Evaluation of Making Every Contact Count (MECC) in Salford

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Executive Summary

Background

There is overwhelming evidence that changing people's health related behaviour can have a major impact on some of the main causes of premature mortality and morbidity.[1,2] Health and social care organisations, and professionals, have significant potential to encourage, inform and enable people in making decisions that may enhance their health and well-being.

The NHS, as the biggest healthcare workforce in Europe, is in a unique position to influence the health and wellbeing of the population in the UK. The NHS Futures Forum[3] highlighted potential opportunities for health gain through staff in the NHS interacting with the public in a systematic way in order to promote health:

> "*Millions of people talk with a member of NHS staff every day, spanning a diverse range of professions…There are millions of opportunities every day for the NHS to help to improve people's health and wellbeing and reduce health inequalities, but to take this opportunity it needs a different view of how to use its contacts with the public*"

Addressing health gain with both system and scale responds to the direction set out in the NHS White Paper, *Equity and Excellence: Liberating the NHS*[4]. This mandate also outlines the partnership approach required between the public and the NHS '*no decision about me without me'* and the rationale for implementing system-wide approach to behaviour change and health gain '*Making Every Contact Count*'. Making Every Contact Count (MECC) implements the NICE guidance[2] using large scale change methodology to 'industrialise' the delivery of behaviour change into the workforce.

There are already a number of services delivering behaviour change interventions across Salford. However, this is patchy and uses different approaches and rarely measures outcomes effectively. The MECC in Salford programme aimed to provide a systematic and consistent approach to behaviour change, not just in the NHS but across the Council and other public sector and voluntary organisations, in order that the citizens of Salford receive comparable interventions with any contact with front line staff across the City.

Whole Systems working recognises that some problems cannot be solved by dealing with discrete 'sections' of the system. Instead, it emphasises the necessity of involving as many of the players within a system to find innovative ways to solve the problem by working together. Evaluating the factors that contribute to population level health gain and disentangling cause and effect are extremely difficult due to the complexity and interconnectedness of each factor. Evaluating a systems approach requires flexibility and methods of exploring the relationships between the different elements of a system.

The MECC in Salford programme was designed to deliver outcomes for end users (behavioural changes), for the front line workforce (increased effectiveness of health advocacy) and assist services in achievement of their delivery targets. Staff would be trained to engage and provide consistent core health messages, signposting and referral to specialist services, enabling people to find it easier to self-care, and make choices early about their behaviours which impact on their own and their family's health and wellbeing. The outcomes framework consisted of the 3 critical strands: System Outcomes; Staff Outcomes; and End User Outcomes.

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[1] Department of Health, 2010, Healthy Lives, healthy people: our strategy for public health in England.
[2] NICE (2007) *Behaviour Change at Population, Community and Individual Levels*. www.nice.org.uk
[3] NHS Futures Forum (2010). The NHS's role in the Public's health.
www.gov.uk/government/uploads/system/uploads/attachment_data/file/152170/dh_132114.pdf.pdf
[4] www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

Evaluation Strategy: Aims, Methodology & Approach

In December 2011 The Evaluation Partnership (EP) was commissioned by NHS Salford to design an independent prospective evaluation to assess whether the original objectives of Salford MECC were achieved and to identify what can be improved for the future. This was achieved through consideration of (a) the inputs i.e. what went into the activity, in terms of time, materials and resources (b) was it delivered according to plans (c) how well was it delivered and (d) what has been achieved (Outcomes).

The **overall aim of the *evaluation*** of Salford MECC was to:

> *Assess whether the implementation of the Salford MECC has been successfully embedded in organisational procedures in relevant organisations in Salford and has been effective in terms of training front-line staff to deliver behaviour change interventions and benefiting service users' health and wellbeing.*

The **objectives** for the evaluation of Salford MECC were to:

1. Assess impact of the MECC Programme on services, beneficiaries' (frontline staff) and end users (public)
2. Review the approach used for scaling up a systematic behaviour change intervention across the City
3. Assess whether the MECC Programme provides value for money
4. Review the sustainability of the approach used to embed the behaviour change interventions into service delivery across service providers.

