little bit more of that…'* [HHFT]

Despite initial resistance staff acknowledged the benefits of the training:

> *'So it did take a bit of convincing when you're first teaching staff as to why this is any different to what we're already doing, and what it was very good at doing was…making people far more aware of how much further afield they need to be questioning patients, rather than sticking black and white to what's written on the referral…'* [HHFT]

Administrative staff were also involved in the training:

> *'…it was felt it was important that they had an understanding of what we were experiencing and trying to initiate, and they kind of welcomed that…from a personal point of view they felt it was interesting and beneficial for them.'* [HHFT]

Aspects of the training that were appreciated included the pre and post training scenarios, despite dislike of role play, but some of the background was considered unnecessary.

> *'...I always find that [role play] difficult to do off the cuff. But actually the before and after comments were quite enlightening really…'* [HHFT]

> *'…it was kind of an hour sitting through a Powerpoint which didn't really capture people's interest. And a lot of that was…on the background…of why these things are unhealthy and the facts and figures, and I think we are fairly tuned into those reasons really.'* [HHFT]

Some of the training was adapted to make it *'relevant to setting',* and to fit it into a two hour session, so the trainer

> *'had to make a decision what the vital exercises were for our team, given the time that we had.'* [HHFT]

'…what I liked about the course is I could tailor it so each one has been different and I've tailored it to that department, as sometimes that's just about the amount of time, sometimes it's what the exercises [are] in there, and always the different role plays.' [HHFT]

The key skills that staff acquired from the training were thought to be:

'…the what and the how, the open discovery questions, most people that is the thing that they've taken away from it. The least beneficial, now some of them have said this, goal-setting, the smart goals, but I think that's only because they do that anyway.' [HHFT]

Where training had had to be shortened it was noted that staff were *'a little bit shaky, they needed more role play'* so further training was going to be provided *'to embed their skills'*. As the interviewee noted:

'…so what I love about the course is you can play around with it, you can change it to fit things, but there are certain areas that really need to be done.' [HHFT]

In Southern Health NHS Foundation Trust the training was also widely appreciated, *'well organised'* and *'delivered well'* [SHFT]

'…the training itself was really, really good and it really stuck in. And the approach …made it easier and got us to practice it and role play and things, that was really good.' [SHFT]

Staff reported feeling:

 'more confident to be able to broach…a subject…whereas before maybe I wouldn't…' [SHFT].

Different teams found it helpful, for example from the respiratory team talking to patients about smoking cessation, through to end of life care:

'…they have found it useful not only in lifestyle advice, but also in end of life…they've been using the skills to broach end of life, which obviously helps with giving patients time to plan …' [SHFT]

Unlike in other pilot sites Southern Health NHS Foundation Trust standardised the training they provided.

'…I kept it the same … because I thought if it's going to be something that can be picked up and used, to actually have the same training so it can literally be picked up and taken to wherever…I wanted to test to see if I could do that, because I felt that if we had something that we had to keep changing, that that would make it more difficult to implement and sustain.' [SHFT]

However there were still concerns about the length of the training and the ability to allow staff the time to attend it.

> *'…it might be that there needs to be some changes in the Making Every Contact Count Healthy Conversations, because…of the difficulties we've all had in trying to get to the training, and it's been too long, it takes too long…it all is necessary, but you see it from their point of view, two days! I can barely get someone to do an hour of mandatory training on how to do cardiac massage you know.'* [SHFT]

In the Portsmouth housing office there were also issues with time and release of staff which were resolved by keeping

> *'the training to a minimal level as possible so that we could finish the training within the whole day…morning and afternoon, both sets of teams'* [PCC].

Training was done in the workplace to minimise travel time and the staff were split into two groups to maintain duty cover. The content of the training differed to the Healthy Conversation Skills training and covered:

> *'Really we focussed in on the skills as tools, so recognising what their cues to action were…what their way in was into a conversation. Alongside that we also had some very simple, smart action planning sheets we used. And we kept it all very, very simple and clear'* [PCC]

In addition staff were given an accompanying manual so they had *'a constant reminder of what they've covered in the training'*. The training which has been delivered to other groups of staff since is:

> *'…evolving every time we do it. Every time we work with a new staff group it takes on a different face.'*

> *'…most of what we do…it's really around the motivational interviewing, being able to establish that rapport and to be able to assess people's, where people are at, and to explore what's going on for them. In addition to that, there's also the smart action planning, people understanding what to do, how to do…It's not really the Healthy Conversations Skill training we originally thought it was going to be. It evolved very quickly into a much tighter focussed, yeah, motivational interviewing course.'* [PCC]

The distinction between skills development and knowledge about particular health issues was also recognised. Some staff thought at the outset that they would be *'doing MECC around a specific area.'* So,

> *'…we had to learn very quickly, and then learn how to demonstrate, was that these were generic skills and the information is something slightly different. So we've worked with our Learning and Development team to develop bolt-ons …the idea being that you do your core MECC training, so you learn all the skills.'* [PCC]

Staff valued the connection with the Healthy Living Centre as part of their training, but would have preferred having the training outside their offices so they could see and place where the services were provided.

> *'I didn't necessarily have the contacts down at the Healthy Living Centre before MECC came in.'* [PCC]

> *'…it makes it easier to visualize in your head if you've been there, to think actually right, I can just phone them…'* [PCC]

Staff described the training as '*more of a briefing'* and,

> *'…it was almost a refresher for some of us who knew of the services, but I think some people needed a bit more in-depth.'* [PCC]

Views about future training

In Hampshire Hospitals NHS Foundation Trust it was generally felt that the training should include a revision session at some point after the original training. This was preferred to be a brief face-to-face session, or incorporated as *'peer review'* into regular team meetings in order to share practice and consolidate skills.

> *'Some teams will work differently, but we all like to have it so we can all discuss amongst ourselves, so in a sense we're cementing the ideas.'* [HHFT]

It was suggested that incorporating a formal refresher session three weeks after the training would be valuable to find out:

> *'…what's working well and perhaps what they haven't, and just do some little practice stuff with them bedding in those things a bit more. I think that is, it's vital and we build that in next time.'* [HHFT]

While there were plans to extend the MECC training out to primary care, and perhaps engage more clinicians in the training *'particularly in long-term conditions like diabetes'*, some difficulties were anticipated with providing more training to other staff.

> *'So we're working closely with some GPs and practice nurses who take the lead role for diabetes in their service, and we're hoping to do a bit of an introduction to the principles of MECC with them…so they can actually pick up the MECC principles after we have seen patients, or in their own routine practice.'* [HHFT]

The Train the Trainer model had been developed, however staff were generally not happy about this model of training.

> *'…all the team leads have identified that they don't feel able to train…the idea now is they can go out and train other departments, but they are not confident to do so, and*

> *my feeling is…I don't think a third day would teach us on how to deliver something like this…'* [HHFT]

It was felt that either some *'proper Train the Trainer training'* was needed, or that the co-ordinator should have this role.

> *'…we need to cascade it throughout the Trust…but it needs, we agreed, a co-ordinator to do that and manage that and make sure it happens…[and] provide the training as well'* [HHFT]

The content of the training at Hampshire Hospitals NHS Foundation Trust included a video (see Appendix J), which had a mixed response, some liking to watch it, others preferring more interaction face-to-face. So the trainer decided that in future she would *'bolt it onto the front of the Healthy Conversations training.'* A further change planned was to do some additional training with team leaders so that they would understand their role better and be able to *'model things'* with their team.

In addition a brief description of the MECC approach was going to be included in the induction programme, but it was felt that if the approach was

> *'going to be generic, it should be something that's done globally as part of the Trust induction.'* [HHFT]

It was suggested that a simple information leaflet *'that describes what it stands for and what it it's about'* could go in an induction folder.

Further suggestions to improve future training included providing the information and resources about services that they would refer patients to, such as the Smoking Cessation or Alcohol Advice Service. Rather than having to research the information themselves after the training,

> *'…you need to walk out with pieces of paper in your hand…with the referral forms for alcohol, with the leaflets for smoking, with the contact names.'* [HHFT]

Preferably the services should be part of the training to explain what their service is and how to refer to them, which one service did do on request.

In Southern Health NHS Foundation Trust there was also a call for more refresher training, either as a lunch time session, or possibly online.

> *'…the need to actually give a reminder, just to flag up the use of the what and how questions and you know remember to give those brief opportunistic advice.'* [*SHFT]

There had been interest from other departments and induction to incorporate MECC, and a meeting was being planned with the Learning and Development lead to discuss it. However there were still concerns about the length of the training and the

'need to see proof that it is going to be worth them putting somebody on a whole day's training course.' [SHFT]

The use of online or e-learning packages drew a mixed response:

'I think that's far more attractive and well I mean virtually everything I'm looking at doing now, apart from …CPR, seems to be online, but I don't think that is borne out in our experience. It's, MECC is very skills based, you know you need it to be practical you need to see it in action and you can't just learn it online.' [SHFT]

Housing officers felt that they could also benefit from refresher training, particularly about the local services that are available.

Contextualising the training in the housing service and drawing on the experience of the housing officers that had already implemented it would be welcomed.

'…possibly involving housing officers that are doing that in the future training would be the way forward, because it's completely different for health professionals to come in…' [PCC]

Involving managers as well as staff in the training or refresher sessions was suggested, as well as a more interactive style of delivery.

'I would like to see the refresher also be a bit more involved. I would like to see perhaps information drawn out of housing officers what they think.' [PCC]

'People learn differently don't they, and if you're being spoken at, I don't always take that or absorb that information in, and I enjoy speaking with my colleagues when you've got that opportunity to…and scenarios are always good, because if…you're talking to your colleagues about how everybody would respond to it you always learn something from your colleagues' [PCC]

In response to the comments received from the initial training, amendments were being made including the development of video clips, and an accompanying manual. In addition they were providing half day intensive specialist training around specific subject areas that might be particularly relevant for their area, such as dementia, smoking, employment issues etc.

'…we're in the process of setting those up and tying them all into the MECC programme, so what you end up with is you have the MECC training in the centre, which is the core skills, and then all the way round the outside, orbiting it, you have all the specialist knowledge that people can then tap into.' [PCC]

The training was already being rolled out on request from other services:

'…we've been inundated with requests for MECC training, to roll it out, and we've gone across, we're about to do Looked After Children's teams, … Carers Centres…YOT teams, and you name it, it's come in.' [PCC]

4.4.2.3 Organisational issues and recommendations

This theme contains a number of sub-themes, including: senior level engagement and leadership, recording contacts, referrals, system and service changes and future roll out.

Leadership

Leadership was recognised as being important at a number of levels, senior management and organisational, department or team management, and project co-ordination and training, and at different times during the process.

'…it worked well because I, I got the permission, I had to convince the top of the tree… You know with their support it's a lot easier. It gave me a foot in with their staff… because it was okayed by their senior boss, that helped.' [HHFT]

'So the manager, the team leader, whoever's in charge of that department needs to be really behind it, really supportive….So we need very senior involvement right from [ ] to the heads of department…' [HHFT]

'…the manager [ ] was really behind it, so she modelled it and her staff just, because she implemented her staff did it.' [HHFT]
'High up from the Strategic Directors, there is full support…' [PCC]

Conversely,

'I don't think it's anything that's ever come up in conversation with managers. It's just been left to individual teams to put in place isn't it? ' [HHFT]

There was recognition that consultants had been left out of the process and needed to be engaged:

'There was some issues around consultants, but in a way we bypassed them, but we shouldn't really, they need to be involved. I did a presentation to them…they had a lot of objections, but then they were sort of OK about it, but they're not doing it…' [HHFT]

The role of the project lead or coordinator was key in influencing at all levels and ensuring training and procedures were in place to implement MECC. Enthusiasm for the project and being held in respect by the team were leadership qualities that were valued. The way the pilot opportunity was presented was also key to its acceptance.