Methodology

The research was underpinned by '*Stakeholder evaluation'* methodology, emphasising the involvement of the different stakeholders in the design and/or implementation of the evaluation. The evaluation adopted a longitudinal design (designed over a 21 month period) incorporating process data and outcome measures. The MECC in Salford evaluation was intended to be iterative and formative with on-going review and modification in response to feedback. Regular two-way Commissioner / Partnership meetings were arranged at the outset and it was anticipated that The Evaluation Partnership would feedback to the commissioners who would then refine the implementation of the programme.

Mixed methods

A range of qualitative and quantitative research methods were developed to collect primary data (semi-structured interviews, focus groups, on-line questionnaires). In addition, in consultation with key stakeholders and the commissioning group, appropriate audit tools and systems were developed and utilised to collect information to address the organisational implementation objectives.

Project timeline

The project timeline is summarised in Section 5a of the main report. Phase 1 (September 2011 to March 2013) was closed in early April 2013[5] when the project entered Phase 2. Feedback, from both stakeholders and the Evaluation Partnership, resulted changes to the MECC project overall and therefore in the development of the evaluation tools. These are detailed in the Section 5a in the main report but in summary consisted of:

1. Modification to the Self-assessment tool (SAT) due to review/revision July-Sept 2012
2. Additional interviews as part of a refresh review requested by the Delivery Team
3. Inability to recruit case studies for the evaluation
4. Agreement by the MECC Evaluation Commissioning Group (MECG) not to proceed with end user evaluation
5. Agreement by the MECG that measuring Social Return on Investment was not achievable within the scope and timescales of the evaluation
6. Changes in monitoring[6] resulted in a lack of availability of performance monitoring data
7. An extension to the evaluation contract to enhance recruitment and additional write-up.

[5] Anderton R (2013). Making Every Contact Count in Salford: end stage report.
[6] MECC in Salford (Oct 2012). Monitoring for Impact.