'One of the things you definitely need to do is you really need to go and see the people. I was given names of people who had shown an interest …previously, and people had moved on from the jobs that they'd had, …I found that when I emailed people and there were a lot of negativity from some departments…where I had obstruction was where I didn't make the effort to actually go and see the person face-to-face, and so that was a big lesson learnt.' [SHFT]

'Until [ ] came and sort of gave us an overview of what it was, and I was tasked with sort of setting the day, you know getting people to go, and it was …more, well we've got this, just grin and bear it, but actually it turned out to be very good.' [SHFT]

The leadership skills shown in the delivery of the training also impacted upon staff enthusiasm.

'…if you've got the right person teaching it, which we did with [ ], she made it quite sexy, no, honest, she really livened it up and actually made it quite, very interesting.' [SHFT]

'…and the approach was really good because of the way [ ] taught it, it made it easier and got us to practice it and role play and things, that was really good.' [SHFT]

Recording, referrals and future roll out

In addition to the comments earlier recommending changes to improve the training in the future, there were also other ideas about how MECC could be implemented more widely.

In all the sites there were remarks about the services that they were able to refer patients or clients to for further support. In the City Council the connections with the Health Improvement Team and the Healthy Living Centre needed to be sustained and kept up to date:

'…I don't think we've seen them since [the training]… I pop in there now and again with my tenants but …I don't see the professionals… Something about them seeing you as a service to keep you up to date, you know and give you all the tools you need…even if they came here once a month and just said, oh we're running this now…those things are available.' [PCC]

Other services that were receiving referrals also need to be aware of MECC and be ready to receive referrals,

'We know from the monitoring forms that several people were offered referral. We're still trying to chase up whether or not they went through with the referral or not, and that's one of the main areas that needs tightening up…' [PCC]

'And so not everything was ready to go when we did the training, which was a definite minus in that you're being told all this wonderful stuff and …these great

> *services you're going to be able to refer to…but without the actual referral forms in front of you no-one really believed it was ever going to happen.'* [HHFT]

Recording both the initial MECC contact and any further contacts with other services was also found to be difficult and was frequently mentioned as something to sort out with further roll out.

> *'…these links definitely need to be stronger and seamless. We're looking at …having an automated system for [smoking cessation], so that's going to be really good, referrals will be a lot easier, and I think that needs to be a separate thing in itself, how can we refer much easier, and make it seamless.'* [HHFT]

Solutions to the problem of recording were also seen to be unique to the particular service context. In part of Hampshire Hospitals NHS Foundation Trust:

> *'…we have a system called OPAS, which is occupational health software, and we document …attendances and what sort of conditions they've got, and we've also managed on the dropdown to put MECC. So if we have spoken about any sort of advice or we've referred them to any sort of diet, exercise, alcohol, smoking type service, we can actually tick that, so at least we can get a report off to see how many people we've spoken about it.'* [HHFT]

Similarly the RiO system in Southern Health NHS Foundation Trust had a drop down that enabled recording of MECC contacts and actions, but there were doubts that it was used consistently:

> *'…I've probably been guilty of that myself, I've probably had conversations with patients and haven't always remembered to outcome or put that on RiO…'* [SHFT]

This could impact on recording how successful the initiative was as it wouldn't '*show a true picture'*. Elsewhere in Southern Health NHS Foundation Trust a different system was used which did not allow recording of MECC conversations, unless they were particularly specific to the consultation, and it was also recognised there would be cost implications for changes.

> *'we wouldn't be able to add it to Symphony, because…we piggy back off Southampton's Symphony, their A&E Department…and we have to be very careful what we add or delete, because it has an impact on their system.'* [SHFT]

In general:

> *'I think that's something again that we didn't do well at all, the recording of it. …and each department, I left it to them how they were going to record it, because it's their department, I don't know how they could do that within their systems. …we need to look at that, but the whole bit of recording it is a minefield, and how we're going to track it, because every department's got different things.'* [HHFT]

Staff also noted difficulties with recording MECC efficiently on paper systems:

> '…some people …didn't always record everything down on the sheet that we were given, because it was quite time-consuming to have to write out the hospital number, and you know ticking was fine…you know you've already written that [hospital number] so many times…and then you're asked to get out another sheet, put down the hospital number again tick it off, de, de, de…' [HHFT]

Difficulties with recording MECC conversations and referrals also impacted on the perception of the intervention where it was difficult to monitor activity and impact, or pull data off the systems accurately.

> 'I'm still waiting to see the outcome…[we agreed] we would undertake a measure to see the output of the referrals we had made, if you like with the signposting that we had undertook, how many of those people actually ended up making the calls…So in terms of success I don't think we are at a point where we have the necessary measures in place to be able to validate [it]' [PCC]

> 'I have asked the analyst to pull out the data…and…they added these things for the whole organisation and it didn't really show…' [SHFT]

Having up to date information was seen as essential and it was recognised that information about referrals and other support services needed to be accessible in a variety of ways and kept current.

> 'Simple resources, one telephone number, one website, that was good.' And 'Easy website as well, that's easily accessible' [PCC]

> 'I mean certainly the smoking cessation, we've got direct, we can just directly ring up. And I think with the Slimming World…yes GPs…my understanding is all of them can refer patients on.' [SHFT]

System and service changes

Difficulties encountered during the pilot had some impact on potential wider system and service changes, such as with the patient recording systems.

> '…it's actually helping to drive some improvements…we're looking at our whole RiO system and database to see if we can make sure that people are recording clearly…we've started putting items in the newsletters, saying that we know you ask the question but where do you record the answer…?' [SHFT]

Other changes included ensuring new resources were available, and that follow-up appointments could be made.

> '…we're going to put up a height chart, we're going to order a pair of scales…and we've ordered the booklets and the charts to put on the wall for people to be able to work out their own BMI.' [HHFT]

> *'…so maybe that could be a thing that we can sort of factor into our service…if we have somebody that's having recurrent chest infections…then maybe we should follow them up with a sort of health promotion visit…'* [SHFT]

There were also some signs that the MECC approach was being taken seriously at policy levels regarding indicators for health improvement,

> *…these are the foundations…the number of people trained in healthy conversations in your Trust, that's one key indicator of …your level of engagement …in health improvement.'* [SHFT]

4.5 Limitations of the research

The strengths of the research included the ability to access a wide range of staff from different departments in three different organisations, including acute hospital, community health and a local authority non-health setting. The nature of the services provided meant that patients or clients attending had a wide range of needs, and the service setting and time available for consultations also varied considerably. This has meant that the process has been tested thoroughly under a range of real life clinical and non-clinical settings. A range of staff types were also trained, again enabling the testing of the approach across different staff groups, although as a pilot only relatively small numbers of staff were trained at each site.

The online survey was convenient for the researchers as data were more easily collated and analysed, but in practice it was not found to be accessible for many of the respondents due to lack of regular email access, particularly for clinical staff, and IT problems with local firewalls that barred access to i-survey. These issues would need to be resolved prior to any future research.

As it was a feasibility study a major limitation was that the sample size was small and the survey was underpowered to detect differences. As respondents did not have unique identifiers it was not possible to match pre- and post-survey responses. However response rates were good for two of the three organisations, overall 72% for Pre-MECC and 63% for Post-MECC surveys, however a number of those responding online either did not complete the survey at all, or only partially completed it so they had to be discounted. There is a need to understand more about appropriate ways of capturing information from staff for future research.

The study was designed to assess the feasibility of implementing MECC in different settings and to learn how to improve or change the approach for future work. It was not designed to assess what the effects of the MECC intervention were on patient or client behaviour or health outcomes. Whilst there had been some hope that it would be possible to be able to follow up referrals and signposting in order to monitor impact on take-up of other services, as the research showed, this proved to be a challenging area. The different recording systems, where used, meant that this was not feasible, and is a key area for development for future service monitoring and research on impact.

5. Discussion and Recommendations

This study was a feasibility study of the implementation of a particular approach to Making Every Contact Count (MECC) in three different organisations in Wessex. In two of the organisations separate and different workforces were engaged in the pilot, meaning that the approach was actually assessed in eight different settings. This has led to a rich and rather complicated set of data about the implementation experience in these different contexts. The evaluation has also provided an opportunity for the implementation of MECC to be seen as a feasibility study for the testing of various evaluation methods, to assess and understand: how the approach was tailored and delivered in these different contexts, and thus the potential degree of flexibility and support that may be required in future implementation; what are the barriers and facilitators to the successful introduction and implementation of MECC; what possibilities are there for the future assessment of the impact of MECC; and could the study be scaled up to research the effectiveness of the approaches recommended with patients or clients?

The Organisational Assessment Tool (OAT) adapted from the Midlands & East MECC tools was the first opportunity to attempt to assess some of the key organisational factors felt to be important for the successful introduction of MECC. In Southern Health NHS Foundation Trust and Portsmouth City Council the 'expectations of benefits beyond helping patients' was seen as high, as was importance of staff involvement and training to sustain the process, and senior and team leadership. There was thought to be a very high fit with the organisation's strategic aims and culture but it was recognised by very low scores that there was little in the way of organisational infrastructure in place for sustainability. Hampshire Hospitals NHS Foundation Trust in addition was more confident in the effectiveness of their systems to monitor progress and, some of their services felt they had the infrastructure for sustainability. PCC showed a similar pattern except there were lower scores on staff involvement and training and team leadership. However, only two of the three organisations returned their Pre-MECC OAT *before* staff had had training and only two out of the three organisations returned their Post-MECC OAT.

The OAT, whilst useful for emphasising the importance of organisational issues for the successful implementation of MECC, and indeed pinpointing areas of weakness which other aspects of the evaluation also highlighted, was not found to be an acceptable planning or evaluation tool. It was too lengthy and onerous to complete. It was possibly introduced a little too late in the process of implementation for HHFT and PCC, after the introduction of the in-house training, and it was not necessarily completed by the people it was intended for. For future MECC implementation it would be helpful to summarise each of the items, and suggest its use as an organisational 'readiness to implement' tool. For example the clear identification by the OAT of potential difficulties in the ability of the system to monitor progress and in ongoing sustainability, were evident before training and delivery of MECC, and subsequently highlighted at later stages of the evaluation. The OAT, in a simplified form could be used in future to identify these issues in advance by senior managers and consider how to address them before staff begin to introduce the MECC approach.

A number of organisational issues were discussed in the qualitative interviews, both during and after the implementation period. These included infrastructure issues such as the

physical limitations in departments meaning that it was difficult to have private conversations with patients, and having expectations that all staff not only have access to computers regularly but actually use them to check their emails, and thereby access online training and evaluation forms. Communications about MECC to staff involved in the pilots and more widely across services and the organisation need to be developed, not only to contribute to embedding the changes in organisational culture, but to specifically remind staff implementing MECC to keep it up and record it appropriately.

Recording and referral systems were probably the least satisfactory organisational issues across all the sites and settings. The importance of being able to record a MECC conversation, and then to follow up the patient to see if it had had any effect on their behaviour were seen as vital to be able to evaluate the effect of MECC on patients or clients. This in turn would be fundamental to its sustainability and roll-out to other services. However as was evident from the respondents, the different forms or online recording systems vary enormously from service to service, making a consistent approach to recording MECC very difficult. At best were the services that were able to modify their online systems to record MECC contacts. Others used additional paper forms, and some spoke of doing MECC but simply forgetting to record it. Others mentioned devices to incorporate MECC more naturally in the conversation by for example, adding more healthy lifestyle issues into their routine assessment forms. It is suggested that where services in this pilot have modified their forms or systems as indicated, these be collected and used as examples for services planning to implement MECC. Advice should also be given to project co-ordinators to review their recording systems and discuss possible amendments with IT prior to introducing MECC to facilitate the ability to capture both activity and if possible outcome data.

Referrals were described as another 'grey area'. On the one hand staff needed to know about the services available in the area and what they provided, and whether they were simply 'signposting' or more formally making a referral to them. In Portsmouth City Council there was a network of health improvement services across the city and a single telephone number and website for information. This service co-ordination clearly helped with signposting, but staff still welcomed the personal touch, meeting with local healthy lifestyle providers and visiting premises such as the Healthy Living Centre, so they could be more confident when suggesting them to clients. In HHFT, staff were encouraged to refer patients to the organisation's webpages. Prompt cards and flyers were developed by the pilot lead for this purpose, which were welcomed by staff as they facilitated the referral process. In some departments staff did not have knowledge about local services to hand, and whether or not it was possible to refer to them. In fact some staff spoke of being unable to refer to local services, including smoking cessation, because they did not have the arrangements within their contracts. Where they were allowed to refer it was often only when patients met strict criteria. Some staff seemed to be left rather confused as to whether and where they could refer to, or whether they were simply signposting patients to make their own contacts with other services.

Within organisations the connections between services need to be reviewed and clear protocols developed for referral so that staff are clear about what to say and do when the opportunity arises. Importantly though, commissioners should recognise the value of having

such services to refer or signpost to and aim for increased capacity to take more referrals where necessary, and remove unnecessary administrative barriers to effectively implementing MECC and supporting patients. In addition staff also noted that the services that they were signposting to might be further away and difficult and costly for patients or clients to access on public transport.

On a more positive note, the introduction of MECC was reported by staff as improving job satisfaction, increasing professional empathy, providing team bonding, and having a positive effect on organisational culture. It is clear from the pilots that key to its successful introduction is having an enthusiastic and experienced health promotion champion whose role is to lead it, and ensuring not only senior management buy-in and permission to introduce it, but the engagement of middle or service management and also consultants' involvement from the outset. The inclusion of behaviour change support in staff contracts or through other financial incentives was also noted as important for its sustainability.

The Yorkshire & Humber Behaviour Change Framework (NHS Yorkshire & The Humber, 2010) has informed different approaches to MECC elsewhere in the country. This describes the competencies required for encouraging and supporting behaviour change at three different 'levels' of competence (Fig. 7). The training course selected for this study was that provided by the MRC Lifecourse Epidemiology Unit, Healthy Conversation Skills (HCS) training as described earlier. This training, based on behaviour change theory emphasises the importance of key skills embedded within the competencies described in Fig. 7 at different levels, such as Open Discovery questions, SMARTER planning etc, but it is not directly related to the MECC levels. In fact it was only in the Portsmouth housing office setting that the roles anticipated for the trained staff were established at the beginning as being at Level 1 or 'signposting' by reference to the framework, and their training was limited to the skills required for that. At the other sites the staff roles and whether they were able to use their skills to both motivate and support behaviour change was largely down to pragmatic decisions based on the time they had available with the patients. This comes out frequently in the interviews where staff reflect on the suitability of their role, the type and extent of contact and ability (or not) to continue to support, refer or signpost patients to other services. Before discussing the ways in which the staff were prepared for their new roles in more detail a recommendation from the study would be that it would be helpful for managers to consider how much engagement staff are likely to have following the initial contact, and the extent of training needed to be competent to work at that level. It would also be useful to review the MECC level descriptors in the light of the more recently published behaviour change guidance from NICE (2014) and current psychological behaviour change technique taxonomy (Michie et al, 2013) in order to ensure that there is greater understanding of the connections between the approaches and that all are using the same terminology to describe the same competences and, importantly, role expectations. This is important, not only for taking the Wessex MECC approach forward, but to address the many observations that some staff had 'seen this all before', the sense that came across that this was 'just another initiative', and that some staff felt that they already had and used these skills. Describing and positioning Wessex MECC clearly in both theory and policy context would help to show that this is building on previous initiatives whilst still pointed firmly in the direction of the future for health and other services.

Fig. 7. The Prevention & Lifestyle Behaviour Change Competence Framework (NHS Yorkshire & The Humber, 2010)

Level 1	Level 2	Level 3
The worker is able to engage with individuals and use basic skills of awareness, engagement, and communication to introduce the idea of lifestyle behaviour change and to motivate individuals to consider/think about making changes to their lifestyle behaviour(s).	The worker is able to select and use brief lifestyle behaviour change techniques that help individuals take action about their lifestyle behaviour choices which may include starting, stopping, increasing or decreasing lifestyle behaviour activities.	The worker is able to select and use appropriate techniques and approaches to provide support to individuals as they change their lifestyle behaviour(s) and facilitate individuals to maintain these changes over the longer term.
1.1: Ensure individuals are able to make informed choices to manage their self-care needs 1.2: Support and enable individuals to access appropriate information to manage their self-care needs 1.3: Communicate with individuals about promoting their health and wellbeing 1.4: Provide opportunistic brief advice	2.1: Ensure your own actions support the care, protection and well-being of individuals 2.2: Select and implement appropriate brief lifestyle behaviour change techniques with individuals 2.3: Enable individuals to change their behaviour to improve their own health and wellbeing 2.4: Undertake brief interventions	3.1: Enable people to address issues related to health and wellbeing 3.2: Enable individuals to put their choices for optimising their lifestyle behaviours into action 3.3: Enable individuals to maintain lifestyle behaviour changes

For this study the lead staff in each service and the project (or pilot) leads in the pilot sites attended a 2 day Train the Trainer course on HCS. The intention was for them to take this back and deliver the HCS training to their teams. There were practical difficulties with this model. Some service leads who had been trained initially did not feel competent to train their colleagues in their teams. There is a clear indication from the interviews that the selection and preparation given to staff expected to take a training role in rolling out the MECC training locally needs more consideration. Preparing staff to be 'trainers' needs to be addressed separately from the MECC training, or only staff who have experience in training should be expected to take on this role. In the event it was the pilot leads who had this previous experience who delivered the local MECC training.

When it came to delivering the MECC training in each of the organisations, this varied considerably between not only the organisations, but the individual settings within them. In all cases the amount of time was considerably reduced, compared to the original HCS training and in some broken up into shorter sections over a matter of weeks. In both Southern Health NHS Foundation Trust and Hampshire Hospitals NHS Foundation Trust it was considered that the training provided did cover the four key competencies of the HCS training. In Portsmouth City Council housing office however the training was focussed on only one of the HCS competencies and drew on the local trainer's previous skills and knowledge. Some additional training in knowledge of lifestyle issues was also provided in each site, including access to a video (in HHFT) and online materials, with greater or lesser success. Overall it was felt that background information on MECC, some behaviour change theory, and healthy lifestyle information (relevant to role) was valuable, but if possible should be delivered in a team setting at some convenient point, such as at a team meeting,

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prior to the delivery of the more intensive skills based training, and should involve administrative and reception staff. There was also a difference between the health service sites as to whether the training was customised to the staff group receiving it, or was kept exactly the same. The findings were equivocal in that there were signs of staff appreciating that elements of the training clearly reflected their roles, but also the arguments about consistency and ability to take the training 'off the shelf' were strong. In all cases, whatever the mode of delivery of the initial training, respondents felt that peer support and refresher training would be beneficial. The need for further follow-up and support was also seen in the 'peer support and feedback' observation sheets with respect to the use of the particular healthy conversation skills, so this should be built into the training and support plans for MECC delivery.

The evaluation of the training was done through the online surveys conducted at the beginning and towards the end of the pilot period, the questionnaire evaluation of the HCS training course, and the qualitative interviews. Before this intervention over half of the staff in the pilot sites had NOT received any previous training to promote healthy lifestyles. Despite the small sample numbers it is clear that at least half of the staff had not had previous training on various healthy lifestyle topics or on interviewing skills, and yet the majority of them thought it was very important for them to discuss healthy lifestyles with service users and their carers, colleagues and friends and family. It really is rather an indictment of current basic and post-registration training that so many key workers in the NHS have not had any preparation for supporting behaviour change, and consequently, as was found in the review of hospital health promotion provision, there is generally little evidence of co-ordinated health promotion activity (Lee, Knuckey & Cook, 2013).

Before and after comparisons of the survey data rarely reached significance owing to small numbers, but there were some interesting findings that are deserving of further research. Over the study staff knowledge of the importance of their role in discussing healthy lifestyles rose, as did their confidence. However there was a slight move away from intentions to raise the subject of healthy lifestyles 'at every contact' for all categories but particularly for carers, colleagues and friends and family. This perhaps reflects the learning from reality that it is not always an appropriate moment to raise lifestyle issues with service users, and may be difficult or inappropriate to have such discussions with others, as is depicted in the qualitative data. In the survey there was little change before and after to the issues identified as making discussing the subject of healthy lifestyles easier or more difficult. Time and clients' attitudes were considered to have an effect on making it more difficult, but issues to do with service organisation and facilities etc were seen as less important. Post-MECC the majority of staff thought their lifestyle was healthy with one third reporting that it had improved quite a lot since doing MECC. This is an interesting finding which is deserving of further research. Some staff expressed disquiet at the dissonance between their own lifestyle and the 'healthy role model' they felt they were expected to demonstrate, so it would be interesting to see if participation in MECC was actually encouraging changes in staff's own health.

In the training evaluation conducted immediately after the MECC training had been delivered at each site, using forms provided by the MRC, there were significant increases in confidence and in intention to use the key skills such as open discovery questions rather

than make suggestions or give information. However in the peer observations later, while there was evidence of some of the skills demonstrating a good level of competence, there was clearly a need for further encouragement and ongoing support as indicated above.

Repeatedly staff at all levels stated that finding adequate time for the training was the biggest obstacle. The need to reduce this into achievable chunks, to customise it to the service needs, and to wrap around other important knowledge and information about health issues and most importantly the services available was paramount. Staff spoke of wanting to go away with all the information they needed to use the new skills effectively. At each organisational site there should be a package of local information, such as resources, posters, prompt cards etc., but a template for this could be provided centrally. Further work needs to be done to examine the detail of the training actually provided to review what are the absolutely fundamental elements of the training that must be incorporated and what compromises can be made. Where customisation to service contexts is considered necessary examples could be provided of role plays etc for different settings to facilitate this. Introducing information about MECC and the organisational commitment to prevention and health promotion could be provided briefly in induction or other training opportunities such as e-learning, to gain wider understanding and support for MECC, and to reduce training time for future services beginning to implement it.

This pilot has shown that the MECC approach has successfully been delivered in a variety of different settings in both the health and local authority services context. The particular approaches taken, both to introduce and to prepare staff for MECC, and in the way that it was implemented, have shown its ability as an intervention to be tailored to the very different circumstances in which staff find themselves in contact with the public. The variety of settings has also illustrated a range of issues and learning from its introduction, and ways in which staff could be better supported to deliver it well, either through the organisational changes needed to streamline processes, or through the training and ongoing support provided to staff. During and since the pilot period further organisations and sites have shown interest in the initiative and begun to implement it. Its importance has been endorsed in the NHS Five Year Forward View (NHS England, 2014) with its re-emphasis on the necessity of prevention and promoting health, and whilst recognising that the health service cannot do everything needed by itself, that it should become 'a more activist agent of health-related social change'. It is hoped that the findings of this study will help to provide for clearer mechanisms to sustain and upscale MECC initiatives so that they become embedded in the practice of a wide variety of services and workforces.

Recommendations

Organisational readiness

The Organisational Assessment Tool (OAT) could be a valuable guide to assessing organisational readiness to implement MECC, but it needs substantial simplification and application at an appropriate time in advance of implementation. Organisation-wide communications are necessary to support embedding MECC in the organisational culture, and on an ongoing basis to encourage staff to continue to apply the approach. In addition, review of the physical layout and space in departments needs to be assessed for their appropriateness for holding healthy conversations.

Management and sustainability

An enthusiastic and experienced health promotion champion is needed to lead the MECC implementation both at initiation and on a continuing basis. Senior management buy-in, the engagement of middle or service management and also consultants' involvement is necessary, and consideration should be given to including behaviour change support in staff contracts or job descriptions for those staff taking on MECC roles.

Referrals and recording

Within organisations the connections for referral between services need to be reviewed and clear protocols developed for referral so that staff are aware of further support available. A system wide approach should be taken so that there is increased capacity for more referrals, and unnecessary administrative barriers to effectively implementing MECC and supporting patients can be removed.

Project leads should review their specific local recording systems and discuss amendments with their IT departments prior to introducing MECC to facilitate the ability to capture both activity and outcome data. A review of the modifications to assessment and recording forms used by the sites in this pilot would be useful to provide examples or templates for other implementers.