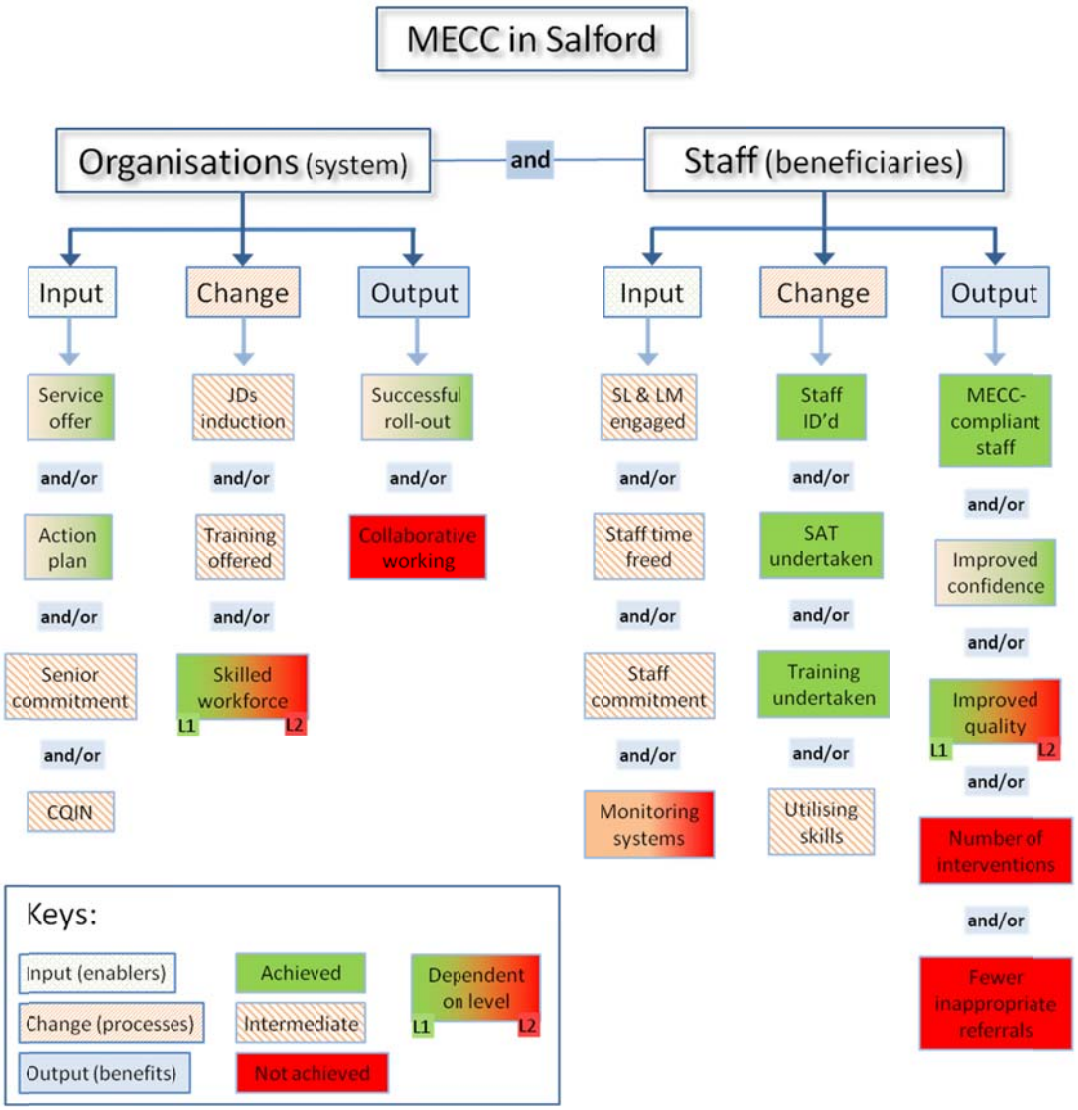
Summary of Evaluation

The evaluation findings against each of the MECC outcomes have been summarised in table i.1. Figure i.1 traffic-lights these against programme inputs, changes and outputs as to whether the evaluation considers them to have been achieved or not. The overall evaluation summary is:

For Organisations: The high-level buy in (Input) has enabled successful engagement in MECC for some organisations. However, this has only partially been translated into process changes within the organisation – ie. longer term requirements such as job descriptions and induction have been slow to be taken up but shorter term developments such as training has happened to a greater extent. Thus, city-wide roll out of the programme has only been partially successful with little impact on improved collaborative working.

For Staff: There was variable support from Service Leads and Line Managers with regard to inputs for staff with limited increase in commitment for, or time allocated to MECC. Also, inadequate monitoring systems did not enable MECC. Nevertheless, changes for staff were evident (but not apparently as a result of input from line managers) with regards to numbers undertaking the SAT and attending training. However, there is evidence that MECC skills are not being fully utilised. The number of MECC compliant staff in Salford was achieved but confidence to deliver behaviour change interventions was only partially improved. This was because there was a greater impact of MECC on staff working at level 1 than on those working at level 2. The outputs in terms of number of interventions delivered and appropriate referrals were not achieved.

Figure i.1. Overall summary of MECC in Salford evaluation, based on a benefits realisation model developed from the programme outcomes



Overall Conclusions

1. Work in progress

- As a systems-wide approach, MECC is only partially embedded at present
- Large numbers of staff have been assessed and/or trained via the programme; around 1,500 staff in 26 organisations in Salford have the knowledge and skills to deliver MECC
- However, the initial 'push' during 2012 has not been sustained during 2013
- There is variable engagement and uptake by different organisations, with some organisations more involved in design and implementation than others
- There has been slow inclusion of MECC into appraisal, induction and core training
- Training does not take account of non-core staff e.g. volunteers
- There is not a clear enough distinction between different staff groups (Level 1, Level 2, volunteers) in the added value of MECC or usefulness of specific training:
    - Some frontline staff (e.g. Level 2) are already equipped to confidently deliver effective behaviour change interventions to the Salford population (but they do not attribute this to MECC – see 2. below)
    - On the other hand, Level 1 staff are more likely to benefit from MECC training resulting in increased knowledge and confidence to deliver signposting interventions
- The complexity of Version 1 of the assessment (SAT) and subsequent modifications to Version 2 made it very difficult to determine the actual numbers going through the system
- The SAT may not be a reliable tool for assessing competencies
- The delivery of MECC training does not take into account the varying structures and processes in organisations and how existing training is delivered.