Training

Managers should consider how much engagement staff are likely to have with patients or clients following initial contact, and the extent of training needed to be competent. Only staff who are experienced trainers, or who have been prepared adequately and are confident should be responsible for staff training on MECC. Training needs to be delivered in sessions of a length that is acceptable in busy settings. This should include: orientation to MECC, appropriate lifestyle topics, communication skills, information about referrals and services available, and recording methods. Refresher training and support sessions should be built in at regular intervals after initial training.

Introducing information about MECC and the organisational commitment to prevention and health promotion could be provided briefly in induction or other training opportunities such

as e-learning, to gain wider understanding and support for MECC, and to reduce training time for future services beginning to implement it. Consideration should also be given to including 'behaviour change' in all professional training as part of widening health promoting organisations and wider workforce training.

Evaluation and further research

Further research could be done to explore whether the introduction of MECC has an impact on wider issues such as reducing staff absence and staff's own health, its cost-effectiveness in different settings, outcomes on behaviour and whether system changes can be put in place to ensure that MECC is sustainable.

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Appendices

APPENDIX A
Wessex Organisational Assessment Tool

The engagement and support of organisations is key in enabling staff and services to be effective in making every contact count (MECC). Organisations have a vital role to play in the development and implementation of MECC by initiating change and transforming how services and staff interact with service users by making every contact count. This organisational assessment tool has been adapted from the Midlands and East MECC model[1] and is there to help you assess your readiness to implement MECC within your organisation. This tool also supports you to develop an action plan which will work towards improving areas that are identified as requiring further work or attention.

The tool supports organisations to implement and sustain effective improvement initiatives that will help increase the quality of services provided and improve service user experience at lower cost. It sets out the three key areas which need to be addressed:

- **Process** is about assessing the existing systems and processes that are in place to mobilise the improvement initiative along with exploring the wider benefits of an initiative. Process consists of four factors.
- **Staff** is about assessing the engagement of workforces at different levels, including support and engagement for leaders at senior and team levels to enable and deliver the improvement initiative. Staff consists of four factors.
- **Organisation** is about assessing how the improvement initiative fits with the organisational aims and culture and exploring whether the organisations infrastructure is supportive of such an initiative. Organisation consists of two factors.

Who should complete this tool?

Before completing the assessment tool you should consider whether or not you want to complete this assessment in the context of the whole organisation or the teams and departments you plan to start working with (or both). The organisational assessment tool should be completed by a group made up of senior leaders, decision makers and staff at either organisational or departmental levels. The MECC Lead and Implementer should facilitate the organisational assessment[2].

How to use the tool

1. Read through each of the 10 factor descriptions.

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[1] *The Midlands and East MECC Organisational Assessment Tool was adapted from the NHS Sustainability Model.*
[2] *For the purposes of the Wessex MECC Pilot Project the results from the organisational assessment tools will need to be shared with the Evaluation Lead.*

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2. For each factor select the level of each factor that best describes the project.
3. Place a score between 1-12 next to the selected 'factor level' (score of 1-12 will depend on the factor level selected). Against each score, list what evidence you have to demonstrate the factor level selected.
4. When you have worked through all of the factors and identified a factor level for each, go to the 'Master Score System' on page 15 and record your scores.
5. Then plot your scores onto the Portal Diagram on page 16.
6. Once mapped onto the portal diagram, you should discuss and identify any areas that may require particular focus.
7. Once specific areas for focus have been identified the group should develop aims for the future in taking this forward.
8. Using the action plan template on page 18 the group should develop an action plan to address the areas identified.
9. Once your improvement initiatives has been implemented revisit the assessment tool and re-assess your organisations score and evidence following steps 1-8.
10. Discuss who you need to communicate the findings of this assessment to and how you will do this.

Factor	Indicator (Examples)	Score		Factor Level	Evidence
1. Benefits beyond helping service users. In addition to helping service users, are there other benefits from initiative(s) to promote health and wellbeing	Changes in staff sickness absence Staff feedback Monitoring outcomes of interaction with service users. Cost/resource saving to service delivery.	10-12		We can demonstrate that initiative(s) are designed to maximise opportunities to promote health and wellbeing has a wide range of benefits beyond helping service users.	
		7-9		We can demonstrate that initiative(s) are designed to maximise opportunities to promote health and wellbeing has some benefits beyond helping service users, but not a wide range.	
		4-6		We can demonstrate that initiative(s) are designed to maximise opportunities to promote health and wellbeing has one or two benefits beyond helping service users.	
		1-3		The benefits of initiative(s) designed to maximise opportunities to promote health and wellbeing are only directly related to helping service users. We have not identified any other benefits that maximising opportunities to promote health and wellbeing could bring.	

2. Credibility of the benefits • Are benefits to patients, staff and the organisation visible? • Do staff believe in the benefits? • Can all staff clearly describe a full range of benefits? • Is there evidence that this type of initiative to promote health and wellbeing is influential elsewhere?	To ensure benefits are visible they should be discussed during training sessions and revisited as part of team meetings, integral to induction etc Staff should be given the opportunity to feedback the benefits they see are happening Mechanisms to capture patient outcomes should be put in place where possible.	10-12		Benefits of maximising opportunities to promote health and wellbeing are widely communicated, immediately obvious, supported by evidence and believed by stakeholders. Staff are able to fully describe a wide range of intended benefits for this initiative.	
		7-9		Benefits of maximising opportunities to promote health and wellbeing are not widely communicated or immediately obvious even though they are supported by evidence and believed by stakeholders.	
		4-6		Benefits of maximising opportunities to promote health and wellbeing are not widely communicated or immediately obvious even though they are supported by evidence. They are not widely believed by stakeholders.	
		1-3		Benefits of maximising opportunities to promote health and wellbeing are not widely communicated, they are not immediately obvious, nor are they supported by evidence or believed by stakeholders.	
3. Adaptability of improved process • Can the opportunities to promote health and wellbeing overcome departmental/service pressures and, or will this disrupt the service? • Do opportunities to promote	Initiative needs to be integral to the organisational vision and beliefs and job descriptions Incorporation into induction for continuity if trained staff leave	10-12		The process of maximising opportunities to promote health and wellbeing can link in with, be adapted and even support other organisational changes. It would not be disrupted if specific individuals or groups left the project. Its focus will continue to meet the improvement needs of our organisation	

health and wellbeing continue to meet ongoing needs effectively? • Do opportunities to promote health and wellbeing rely on a specific individual or group of people, technology, finance, etc, to keep it going? • Can it keep going when these are removed?	Use of organisational surroundings and staff intranet to continue to convey health promoting messages Using the above should support embedding the initiative, thus relying less on individual champions etc Approach should be person-centred to adapt to the patient and promote empowerment Top-up training for staff as appropriate.	7-9		The process of maximising opportunities to promote health and wellbeing can be adapted and support wider organisational change but it would be disrupted if specific individuals or groups left the project. Elements of this work will continue to meet our organisation's improvement needs.	
		4-6		It would be difficult for the process of maximising opportunities to promote health and wellbeing to adapt or support other organisational changes. It would cause disruption if specific individuals or groups left the project.	
		1-3		The process of maximising opportunities to promote health and wellbeing could not adapt or support any other organisational change happening and it would be disrupted if specific individuals or groups left.	
4. Effectiveness of the system to monitor progress • Does the initiative require special monitoring systems to identify and continually measure improvement? • Is there a feedback system to reinforce benefits and progress and initiate new or further action? • Are mechanisms in place to continue to monitor progress beyond the formal life of the initiative? • Are the results of the project communicated to patients, staff,	Activity and outcome monitoring forms Feedback on uptake of referrals Changes in patient's health and wellbeing noted and recorded All the above integrated into team systems and processes and taught at induction Communication strategy of results within teams meetings, newsletters etc to other organisations.	10-12		There is a system in place to provide evidence of impact, including analysis of benefits, monitor progress and communicate the results. This is set up to continue beyond the formal life of the project.	
		7-9		There is a system in place to provide evidence of impact, including analysis of benefits, monitor progress and communicate the results. This is not set up to continue beyond the formal life of the project.	
		4-6		There is a system in place to provide evidence of impact and monitor progress. However none of this information is communicated more widely than the core project team. The measurement system is not set up to continue beyond the formal life of the project.	

the organisation and the wider community?		1-3		There is only a very patchy system to monitor progress and this will end at the same time as the project. There is no system to communicate the results.
5. Staff involvement and training to sustain the process • Do staff play a part in innovation, design and implementation of the initiative? • Have they used their ideas to inform the process from the beginning? • Is there a training and development infrastructure to identify gaps in skills and knowledge and are staff educated and trained to take the initiative forward?	Teams and individuals within the organisation should be involved in designing the process by: • seeking representation from teams to work with senior management • seams being allowed flexibility to incorporate relevant processes i.e. redesigning forms and choosing materials to display	10-12		Staff have been involved from the beginning of the process. They have helped to identify any skill gaps and have been able to access training and development so that they are confident and competent in the new way of working.
		7-9		Staff have been involved from the beginning of the process and have helped to identify skills gaps but they have not had training or development in the new way of working.
		4-6		Staff have not been involved from the beginning of the process but they have received training in the new way of working.
		1-3		Staff have not been involved from the beginning of the process and have not had training or development in the new way of working.
6. Staff behaviours toward sustaining the change • Are staff encouraged and able to express their ideas regularly throughout the initiative process and is their input taken on board? • Do staff think that the initiative is a better way of doing things that they want to preserve for the future?	Teams and individuals within the organisation should be involved in designing the process. This can be achieved by: • staff questionnaires • use of suggestion boxes • tailored and flexible training • meetings	10-12		Staff are able to share their ideas regularly and some of them have been taken on board during the process. They believe that maximising opportunities to promote health and wellbeing are important and have been empowered to undertake, as part of their existing roles, the promotion of health and wellbeing to service users.

• Are staff trained and empowered to promote health and wellbeing based on their ideas, to see if additional improvements should be recommended?		7-9		Staff are able to share their ideas regularly and some of them have been taken on board during the initiative. They believe that maximising opportunities to promote health and wellbeing is important. Staff do not feel empowered to run small scale test cycles (Plan, Do, Study, Act).	
		4-6		Staff are able to share their ideas regularly but none seem to have been taken on board during the initiative. They don't think that maximising opportunities to promote health and wellbeing is important. They don't feel empowered to run small scale test cycles (Plan, Do, Study, Act).	
		1-3		Staff do not feel they have been able to share their ideas. They do not believe maximising opportunities to promote health and wellbeing is important and they have not been empowered to run small scale test cycles (Plan, Do, Study, Act).	
7. Senior leadership engagement and support • Are they involved in the initiative, do they understand it and do they promote it? • Can they influence others to get on board? • Are they taking personal responsibility to help break down barriers and are they giving time to help ensure the change is successful?	Are senior leaders engaged with or aware of the concept and all other elements of this initiative Has the case been made to them – example case, why become a health promoting organisation?	10-12		Organisational leaders are highly involved and visible in their support of an initiative to maximise opportunities to promote health and wellbeing. They use their influence to communicate the impact of the work and to break down any barriers. Staff regularly share information with and actively seek advice from leaders.	
		7-9		Organisational leaders are highly involved and visible in their support of an initiative to maximise opportunities to promote health and wellbeing. They use their influence to communicate the impact of the work and to break down any barriers. Staff typically don't share information with, or seek advice from leaders.	

| | | 4-6 | | | Organisational leaders are somewhat involved but not highly visible in their support of an initiative to maximise opportunities to promote health and wellbeing. They use their influence to communicate the impact of the work but cannot be relied upon to break down any barriers if things get difficult. Staff typically don't share information with, or seek advice from leaders. | |
| | | 1-3 | | | Organisational leaders are not involved or visible in their support of an initiative to maximise opportunities to promote health and wellbeing. They have not used their influence to communicate the impact of the work or to break down any barriers. Staff typically don't share information with or seek advice from leaders. | |

8. Team Leadership engagement and support	Are team leaders engaged with or aware of the concept and all other elements of this checklist?	10-12		Team leaders are highly involved and visible in their support of an initiative to maximise opportunities to promote health and wellbeing. They use their influence to communicate the impact of the work and to break down any barriers. Staff regularly share information with and actively seek advice from leaders.	
• Are they involved in the initiative, do they understand it and do they promote it? • Can they influence others to get on board? • Are they taking personal responsibility to help break down barriers and are they giving time to help ensure the change is successful?	Has the case been made to them - example case, why become a health promoting organisation	7-9		Team leaders are highly involved and visible in their support of an initiative to maximise opportunities to promote health and wellbeing. They use their influence to communicate the impact of the work and to break down any barriers. Staff typically don't share information with, or seek advice from leaders.	
		4-6		Team leaders are somewhat involved but not highly visible in their support for an initiative to maximise opportunities to promote health and wellbeing. They use their influence to communicate the impact of the work but cannot be relied upon to break down any barriers if things get difficult. Staff typically don't share information with, or seek advice from leaders.	

		1-3		Team leaders are not involved or visible in their support of an initiative to maximise opportunities to promote health and wellbeing. They have not used their influence to communicate the impact of the work or to break down any barriers. Staff typically don't share information with, or seek advice from leaders.	

• **9. Fit with the organisation's strategic aims** Are the goals of the initiative clear and shared? • Are they clearly contributing to the overall organisational strategic aims? • Is improvement important to the organisation and its leadership? • Has the organisation successfully sustained quality improvement initiatives in the past?	Tools on reviewing progress i.e. utilising and continuing to use this *Implementation Guide and Toolkit* and Organisational Assessment Tool. Identify all H&WB goals to link to MECC.	10-12		The goals of the initiative are clear and have been shared widely. They are consistent with and support the organisation's strategic aims for improvement. The organisation has demonstrated successful sustainability of improvements before and has a 'can do' culture.
		7-9		The goals of the initiative are clear and have been shared widely. They are consistent with and support the organisation's strategic aims for improvement. The organisation has not demonstrated success in sustaining previous improvements and does not have a 'can do' culture.
		4-6		The goals of the initiative are clear and have been shared widely. However they have not been linked with the organisation's strategy so we don't know if they support any organisational aims for improvement. The organisation has not demonstrated success in sustaining previous improvements and does not have a 'can do' culture.
		1-3		The goals of the initiative are not really clear and have not been shared widely. They have not been linked with the organisation's strategy so we don't know if they support any organisational aims for improvement. The organisation has not demonstrated success in sustaining previous improvements and does not have a 'can do' culture.

10. Infrastructure	Attrition rates, induction checklists	10-12		Staff are confident and trained in the new way of working. Job descriptions, policies and procedures reflect the new process and communication systems are in place. Facilities and equipment are all appropriate to sustain the new process.	
• Are staff fully trained and competent in the new way of working?	Staff questionnaires to seek feedback				
• Are there enough facilities and equipment to support the new process?	Example sentences for JDs and Person Specifications	7-9		Staff are confident and trained in the new way of working. However, job descriptions, policies and procedures do not reflect the new process. Some communication systems are in place. Facilities and equipment are all appropriate to sustain the new process.	
• Are new requirements built into job descriptions?	Draft example for terminology for generic organisational policies i.e. PDPs				
• Are there policies and procedures supporting the new way of working?	Draft example materials for promoting health and wellbeing and supporting staff in making contacts count.	4-6		Staff are confident and trained in the new way of working. However, job descriptions, policies and procedures do not reflect the new process and there are no communication systems to adequately support the new process. Facilities and equipment are not appropriate to sustain the new process.	
• Is there a communication system in place?					
		1-3		Staff have not been trained in the new process and are not confident in the new way of working. Job descriptions, policies and procedures do not reflect the new process and there are no communication systems to adequately support the new process. Facilities and equipment are not appropriate to sustain the new process.	

The Master Scoring System

Process

1. Benefits beyond helping patients	*Write your score here*	2. Credibility of the evidence	*Write your score here*	3. Adaptability of improved process	*Write your score here*	4. Effectiveness of the system to monitor progress	*Write your score here*

Staff

5. Staff involvement and training to sustain the process	*Write your score here*	6. Staff behaviours toward sustaining the change	*Write your score here*	7. Senior leadership engagement	*Write your score here*	8. Team leadership engagement	*Write your score here*

Organisation

9. Fit with organisation's strategic aims and culture	*Write your score here*	10. Infrastructure for sustainability	*Write your score here*

Date:

Portal Diagram

Map your scores from the Master Scoring Sheet onto the Portal Diagram.

By mapping your scores onto the diagram, this will provide you with a visual representation of where you might want to focus your action plan on. Whether the action plan needs to be across all areas or whether, based on your scores, you feel it needs to focus on Process and/or Staff and/or Organisational factors.

Use the Portal Diagram to again at the end of your project to see whether there has been an improvement.
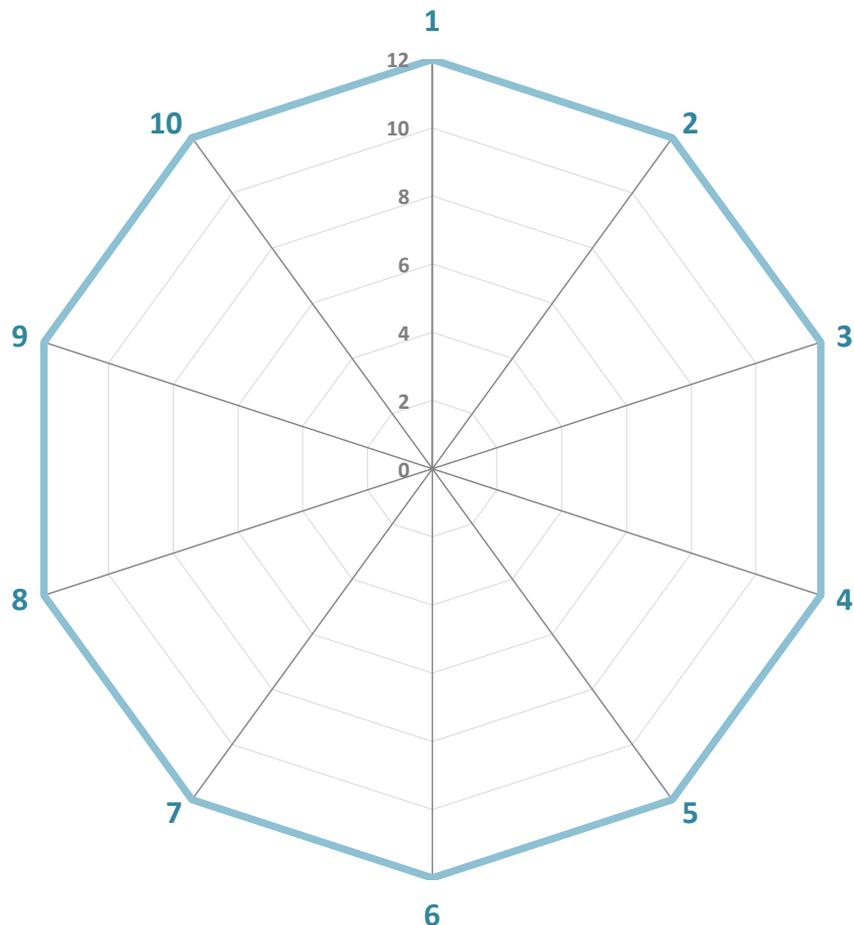
Observations & Comments

2. What have you found from completing the assessment tool?

3. Do you think there are specific reasons why you have scored high/low in some areas?

4. What (if any) factors/areas do you think you will need to focus on/develop further?

Organisational Aims

Based on the results from this assessment and your discussions, what are your aims to develop opportunities to promote health and wellbeing for the future?

Organisational Assessment Action Plan

Factor	Action	Lead	Measure	Resources	Timescale
1. Benefits beyond helping service users					
2. Credibility of the benefits					
3. Adaptability of improved process					
4. Effectiveness of the system to monitor progress					
5. Staff involvement and training to sustain the process					
6. Staff behaviours toward sustaining the change					
7. Senior leadership engagement and support					
8. Team Leadership engagement and support					
9. Fit with organisation's strategic aims and culture.					

Appendix B Pre-MECC Staff Survey

Covering Letter/ Email for Pre-MECC staff survey
Email Subject: Staff Survey-Making Every Contact Count-Win a £50 voucher!

Dear Staff member
Making Every Contact Count- Staff survey from University of Southampton

We would be most grateful if you could complete this online survey to help us to find out your views at the beginning of the Making Every Contact Count (MECC) initiative, which is about raising the subject of, or discussing, healthy lifestyles with patients/ clients.

We would like to find out some background information at the start of this process, including any previous training in health you may have had. Your responses are anonymous and your name will never be asked for or linked with the information you provide, so please answer as fully as possible. It will only take 5 to 10 minutes of your time.

Every staff member who completes this questionnaire will have the option to be entered into a prize draw! The winner will receive a £50 voucher towards a 'virgin experience day', such as a spa treatment, or a gift! (Link added)

We hope that you will also be willing to share your views in another similar survey early next year.
To begin the staff survey for NHS Hampshire Hospitals please click on the link below (Link added)
Many thanks

The Wessex MECC evaluation team
University of Southampton

Pre-MECC Questionnaire (distributed through the 'I-Survey', University of Southampton)
Thank-you for taking part in this pilot for the evaluation of the Wessex Making Every Contact Count (MECC) pilot.

Please complete this questionnaire so we can evaluate the implementation process of the Wessex Making Every Contact Count (MECC) pilot, the impact of MECC training and the potential benefits of MECC to both staff and patients/clients. The information you give will be confidential and will not be linked with your name so please give answers that are as honest as possible.

NB. 'Raising the subject of healthy lifestyles' means mention OR discuss healthy lifestyles

1. Gender

2. Age. Categories <25; 25-34; 35-44; 45-54; 55-64; 65+

3. Name of Organisations: NHS Hampshire Hospitals, Portsmouth City Council and Southern Health

4. Main site(s) where you work:
       Hampshire Hospitals: Andover/ Winchester/ Basingstoke/ Alton
       Portsmouth City Council: Paulsgrove Housing Offices
       Southern Health: Waterlooville Health Centre/ QA Hospital (Portsmouth)/ Lymington hospital

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5. Job Roles:

NHS Hampshire hospitals: Consultant, Doctor, Diabetes Nurse, Physiotherapist, Diabetes Nurse, Dietician, Occupational Health Nurse, Receptionist, Administrative, Clerical, Technician, Therapy Services Nurse, Other.

Portsmouth City Council: Housing Officer, Administrative, Clerical, Receptionist, Referrals, Other

Southern Health job roles: Minor Injuries Nurse, Consultant, Receptionist, Administrative, Clerical, Technician, Doctor, Respiratory Nurse, Heart Failure Nurse

6. Highest qualification(s) tick list

No qualifications; CSE 2-5/GCSE D-G/ NVQ 1&2; CSE 1/O Level/ GCSE A-C/ NVQ 3; NVQ 4/ 'A Levels/ BTEC, HND/HNC/ Teaching qualification, Undergraduate degree, Postgraduate degree

7. How long have you been in your current role? New/ less than 1 month; 1 to 6 months; 6 months to <1 year; 1 to <5 years; 5 to <10 years; 10-<20 years; 20+years

8. Have you had any previous training which has enabled you to promote healthy lifestyles?
    a)   Yes,   No
    b)If Yes, was it in a specific topic area?: (Tick all that apply)
    Alcohol,
    Smoking
    Drugs
    Healthy eating
    Sexual Health
    Physical activity
    Mental health
    Motivational Interviewing
    Other training (please specify)……………………

9. Have you received any information about Making Every Contact Count (MECC)?
    Yes   No
    If Yes:
    Was this from: Newsletter; Communications department;   Your manager; Other staff; Previous job; Other (please specify)
10a) Have you received 'MECC training' on how to discuss healthy lifestyles?
    Yes, in previous job   Yes, recently   No, Not Yet but planned   No, not planned

10b) If yes, How useful was this training in helping you to carry out MECC?
10c) If Yes, Please add any comments about the training

11. How important do you think it is for YOU to discuss healthy lifestyles with?
    Service users (Patients/ Clients)
    Carers
    Colleagues
    Family or friends
    Scale: 1 Not at all Important to 5 Very Important

12. How much do you feel you know about
    The factors that influence healthy lifestyles
    The importance of your role in discussing healthy lifestyles

Scale: 1 (nothing) 2 3   4 5 (a lot)

13. How confident do you feel about raising the subject of healthy lifestyles with...
      Service users
      Carers
      Colleagues
      Family or friends
      Scale: 1 (not at all) 2   3   4   5 (very)

14. How motivated are you to raise the subject of healthy lifestyles with...
      Service users
      Carers
      Colleagues
      Family or friends
      Scale: 1 (not at all) 2 3   4 5 (very)

15) How often CURRENTLY do you raise the subject of healthy lifestyles with
      Service users
      Carers
      Colleagues
      Family or friends
      (Scale: 1 Never to 5 At every contact

16. How often do you EXPECT TO be able to raise the subject of healthy lifestyles with
      Service users
      Carers
      Colleagues
      Family or friends
      (Scale: 1 Never to 5 At every contact

17. Is there anything that makes it EASIER or MORE DIFFICULT for you to raise or discuss the subject of healthy lifestyles? Tick all that apply.
      Service organisation,
      Time,
      Clients' interest;
      Client's knowledge;
      Work facilities;
      Work environment eg.privacy;
      My own confidence;
      My own knowledge;
      Training I have received;
      Other...