2. Value

- MECC does not stand out from other initiatives, or have a clearly defined 'unique selling point', so that the value for staff and benefits to the Salford population cannot be understood
- The aim should be to assimilate MECC into everyday practice so that it becomes part of core values
- Accreditation for those who have successfully completed SAT or training might help to add value
- Front line workers (FLW) appreciate how health and wellbeing are part of their organisations' core business and central to their individual role and appeared more willing to be involved in MECC than managers
- MECC has a strong resonance with what staff are already doing: they recognise the skills and knowledge necessary to undertake this kind of work and already feel confident in raising issues with the public
- Managers and Service Leads seemed more cynical about MECC, were less engaged and less optimistic about the challenges of roll-out or how long MECC would be operating in the future
- However, the value of MECC also varied widely between staff groups:
    - Those already using the principles of MECC in their everyday work were more negative and stated that there was little or no evidence of change in practice due to the programme
    - Level 1 FLW showed a greater change due to the MECC process/training than Level 2 FLW.

3. Tools and support

- In order to embed MECC, there is a need to provide guidance, support and examples of tools
- To sustain engagement, support should be resourced with designated staff who already have established relationships with the organisations
- Signposting information and a directory of services /pathways were seen as the tools most likely to help FLW implement MECC, although self-reported knowledge of signposting and referral information was generally high and did appear to benefit from the training
- Communication is key but currently variable – it cannot rely solely on IT or assumptions that cascading will happen.

4. Leadership

- Although some senior leaders are committed and engaged, however, this has not been transmitted through all levels of the organisations
- Managers believe that there may not be the commitment to sustain MECC in the future
- Strong and continuous leadership is required both from a delivery team and from managers within each organisation
- A prescriptive approach to sustainability is unlikely to succeed.

5. Monitoring of MECC

- There is evidence that inclusion of MECC in contracts has not acted as a stimulator and could be counterproductive, due to emphasis on recording data for what should be a relatively routine activity
- Systems for monitoring MECC are not systematic or consistent but they are in practice in some places
- Organisations that were subject to a CQUIN had formal monitoring systems in place but those not subject to CQUIN were doing some form of monitoring, even though not a formal requirement
- Without monitoring data, it is difficult to draw any conclusions in relation to increased number of behaviour change interventions and the majority of staff interviewed or surveyed stated no change in working practice or the interventions they delivered
- FLW were not aware of methods to embed monitoring requirements in their organisation's contracts
- Overall the majority of interviewees felt that collaborative working had stayed the same and it is difficult to develop measures of collaborative working without detailed systems to record referrals
- FLW completing the survey suggested that the referrals pathways and appropriate referral had not altered since MECC .

6. Social Value

- Evaluating social return on investment was not viable within the evaluation budget and timescales
- However, a benefits-realisation model has been used to summarise this evaluation as a whole
- Future Salford Health and Wellbeing Surveys could provide useful measures of the social value of wellbeing and motivations for behaviour change.

Recommendations

The lessons learned from the MECC in Salford evaluation (see Table i.1) can be grouped into four overarching recommendations:

1. **Tailored Delivery**: the continuation of MECC in Salford should build upon the findings that staff currently work at varying levels with regard to behaviour change interventions and that '*one size does not fit all*'. We suggest that the programme:

- Develops a clear definition of a MECC intervention and its benefits based on underlying theory, to help prevent the criticisms by staff taking part in the assessment and training
- Defines what MECC is over and above current job roles ie. understand current behaviours, structures, and theory
- Removes assessment and competencies in terms of 'pass' or 'fail'
- Targets training differently for Level 1 and Level 2 staff; by :
    - focusing training to those who do not necessarily provide interventions at the moment (e.g. opportunistic workers - Level 0/1)
    - consider that Level 0 (Level 1 introductory) showed the greatest benefit from MECC training and targeting these staff may well create the greatest added value (also see 3 below)
    - understand that Level 2 staff are *'doing it already'* and link MECC principles into normal training and/or staff development.

2. **Staff Inclusion and Support**: to maintain momentum and enthusiasm for an ambitious city wide project and ensure that MECC is embedded into working practice, staff require buy-in, involvement and support. We recommend that:

- There is regular review, reflection and response to issues identified by stakeholders and that communication / feed-back is geared towards the needs of the individual organisations
- Stakeholders are more involved in the design of the programme now and in the future, especially around the measures needed to enhance collaborative working
- More information is shared about what being *'MECC competent'* means with regard to intervention activity – this is linked to a clear definition of what a MECC intervention is (above)
- Up-to-date and accessible service directory and referral / signposting manuals are developed and maintained.

3. **Added Value / Value Added**: for MECC to achieve its overall aims and objectives, both organisations and staff need to see the added value of continuing to deliver appropriate MECC interventions. The programme as a whole needs to demonstrate what value is achieved through its implementation. Thus:

- The MECC programme may not have been designed to achieve outcomes that were created:
    - Achievable measures (both process and outcome) of success are required at the outset, not aspirational high-level (and un-measurable) outcomes
    - Once developed, specific outcomes relating to the SAT and training should be built into the databases at the development stage
- To better value the programme, staff need to be able to differentiate between a MECC intervention and current practice (relates to 1.)
- Effective and appropriate monitoring system for all participating organisations are required with regular feed-back to the Health and Wellbeing Board
    - Perhaps with a small number of core measures that are sympathetic to each organisation
- There is a need to establish measures by which the value to the Salford population can be assessed
    - A dedicated cost-effectiveness / social return on investment analysis of MECC should be undertaken by an experienced health economist
    - There is some evidence that the MECC programme achieved greatest impact on Level 0 staff, which may be shown to be the most cost-effective way to proceed.

4. **The Future and Sustainability**: the complexity of a city-wide MECC means that considerable resource will be required to sustain its momentum, monitor its implementation and assess the long-term, and specifically the social impact. As well as the above recommendations, MECC in Salford will require:

- Senior leads in each organisation being held to account to the Health and Wellbeing Board for commitments to build MECC targets into health outcome frameworks:
    - Simply signing up to MECC does not necessarily result in actually embedding into practice
    - Realistic expectations for each organisation must be developed and supported
- For more appropriate referrals to be demonstrated, the development of monitoring systems should draw upon the experience of other projects where referrals have been monitored
- Any further re-development of the SAT database should be directly and seamlessly linked into the training databases, so that the process can be streamlined.

Table i.1. Summary of evaluation of MECC in Salford using measures from a) surveys and interviews with front line workers (FLW) and service leads/line managers (SL/LM) or b) the self-assessment tool (SAT) – [as at June 2013, the planned use of internal monitoring data was not possible]

1 System Outcome:	Organisations have embedded behaviour change interventions into service development through: **a)** the inclusion of behaviour change statements/ measures in job descriptions (JDs); **b)** change modules included as part of staff induction; and **c)** mandatory training programmes.
Evaluation Measures:	1. Service Leads & Line Managers (SL/LM) state that there is inclusion of MECC in job descriptions, staff induction and appraisals for relevant staff groups 2. SL & LM state that there is increased inclusion of MECC in performance targets 3. SL & LM state that the organisation completed a sustainability plan? 4. MECC is mandatory part of staff training; including training for Managers of frontline staff 5. Inclusion of MECC in the CQUIN, Local Enhanced Service or contracts as a stimulator.