18. The people that I work with have a positive impact on:
      My health and well-being
      My confidence in carrying out my role as a health promoter
      My morale
      Scale: 1 (Strongly disagree) 2   3   4 5 (Strongly agree)

19. The people in the team that I work with interact well with:
      Each other/ other team members

Their line manager(s)
Senior managers (people who the line manager(s) report to)
Scale: 1 (Strongly disagree) 2 3   4 5 (Strongly agree);

20. My line manager is supportive of me raising the subject of healthy lifestyles with clients
Scale: 1 (Strongly disagree) 2 3   4 5 (Strongly agree)

21. My organisation values the way it interacts with the public
Scale: 1 (Strongly disagree) 2 3   4 5 (Strongly agree);

Thank you very much for taking part in this questionnaire.

APPENDIX C – Post-MECC Staff Survey

Post-MECC Questionnaire for ALL staff, from end March 2014 (distributed through the 'I-Survey', University of Southampton)

Thank-you for taking part in this pilot for the evaluation of the Wessex Making Every Contact Count (MECC) pilot.

Please complete this questionnaire so we can evaluate the implementation process of the Wessex Making Every Contact Count (MECC) pilot, the impact of MECC training and the potential benefits of MECC to both staff and patients/clients. The information you give will be confidential and will not be linked with your name so please give answers that are as honest as possible

NB. 'Raising the subject of healthy lifestyles' means mention OR discuss healthy lifestyles

Section 1: Personal details

1. Gender

2. Age. Categories <25; 25-34; 35-44; 45-54; 55-64; 65+

3. Name of Organisation: NHS Hampshire Hospitals/ Portsmouth City Council/ Southern Health

4. Main site(s) where you work:
    Hampshire Hospitals: Andover/ Winchester/ Basingstoke/ Alton
    Portsmouth City Council: Paulsgrove Housing Offices
    Southern Health: Waterlooville Health Centre/ QA Hospital (Portsmouth)/ Lymington hospital

5. Job Role:
    NHS Hampshire hospitals: Consultant, Doctor, Diabetes Nurse, Physiotherapist, Allied Health Professional, Occupational Therapist, Diabetes Nurse, Dietician, Physiotherapist Assistant, Occupational Health Nurse, Receptionist, Administrative, Clerical, Technician, Therapy Services Nurse, Other.
     Portsmouth City Council: Housing Officer, Administrative, Clerical, Receptionist, Referrals, Other
    Southern Health job roles: Minor Injuries Nurse, Consultant, Receptionist, Administrative, Clerical, Technician, Doctor, Respiratory Nurse, Heart Failure Nurse

6. Highest qualification(s) (Please choose one from the list)
     No qualifications; CSE 2-5/GCSE D-G/ NVQ 1&2; CSE 1/O Level/ GCSE A-C/ NVQ 3; NVQ 4/ 'A Levels/ BTEC, HND/HNC/ Teaching qualification, Undergraduate degree, Postgraduate degree (Masters/ MD/ PhD)

7.How long have you been in your current role? Less than 1 month; 1 to 5 months; 6 months to 11 months; 1 to <5 years; 5 to <10 years; 10 to <20 years; 20+years

8. If you would like to be entered into the prize draw please enter your email address

Section 2: Training and Current Practice

1.Have you had any training in the last few months which has enabled you to promote healthy lifestyles?

    Yes,   No,   No, but due to receive training   (Please select)

2. If Yes, was it in a specific topic area?: (Please tick ALL that apply)
    Alcohol,

Smoking
Drugs
Healthy eating
Sexual Health
Physical activity
Mental health
Motivational Interviewing
MECC Healthy Conversations training
 MECC video presentation training
Other training (please specify)……………………

3) If you have received recent 'MECC training' (since October 2013) What form did this take? Tick all that apply:

Healthy conversations/ MECC training session 1 Half-day
Healthy conversations/ MECC training session 2 Half Day
Healthy conversations/ MECC training session 1 Whole-day
Healthy conversations/ MECC training session 2 Whole Day
Healthy conversations/ MECC training session 3/ follow up/ observation
MECC Video presentation training
Other training (Please specify eg. Briefing)….

4) How many of the training sessions that you were invited to did you attend?

Options: All of them, Some of them, One of them, None of them. If this response is none please give reasons why you were not able to attend

5) How helpful was the face to face 'healthy conversations'/MECC training in increasing your confidence to deliver MECC?

Scale 1 to 5 Very helpful, Quite helpful, not helpful or unhelpful, unhelpful, very unhelpful

6) Overall, how helpful did you find the MECC video presentation training in increasing your knowledge or confidence to deliver MECC?
Scale 1 to 5 Very helpful, Quite helpful, not helpful or unhelpful , unhelpful, very unhelpful

7). How important do you think it is for YOU to discuss healthy lifestyles with?

Service users (Patients/ Clients)
Carers
Colleagues
Family or friends
Other
Scale: 1 Not at all Important to 5 Very Important

8) How much do you feel you know about

The factors that influence healthy lifestyles
The importance of discussing healthy lifestyles
Scale: 1 (nothing) 2 3   4 5 (a lot)

9. How confident do you feel about raising the subject of healthy lifestyles with...

Service users
Carers
Colleagues
Family or friends

Other
Scale: 1 (not at all) 2   3   4   5   (very)

10. How motivated are you to raise the subject of healthy lifestyles with…
Service users
Carers
Colleagues
Family or friends
Other
Scale: 1 (not at all) 2 3   4 5   (very)

11) How often either since MECC Training or currently do you raise the subject of healthy lifestyles /use MECC/ use 'Healthy Conversations' with
Service users/ Patients
Carers
Colleagues
Family or friends
Other
(Scale: 1 Never to 6 At every contact
Never, rarely, occasionally. Some, most, all

12). Do you record that you have used MECC with individual patients/clients? If so how
(Please tick all that apply)
Added written record to current written patient notes?
Added written record to new written record system?
Added to current Online data base?
Added to new online database?
Submitted online referral?
Submitted written referral?
Other? (If so, What is your Other method of recording MECC?)

13) Do you know if someone has been referred to another service due to MECC, or referred themselves to another service? If so how?
(Please tick all that apply)
A written record is on the patient notes?
A record is available on the online database?
I can check online referrals?
I can check written referrals?
I can check verbally with relevant health professional?
Other? (If so, What is the Other method of referral due to MECC)

14) What was the one thing you signposted patients to most?
Options: Leaflets? Internal Website? External website? Other Health professionals? Other?
If Other, What Other form of signposting have you used?

15) How do you rate the responses you get in general from doing MECC with Patients/ Service users?
Very Positive, Quite positive, Very negative, Quite negative, indifferent?
16). How often do you EXPECT to be able to raise the subject of healthy lifestyles/use MECC/ use 'healthy Conversations' in the future with
Service users
Carers

Colleagues
Family or friends
Other
Scale: Never, rarely, At Some contacts, At most contacts, At all contacts –(1 Never to 6 At all contacts)

17). Is there anything that makes it easier for you to raise the subject of healthy lifestyles? Tick all that apply.

Service organisation,
time,
clients' interest;
client's knowledge;
clients' attitudes to sustaining change
work facilities/ equipment
work environment eg.privacy;
my own confidence;
my own knowledge;
training I have received;
my own lifestyle/ behaviour;
other...

18) Is there anything that makes it more difficult for you to raise the subject of healthy lifestyles? Tick all that apply.

Service organisation,
time,
clients' interest;
client's knowledge;
clients' attitudes to sustaining change
work facilities/ equipment;
work environment eg.privacy;
my own confidence;
my own knowledge;
training I have received;
my own lifestyle/ behaviour;
other...

19) How healthy do you feel your current lifestyle is?
Scale: 1 Very Unhealthy to 5 Very healthy

20) Has your own lifestyle improved since being involved with MECC?
Yes, has improved a lot   Yes, has improved a little   No , Stayed the same   No, Has got worse

Section 3: My team and my organisation
1.) The people that I work with have a positive impact on:
My health and well-being
My confidence in carrying out my role as a health promoter
My morale
Scale: 1 (Strongly disagree) 2   3   4 5 (Strongly agree)

2) The people that I work with interact well with:

Each other/ other team members
Their line manager(s)
Senior managers (people who the line manager(s) report to)
Scale: 1 (Strongly disagree) 2 3   4 5 (Strongly agree);

3) I feel that my line manager is supportive of me raising the subject of healthy lifestyles with clients
Scale: 1 (Strongly disagree) 2 3   4 5 (Strongly agree)

4) I feel that my organisation values the way it interacts with the public and supports me in raising healthy lifestyles
Scale: 1 (Strongly disagree) 2 3   4 5 (Strongly agree);

Thank you very much for taking part in this questionnaire.

Appendix D

ID No:

Healthy Conversation Skills Evaluation

Please turn over…

Session 1   Group: _____   ID No:

Please circle one number for each item

1. On a scale of 1 – 10 how **confident** do you feel about supporting individuals to make a lifestyle change?

☹ (Not confident) 1 2 3 4 5 6 7 8 9 10 (Very confident) ☺

2. On a scale of 1 – 10 how **important** is it for you to support individuals to make a lifestyle change?

☹ (Not important) 1 2 3 4 5 6 7 8 9 10 (Very important) ☺

3. On a scale of 1 – 10 how **useful** do you think the conversations you have are at supporting individuals to make a lifestyle change?

☹ (Not useful) 1 2 3 4 5 6 7 8 9 10 (Very useful) ☺

Please now pass this completed sheet to one of the trainers

Below are four things individuals might say. Please write in the bubbles below, the next thing **you might say** to support this individual to make a lifestyle change.

4.   "I need to lose weight, but I don't like vegetables."
You say:

5.   "I should cut down on my alcohol intake, but my partner likes to open a bottle of wine after work."
You say:

6. *"I've lost count of the number of times I've tried to stop smoking—it's hopeless!"*
    You say:

7. *"I just don't seem to have time to do any exercise."*
    You say:

Healthy Conversation Skills Evaluation

Please turn over…

Please circle one number for each item

1. On a scale of 1 – 10 how **confident** do you feel about using the skills you learnt on this course, in conversations with individuals to support them to make a lifestyle change?

    ☹ (Not confident) 1 2 3 4 5 6 7 8 9 10 (Very confident) ☺

2. Do you feel **more or less confident** about having conversations with individuals to support change, since the beginning of this training? *[Circle one number, circling 'O' means 'no change']*

    ☹ (Less confident) -5 -4 -3 -2 -1 0 1 2 3 4 5 (More confident) ☺

3. On a scale of 1 – 10 how **important** is it for you to support individuals to make a lifestyle change?

    ☹ (Not important) 1 2 3 4 5 6 7 8 9 10 (Very important) ☺

4. On a scale of 1 – 10 how **useful** do you think the skills you learnt on this course will be, at supporting individuals to make a lifestyle change?