Quantitative Indicators	Qualitative Indicators	Conclusion
(1) Half (50%) of SL/LM said that MECC is linked to induction of new staff. However, only 7% said it is linked to job descriptions (JDs) and a fifth (22%) that it is linked to appraisals. Q24 - Around half say the organization is monitoring MECC, 1/3 did not know, 16% said there wasn't any monitoring. (2) The majority of SL/LM (57%) felt that MECC was embedded in their organisation's strategic and business plans. A quarter (26%) thought it was moderately embedded but 17% thought it was not embedded. The majority of FLW (67%) believed that their organisation demonstrates a long-term commitment to MECC. Most of the remainder (31%) said that they didn't know. (3) Over half (55%) of SL/LM said that MECC had been communicated well within their organisation. However, a third (31%) thought only moderately and 14 said it had been communicated little.	(1) **JDs**: 3 SL/LM have them linked into JDs. 4 others stated that the aim is to link MECC into job descriptions in the future. However, the majority did not have them linked in and one of these stated they would if the commissioners asked them to. **Appraisals:** The majority of the SL/LM interviewed reported that appraisals are done within their organisation and 6 indicated that MECC was currently linked to these. 3 stated that there was an intention to do so. **Induction of new staff:** 11 interviewees stated that MECC was linked into induction. 1 did not know, referring to there having been no new staff employed within the organisation. (2) Some of the SL/LM reported that they were not aware of any on-going specific or new monitoring requirements in respect of MECC; whereas others were incorporating MECC into their existing monitoring, developing their own monitoring or doing it in an informal or slightly different way. 3 of the organisations were subject to a CQUIN with the PCT and therefore reporting it back officially.	• MECC is only partially embedded at present • Some evidence of linkage to appraisal, induction and training but the majority not yet linked into job descriptions - possibly due to legal and contractual issues • Overall little evidence that inclusion of MECC in contracts has acted as a stimulator • FLW generally not aware of methods to embed, or monitoring requirements in their organisation's contracts. Traffic Light: Amber **Lessons learned:** • Prescriptive approach to sustainability does not work because of wide range of organisations across many differing sectors - one size does not fit all. Therefore, a flexible approach to sustainability is required • Need for guidance, advice and support - working around existing systems.

(4) The majority (60%) of SL/LM said that MECC is linked to mandatory training for staff and a quarter (24%) said it is linked to mandatory training for managers. (5) Internal monitoring data not available	(3) Most of the SL/LM were not sure whether MECC is mentioned specifically in their organisation's strategic or business plans. All of these made reference again to the fact that MECC was something their organisations do already. One said it was mentioned. Some of them did mention it as happening through appraisals and job descriptions, but others acknowledged that it was not yet 'embedded' directly into their plans. (4) The majority of the SL/LM were unaware of MECC being linked into mandatory training for managers, although 2 suggested it was in certain sections of management. 1 from a large statutory agency referred to the organisation's electronic mandatory training record which records all mandatory training – but this did not currently include MECC. 9 SL/LM reported that MECC training was mandatory for core staff (i.e. not for volunteers or sessional staff.). (5) Three of the organisations were subject to a CQUIN with the PCT and therefore reporting it back officially. Though not asked directly, only one SL/LM referred to their contract as being a stimulus for implementing MECC. However, the experience of FLW was different; when they were asked what the key barriers to implementing Salford MECC might be; they responded that MECC is not embedded into their organisations. When asked what factors are important for a successful roll out of MECC across the organisation 1 interviewee suggested that MECC should be included in induction. There were also suggestions regarding the need for regular updates and on-going training. These comments from FLW suggest that staff are not aware of the existence of induction and mandatory training. There was no reference to MECC being included in appraisal (despite many indicating that they have annual appraisal) or job descriptions. – only 2 FLW referred to monitoring requirements that exist at present.	