    ☹ (Not useful) 1 2 3 4 5 6 7 8 9 10 (Very useful) ☺

    ### Please now pass this completed sheet to one of the trainers

Below are four things individuals might say. Please write in the bubbles below, the next thing **you might say** to support this individual to make a lifestyle change.

5. "I just don't seem to have time to do any exercise."
   You say:

6. "I've lost count of the number of times I've tried to stop smoking—it's hopeless!"
   You say:

7. "I should cut down on my alcohol intake, but my partner likes to open a bottle of wine after work."
   You say:

8. "I need to lose weight, but I don't like vegetables."
   You say:

Healthy Conversation Skills Feedback
This training has been developed to support you in your work with individuals. We therefore welcome your feedback.

9. On a scale of 1-10 how **valuable** do you think this training has been for you? *[Circle one number]*

☹ (Not valuable) 1 2 3 4 5 6 7 8 9 10 (Very valuable) ☺

24.   What could we do to **improve** this training?

25.   What did you find **useful** or **enjoyable**?

Thank you for your feedback.

Appendix E

Healthy Conversation Skills- Coding Matrix for responses to statements

1st Response– Code	Description	Example
0. Unable to code	The individual has not responded appropriately—i.e. they haven't written what they would say, or they have reworded the statement rather than given a response. Or no response.	eg "I'd probably say something about exercising with their children". Or "Find out if they know about our courses and give them a leaflet".
1. Telling / suggestions (giving information) Sign-posting	Telling someone what to do; telling them something about themselves; giving information, including specific suggestions about what someone could try, or offering options. Might start with 'what/how about', 'what if' or 'why don't you'.	eg "Get a recipe book." Or "It's never too late to learn." Or "Tell me about your day". Or "Try running up and down the stairs everyday". Or "How about walking to work".
2. In my experience	A statement with a specific example of how the responder deals with a situation, including agreeing with the statement. Not if they demonstrate own knowledge (ie telling, Code as 1), but when share own behaviour.	eg "I try to build it into my day." Or "I find it difficult too." Or "This is what I usually do…"
3. Reflection / empathy (See Code 7)	A statement that indicates an understanding of the person, or their situation. Can be repeating back what they've said in different words, or clarifying understanding. (If precedes an ODQ, Code as 7).	eg "That must be difficult." Or "Seems like you'd really like to do more exercise"
4. Closed Question	A question with 'yes' or 'no' as possible answers	eg "Would you be interested in attending a workshop?" Or "Do you feel you have to go to a gym to exercise more?"
5. Open Question (other)	A question that requires more than just a 'yes' or 'no' answer. May test knowledge, but does not support people to explore their current behaviour, verbalise the benefits or barriers to change, or to come up with their own solutions. Often	eg "Why can't you fit that into your life?" Or "When are quiet times for your family?" Or "What did they look like?" Or "Where do you do your shopping?"

	starts with 'why', 'when', 'who' or 'where'. Can start with What/How if not exploratory/empowering.	
6. Open Discovery Question (But not 1st response)	**The individual has provided an Open Discovery Question (see Code 7) somewhere in their response, but it is not the first thing written down. Except if 1st response is empathy (Code as 7). NOT if ODQ is lost in list of unrelated suggestions (code as 1).**	**eg "Would you like to learn how to cook and what to eat? How would it benefit your family's life?"**
7. Open Discovery Question	**A question that requires more than just a 'yes' or 'no' answer. Supports people to explore their current behaviour, verbalise the benefits or barriers to change, come up with their own solutions or make their own plan, ie is empowering. Begins with 'what' or 'how'. NOT 'how about/what about' or 'what if' (this is telling, Code as 1). Include when directly following empathy.**	**eg "What could you do to change this?" Or "How do you think you might find out**

Appendix F

Healthy Conversation Skills Peer Support and Feedback Worksheet

Observer: _____ _____ _____ _____

Context of conversation

Date _____ /_____ /_____   Location: _____ _____ _____   Session: _____ _____ _____

The conversation – focus on the practitioner (not the client/patient)

ID No:

Healthy Conversation Skills No.1:   Use Open Discovery Questions to help someone explore an issue

2.   **What questions did the** practitioner **ask to explore the issue? [Provide examples]**
Observer:
Location:
Session:

3(a) 'What' or 'How' questions? *(Tally)*	*(eg What actions do you need to take to make the change happen?)* *(eg How important is it for you to make these changes?)*
3(b) 'Other' responses?*(Tally)*	*(eg I look forward to seeing how your changes are going next week)* *(eg When do you think you can start?)*

5(a)   Who did most of the talking?

☐   Client/patient

☐   Practitioner and client/patient talked about the same amount

☐   Practitioner

5(b)   How much time did the practitioner **spend asking Open Discovery Questions? (What / How)**

☐   Most of the time

☐   Half of the time

☐   Less than half the time

Healthy Conversation Skills No.3:   Spend more time listening than giving information or making suggestions

4.   **How long did the conversation last?   Start…………………   End…………………**

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3.   What questions did the practitioner ask to support SMARTER planning? [Provide examples]

Healthy Conversation Skills No.4:   Use Open Discovery Questions to support someone to make a SMARTER plan
total minutes
How useful did you find the course?

What was of value or not of value?

How has your practice changed?
What would you like to do differently next time?

(If more than 1 thing) … what's the most important change you would like to plan first?

So, what will you do next? [SMARTER planning tool]

Against the competencies, what do you think about … (talk through evidence of Healthy Conversation Skills Nos 1, 3, & 4)

What happened when you … (refer to notes from 2(a) & 2(b))

What do you think you could have done differently?

What BCT's did you use?

How do you feel the conversation went?

What went well?

What do you think you could have done differently?

What did you do to support the person in planning a change?

Healthy Conversation Skills No.2:   Reflect on your practice and conversations
Feedback

6.   Help practitioner reflect on their conversation by using Open Discovery Questions.
From their perspective (egs):

From your observation (egs):

As a result (egs):

Comments about the training:

APPENDIX G

Wessex MECC Pilot Interview questions for Process Evaluation –Front-line staff

1)   Staff Lead: Name, Role, brief background/ expertise
How/ why was this setting/ 'work area' considered most suitable for the MECC pilot?
How has your training and/ or experience helped you to get involved in MECC?
How did you feel about getting involved initially?

2)   Work setting Engagement
Why do you/ your work setting think that MECC is important?
What are/ were the barriers to introducing MECC in your setting?
What has made it easier to introduce MECC?
How was involvement in MECC disseminated to your staff group?
How were you then engaged with the Healthy Conversations training?

3)   Communications Strategy
How did you hear about MECC?
What did you think about the way it was publicised?
What do you think are the challenges/ facilitators to communicating about MECC?

4)   **Initial Healthy Conversations Training**:
How was the initial 'Train the Trainer' training for you?
(Was it enjoyable? Interesting? Useful? Too long?)
How would you improve or modify the training to suit you or your staff's needs?

5)   Staff online survey/ Pre-MECC questionnaire:
What did you think of the questionnaire? How easy/ difficult was it to complete?
Was 'online' the best method of receiving the survey?
What encouraged you to complete the survey?

6)   Healthy Conversations training
How did you feel about facilitating this training with your staff group?
How similar was it to the initial training that you received? What, if anything, had changed?
What did you think of the way the staff responded to the training?
Was there anything about the training that you would improve?

7)   Additional training
What other MECC training have you completed?
(eg Online? Face to face? Specific topics or more general?)
What did you think of this training? Was it appropriate? What were the benefits of doing it?
What ways could it be improved?

8)   Methods of recording MECC and Systems changes
What methods have you developed to record that MECC has been used with a patient/ client? What is recorded? How?
How are referrals to other services recorded? Have there been any changes or improvements in methods of recording them?
How will you know if MECC has had any impact? What factors have to be taken into account? (eg patient/staff relationship, regular contact with client, patient history…, staff training/ experience, organisational ethos)

9)   Future roll out of MECC

How representative of the organisation is this chosen setting?

In your experience how easy/ difficult would it be for MECC be rolled out in other settings in your organisation on the basis of your experiences so far?

How easy/ difficult would it be to continue implementing MECC in your work setting?

What do you think are the benefits of introducing MECC to any organisation?

What would be the challenges?

10)   Have you some other comments or questions you wish to add?

Wessex MECC Pilot Lead and Senior Manager interview schedule for the Process Evaluation

1)   Pilot Lead/ Senior manager: Name, Role, brief background/ expertise

How has your training and/ or experience helped you to get involved in MECC as a Pilot lead/ Senior manager?

How did you feel about getting involved initially?

2)   Organisational Engagement

Why has your organisations chosen to implement MECC?

Why do you/ your organisation think that MECC is important?

How did you get senior level 'buy in' to MECC?

How have you used the Organisational Assessment Tool?

Who did you/ would you use this with? (team? Managers/ senior managers? Cross-organisation?)

 How easy or difficult was the process? Was the Organisational Tool helpful?

What are/ were the barriers to introducing MECC in your setting/ organisation?

What has made it easier to introduce MECC?

3)   Choice of Organisational Settings

Why were the settings or particular workforce(s) chosen?

Was (were) the choice(s) based on the needs of staff, or clients or both?

How was involvement in MECC disseminated to these staff groups?

How were staff then engaged with the Healthy Conversations training?

How did you decide who would be invited to attend?

4)   Communications Strategy

How did you raise awareness of MECC through communication within your organisation

- at senior level
- at specific staff team level?

Did you develop any publicity?

What were the challenges/ facilitators that you encountered to communicating about MECC

5)   **Initial Healthy Conversations Training**:

How was the initial 'Train the Trainer 'training for you?

(Was it enjoyable? Interesting? Useful? Too long?)

How would you improve or modify the training and the evaluations to suit you or your staff's needs?

6)   Use of other MECC Tools (eg Midlands and east tools):

How useful were the Midlands and East tools? (Guidance document ; website ; Implementation checklist ; Communications tools ; prompt cards etc)

Which tools have been modified for the Wessex pilots and for your own organisation?

How have each of the tools been modified? What were the benefits to doing this?
If you haven't used any tools, or particular tools, why haven't you?
How could they be adapted to be more useful for future pilots?

7)   Staff online survey/ Pre-MECC questionnaire:
How easy/ difficult was it to implement?
From the initial results, was the response rate better/ worse than expected? Why?
What has helped to engage staff with the survey?

8)   'Roll out' of Healthy Conversations Training:
Can you describe the modifications you have made to Healthy Conversations training to adapt it for your workforce and any constraints?
How/ in what format has this training been rolled out to staff?
What were the barriers/ facilitators to engage staff in the 'Healthy Conversations' training?
How would you do it differently another time?
How are you evaluating this training?

9)   Additional training
What other training have you introduced?
(eg Online? Face to face? Specific topics or more general? Developed your own or used 'off the shelf' training package?)
Who is this training for?
How did you engage staff?
What would you do differently another time?

10)   Methods of recording MECC and Systems changes
What methods have you developed to record that MECC has been used with a patient/ client? What is recorded? How?
How are referrals recorded? Have there been any changes or improvements in methods of recording them?
How will you know if MECC has had any impact? What factors have to be taken into account? (eg patient/staff relationship, regular contact with client, patient history…, staff training/ experience, organisational ethos)

11)   Future roll out of MECC
How representative of the organisation is the chosen setting(s)?
In your experience how easy/ difficult would it be for MECC be rolled out in other settings in your organisation on the basis of your experiences so far?
How easy/ difficult would it be to get management buy in for further roll-out?
What do you think are the benefits of introducing MECC to any organisation?
What would be the challenges?
What is your / senior management's future communications strategy for MECC within your organisation?
Are there organisations where it will be easier/ more difficult to do this?

12)   Have you some other comments or questions you wish to add?