2 System Outcome:	Successful roll out of a comprehensive citywide behaviour change intervention programme.
Evaluation Measures:	(1) Number of organisations who have signed off Service Offers (2) Number of organisations with Action Plans in place (3) Increasing numbers of staff have completed the SAT (4) Increasing numbers of staff attended MECC training (5) Increasing numbers of staff completing the MECC training (incl post assessment) (6) Factors enhancing or hindering provision, implementation and uptake by staff; for example capacity to undertake this work * also by indicators of staff outcomes

Quantitative Indicators	Qualitative Indicators	Conclusion
(1) Internal monitoring data not available By April 2013, there were registrations from 26 different Organisations on the SAT. As well as the Council and Salford Royal, there were staff from 7 smaller NHS and 16 other organisations involved. (2) Internal monitoring data not available (3) By April 2013, there were 2,214 active registrations on the SAT but 350 of these had yet to complete the assessment. SAT activity was greatest between Dec 2012 and Dec 2013, when there were 136 completions / month. There were few new registrations between January and April 2013 (4) From the Phase One sign of report, 59 training courses have been undertaken which have trained 560 staff (5) By April 2013, 660 staff taking the SAT (36%) were identified as requiring training; 450 had set a training date and 350 had completed the post-training SAT (6) A third of SL/LM did not envisage any challenges in the roll-out of MECC but a third did. The remainder did not know. The majority of SL/LM (51%) weren't sure if MECC will be operating in their organisation over the next 5 years. Only 4	(6) Almost half of the SL/LM (6) stated that there had been no problems in implementing MECC but 1 did qualify this by referring to the small size of their organisation. It was reported that they were aware of other SL/LM facing challenges. Within the group of 6, 2 voiced the opinion that staff might cite reasons for not being able to implement MECC, but these were excuses rather than real barriers / challenges, and or it is not a priority for them. This perhaps links to FLW's perception of MECC. Five FLW suggested there were no barriers to implementing MECC; the remainder gave no specific answer. 18 FLW felt they were already talking to people about health and wellbeing before the MECC project was implemented. Most of these saw themselves as advocates for H&W. Most were happy to get involved, but generally they believed they were doing it already. The vast majority appeared to understand the MECC concept in some way. SLs & FLW's mentioned very similar issues regarding factors hindering / enhancing MECC. Factors for a successful rollout or enhancing MECC included: • Development of Service Directory (x8 SLs & FLWs) • Continued & Clear communication • Effective & simple system of monitoring MECC contacts and interventions	• Large numbers of staff from 26 organisations in Salford have been assessed and/or trained via the programme • The technical roll-out has led to engagement of staff in MECC, but this has not been sustained beyond 2012 • There was not a great deal of optimism within SL/LM with regard to the challenges of roll-out and how long MECC would be operating. • The majority interviewed felt that they were already using the principles of MECC in their everyday work and there was little or no evidence of change in practice. Traffic Light : Amber - Green **Lessons learned:** • Staff buy-in, especially managers, is required to help maintain momentum and enthusiasm for an ambitious city wide project • FLW cannot differentiate between a MECC intervention and current practice, so understanding of what staff already do before developing the training would help add value

in 10 (41%) thought that it would and 7% thought that it wouldn't. Half of SL/LM thought both staff and service users would be neutral about MECC and only a third thought positively.	• Changes to MECC Training • Reassurance to staff that MECC = enhancement not more work • Simplify MECC and make SAT more accessible • Continued support from the top • Timing & economic climate • Flexibility of approach • Properly resourced • Clarity re what constitutes a 'MECC' intervention • Good support from line manager. The majority of SL/LM & FLW identified at least 1 barrier / challenge: • Time / frenetic pace of work with high volume of clients / Money (6) • Questionable relevance to service / "not our job" • Definition of MECC • Monitoring - in some cases complicated / impractical • Lack of a service directory / database as an aid to referral • Dwindling support from Delivery Team and loss of momentum • Access to computers • Client's resistance to change and feeling bombarded. **The future of MECC in the next 5 years**. Here there were some very different answers. Only 1 SL/LM could not see a future for MECC, 3 were unsure and a small number of SL/LM stated that MECC is very much what they do anyway. The majority could see a future for MECC and identified actions that would be required over the next few years. As well as those referred to above, other factors cited included: • Priority to formalise and embed MECC • Extending MECC to non-core staff • Training including refreshers • Introduction of train-the-trainers • Measuring success/linking performance with feedback to show purpose (x5 FLW) • Continual push & direction from manager / leadership (x3 FLW) • Broadening out MECC to more services (FLW).	• Involve stakeholders at the beginning in the design of the project ▪ Regularly review, reflect and respond to issues identified by stakeholders.