APPENDIX H

Post MECC Questions for Focus Group and front line staff for Wessex MECC pilot 2014
Interviews will be recorded for transcription purposes.
ANY INFORMATION THAT YOU GIVE ME WILL BE ANONYMISED FOR THE PURPOSES OF THE EVALUATION

Benefits of implementing Making Every Contact Count (MECC):
1)   In general, what do you think is/are
   - the importance or benefits, if any, of 'doing MECC' / asking open discovery questions (using 'What' and 'How')/ discussing healthy lifestyles with clients/ patients
   - the benefits, if any, of the implementation of Making Every Contact Count to your department and/or organisation
   - the benefits, if any, to your own practice and/ or to you personally from doing Making Every Contact Count

 Challenges of implementing Making Every Contact Count (MECC):
 2)   In general, what do you think is/are
   - the personal challenges of implementing Making Every Contact Count/ encouraging your clients to change their behaviours by asking open questions
   - the impact on your clients/ patients of introducing MECC/ using open discovery questions about their health
   - the challenges for the clients themselves to changing their behaviour?

Communication and Organisational impact
3)   What did you think about the way that Making Every Contact Count
   - was communicated to you *before* the training
   - fits with the ethos/ culture of the organisation
   - encouraged and supported by managers/ senior managers

Survey tools and training
4)   What did you think about:
   - the Pre and Post MECC online surveys (both the way they were received and the questions within them)
   - what you gained most, if anything, from the Making Every Contact Count training
   - What was least beneficial about the training you received?

Recommendations and Improvements
5)   NHS Hospital staff only: If you also received online training what did you like / dislike about this training? How could it be improved?

6)   What would you suggest could be changed or improved in the future about
   - the communications
   - Surveys
   - training
   -
7)   What further training do you think you or your colleagues might benefit from in order to deliver MECC more effectively?

8)   Is there something else about MECC that you would like to add?
Thank-you!

Wessex Pilot Post-MECC Evaluation Interview questions-Senior managers and Pilot leads
Interviews will be recorded for transcription purposes. ANY INFORMATION THAT YOU GIVE ME WILL BE ANONYMISED FOR THE PURPOSES OF THE EVALUATION

1) Benefits of implementing Making Every Contact Count (MECC):
   What do you think is/are
   - the importance or benefits, if any, of staff in your organisation 'doing MECC' / asking open discovery questions/ discussing healthy lifestyles with clients/ patients
   - the main benefits, if any, of the implementation of Making Every Contact Count in the selected individual department(s)/ workforce(s)
   - the main benefits, if any, of the implementation of Making Every Contact Count to your organisation as a whole
   - the benefits, if any, to your own practice in your workplace
   - the benefits, if any, to you personally from implementing Making Every Contact Count in your department or organisation

2) Challenges of implementing Making Every Contact Count (MECC):
   In general, what do you think is/are
   - the challenges to staff of implementing Making Every Contact Count/ encouraging clients/ patients to change their behaviours by asking open questions
   - the impact on your clients/ patients of introducing MECC/ using open discovery questions about their health
   - the challenges for the clients/ patients themselves to changing their behaviour?
   - the challenges to introducing MECC in other settings in your organisation?

3) Communication and Organisational impact
   - What made it easier/ more difficult to introduce the idea of MECC to staff?
   - What do you think about the way that Making Every Contact Count was communicated to staff/ managers *before* the training-are there any improvements that could be made in the future? What went well? What would you do differently another time?
   - Now that MECC has been implemented how do you think it fits with the ethos/ culture of the organisation?
   - How, if at all, is MECC encouraged and supported by managers/ senior managers?
   - How will you or others continue to engage staff/managers/senior managers in the future?
   - How could your organisation support or enhance the linkages to other services in the wider health system to which staff refer or signpost clients/ patients

4) Use of MECC Tools and recording MECC
   - How useful were the tools provided? E.g. prompt cards, website, posters. How would you modify them further, if at all, in future?
   - What do you think about the Post-MECC Organisational Assessment Tool? Was it helpful? If not why not?
   - How do you know if MECC has had any impact? What changes to systems of recording have been made, if any?

5) Survey tools and training
   What did you think about:
   - the Pre and Post MECC online surveys (both the way they were received online and the questions within them)

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- What made it easier/ more difficult to engage staff in the Healthy Conversation skills training
- what the staff gained most, if anything, from the Making Every Contact Count training
- What was least beneficial to staff about the training received?
- NHS Hospital staff only: If you also provided online or additional training what did you like / dislike about this training? How could it be improved? What would you do differently another time?

6) Recommendations and Improvements (if not already mentioned above)

What would you suggest could be changed or improved in the future about

- the communications
- surveys
- training

Is there something else about MECC that you would like to add?

Thank-you!

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APPENDIX I

Steering Group

This was formed at the beginning of the project in 2013 to oversee the pilot site implementation and the evaluation process. It included:

Em Rahman, Head of Public Health Workforce Development, Health Education Wessex (Chair)
Judy Curson, Public Health England (Regional)
Sallie Bacon, Public Health, Hampshire County Council
Ileana Cahill, Public Health, Hampshire County Council
Sue Dewhirst, Evaluation Lead, Research Fellow, University of Southampton
Viv Speller, Evaluation Adviser, Public Health Consultant, Health Education Wessex
Wendy Lawrence, Healthy Conversation Skills trainer, MRC LEU, University of Southampton
Lee Loveless, Pilot site lead, Health Improvement Manager, Portsmouth City Council
Beverly Harden, Workforce & Education, Hampshire Hospital NHS Foundation Trust
Meyrem-Rawes-Enver, Pilot site lead, Health4Work Services, Hampshire Hospitals NHS Foundation Trust
Diane Pittard, Head of Wellbeing and Engagement, Hampshire Hospitals NHS Foundation Trust

From January 2014 the following joined the Steering Group:
Claire McLeod, Public Health Wider Workforce Lead, Health Education Wessex
Julia Robson, Clinical Service Manager, Southern Health NHS Foundation Trust
Trish Philips, Pilot site lead, Heart Failure Nurse Specialist, Southern Health NHS Foundation Trust

The project management of this pilot was undertaken by Em Rahman, Head of Public Health Workforce Development at the Wessex School of Public Health up until January 2014. During this time he set up the pilot projects, commissioned the Healthy Conversation Skills training and commissioned the University of Southampton to undertake the evaluation. The MECC steering group was also set up. From January 2014 Claire McLeod, Public Health Wider Workforce Lead at the Wessex School of Public Health took over project management of the pilot which included the later introduction of Southern Health NHS Foundation Trust and take over the management of the Steering group, pilot sites, and training delivery .

Wessex Making Every Contact Count (MECC) Pilot Steering Group
Terms of Reference

1. **Purpose**
The Wessex MECC pilot steering group will monitor the development, delivery and evaluation of the project ensuring that regular updates on progress is provided by project partners. The steering group will also provide a forum to explore issues that may arise from the pilot and provide a steer to addressing these in order to inform the future roll out of MECC across Wessex.

2. Background

Pilot Project

The MECC project will be delivered as a pilot in Wessex testing and evaluating the Midlands & East MECC model[3]. The delivery of the pilot will take an organisational development approach to the implementation focusing on:

- Organisational Readiness: Support senior buy-in and board level sign-up to MECC in order to ensure strong leadership at the very top is in place.
- Staff Readiness: Support managers and service leads to champion and implement MECC by providing them with a development programme which will enable them to understand MECC, their role in implementation and supporting their staff to deliver MECC.
- MECC Training: The delivery of MECC training to frontline staff who will be equipped to raise the issue, give brief advice and signpost.

Project Delivery

The pilot organisation will use the Midlands and East MECC model to:

1. To assess the organisations readiness to implement MECC using the Midlands and East MECC Tool[4].
2. To identify the target workforce to deliver MECC. Criteria for choosing workforce will need to:
   - One to one contact with patients or clients.
   - Large numbers in the organisation to demonstrate organisational change/impact.
   - Easily accessible to deliver MECC and to follow up for evaluation.
3. To use the MECC Toolkit[5] providing a framework for MECC implementation.
4. To roll out the Healthy Conversations training to all front line services as the MECC training.
5. To evaluate the model and its application in Making Every Contact Count.
6. To support the Wessex School of Public Health in informing and developing a MECC business case to the Wessex LETB for wider roll out.

Project Resources

- Wessex School of Public Health will commission the roll out of a train the trainer programme of the Healthy Conversations Training as the MECC training for front line services.
- Pilot organisations will need to contextualise the training to fit with their organisation.
- Pilot organisations will be awarded a total of £15,000 to lead and implement the Midlands and East MECC Model.
- Evaluation of the MECC Pilot will be commissioned by Wessex School of Public Health and carried out centrally with pilot organisations fully engaged in evaluation of the approach.

Project Evaluation

The evaluation will use the tools and guidance from the Midlands and East MECC toolkit and develop an evaluation framework which both pilot sites will use to evaluate their pilot projects. The

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[3] http://learning.nhslocal.nhs.uk/feature-list/making-every-contact-count
[4] http://learning.nhslocal.nhs.uk/sites/default/files/organisational_assessment_tool.doc
[5] http://learning.nhslocal.nhs.uk/sites/default/files/implementation_checklist.doc

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evaluation framework will need to determine before and after measures so that demonstration of MECC implementation can be shown.

The evaluation lead will need to ensure that the evaluation framework also incorporates the Healthy Conversations evaluation methods for measuring the change in practice from skilling up front line services to deliver MECC. A total of £15,000 will be allocated for Evaluation.

Project Timescales

January to March
- MECC Pilot sites identified and funding awarded.
- Healthy Conversations Train the Trainer programme commissioned for roll out in April – June.
- Evaluation Lead commissioned to develop Evaluation Framework for March to May.

April to June
- MECC Pilot Organisations begin implementation.
- Evaluation Framework agreed and in place.
- Healthy Conversations Train the Trainer delivered.

May to March 2014
- MECC Pilot Organisation will have implemented MECC.
- Evaluation of MECC underway.

October to November
- Business Case to Wessex LETB for MECC roll out submitted.

3. Objectives

The core objectives of the Wessex MECC Steering will be to:
- To ensure the monitoring of pilot projects against the Project Proposal.
- To support and advise on issues relating development, delivery and evaluation of MECC project.
- To support the development of a business case to Wessex LETB for wider roll out across Wessex.
- To champion MECC at Regional and Local levels.

4. Steering Group Frequency

The Steering group will meet bi-monthly.

Appendix J

Video presentation content at Hampshire Hospitals NHS Foundation Trust

These four key areas were covered:

1) *Healthy Eating* - facts and figures about how unhealthy eating affects our health, public health and costs to the nation , the 'eatwell plate', the benefits of healthy eating,
The government guidelines:
   - Increase fruit and vegetable intake to 5 portions a day

   - Increase the intake of dietary fibre

   - Reduce the intake of salt

   - Reduce the intake of saturated fat

   - Reduce the intake of sugar

2) *Stopping smoking* - facts and figures about how smoking affects our health, public health and costs to the nation, the benefits of stopping smoking and what help is available , links to the quit4Life website (Hampshire stop smoking service).

3) *Reducing alcohol intake* - facts and figures about how drinking over the guidelines affects our health, PH and costs to the nation, the benefits of reducing alcohol intake. What is a unit of alcohol. The government guidelines:

- Male - Weekly limits 21 units.

   3-4 units per day, 2 alcohol-free days per week

- Female - Weekly limits 14 units

   2-3 units per day, 2 alcohol-free days per week

4) *Increasing Physical activity* - facts and figures about how not being physically active affects our health and costs to the nation. The benefits of exercising and government guidelines:

- Adults should aim to do a mixture of aerobic activities and muscle-strengthening activities

- Over a week, activity should add up to at least 150 minutes (2½ hours) of moderate intensity activity in bouts of 10 minutes or more. For example, 30 minutes on at least five days a week

- Comparable benefits can be achieved by 75 minutes of vigorous intensity activity spread across the week or combinations of moderate and vigorous intensity activity.

Staff were signposted to HHFT web pages where the above information can be found and encouraged to use these with patients. The webpages also contain tools and resources to help patients to change their behaviours. For patients without internet access a flyer was developed to give to them at the end of their consultation, with various contact details. Bespoke webpages and flyer were developed for the Diabetes service.