3 System Outcome:	Development of a highly skilled, knowledgeable and motivated frontline workforce that is confident in delivering behaviour change interventions to the Salford population.	
Evaluation Measures:	(1) % staff at each level who are confident to use the approach advocated by MECC (2) Effect of training on confidence (3) Quality indicators in terms of knowledge, confidence & skills * also by indicators of staff outcomes	
Quantitative Indicators	**Qualitative Indicators**	**Conclusion**
(1) Two thirds (65%) of staff 'passed' the SAT and were therefore MECC- compliant. High proportions of these (80-100%) were confident in using the MECC approach. Level 0/1 staff who 'failed' the SAT were less confident (50-75%). Level 2 staff were more confident than level 0/1 staff. (2) Confidence increased to 90-100% in all staff following training (SAT). (3) A significantly higher proportion of Level 1 (60%) and Level 2 (71%) staff found implementing MECC easy compared with Level 1 introductory (31%). Over three quarters of staff (77%) felt fully equipped to deliver MECC (82% of Level 2 staff compared with 76% of Level 1 and 69% of Level 1 introductory).	(2&3) 13 of the FLW suggested they could not put their experience of initiating a conversation with a person about their Health & Wellbeing (H&W) down to MECC or did not even consider MECC. Only 1 of the FLW felt that they were tuning in more for cues from clients following their involvement in MECC. The vast majority of FLW (18 out of 22) found it difficult when asked to describe a successful MECC intervention as they did not feel that they were seeing successes (or indeed difficulties) as a result of / anything to do with MECC as such. It was not felt to be over and above what they were doing anyway. One individual could link her actions to MECC. There was some indication that MECC reinforced what they are doing or strengthened it, even though they felt it did not influence them. The FLW were able to identify skills and knowledge that they felt they needed to interact with people, but these were not attributed to 'doing MECC'. 100% of FLW said that	• There was a clear distinction between Level 1 and Level 2 staff with regards to whether training increased knowledge, skills and confidence to deliver MECC • In Level 2 staff, MECC does not appear to have had any real impact on the development of new skills or increase in confidence to deliver these interventions • Level 1 staff (especially at the introductory level) did benefit from training with regard to confidence and knowledge • It does seem that MECC has a strong resonance with what staff are already doing and that they recognise the skills and knowledge necessary to undertake this kind of work. Traffic Light: Level 1 ; Level 2

	the skills had nothing to do with MECC – because they were referring to skills they have / already use. Skills, attributes and knowledge included self-awareness, influencing skills, insight, being a "people" person; ability to be detached & able to see the bigger picture; listening; empathy; understanding & tolerance; compassion; mentoring. Those FLW interviewed did find it difficult to identify the level at which they were working. Those who had done the training were not able to say what level of training they had attended. The majority of FLW felt that nothing had really changed for them since the introduction of MECC, possibly due to lack of definition; they have completed the SAT / training but are not sure what is expected of them next. The FLW did not disagree with the MECC principles but basically felt they were doing it already.	**Lessons learned:** • Target training to those who do not necessarily provide interventions at the moment (e.g. opportunistic workers / Level 0/1) rather than to those who are 'doing it already'.

4 System Outcome:	Identified clear social return on investment and efficiency cost savings/outcomes.	
Evaluation Measures:	(1) Ratio of costs (MECC inputs) to benefits (at workforce and population level) (2) Comparison between cost of this intervention and comparable interventions	
Quantitative Indicators	**Qualitative Indicators**	**Conclusion**
In discussion with the MECC Evaluation Commissioning Group (MECG), it was agreed that measuring social return on investment was not viable: • Data could not be collated across all organisations nor extrapolated from one • End user benefit could not be attributed to MECC • Health and wellbeing survey data were not available • The evaluation in its entirety represented a benefits-realisation model.	It was agreed with MECG that an attempt would be made to elicit the value that end users place upon a positive interaction with staff by undertaking focus groups or opinion survey. However, recruitment was problematic and no useable results were obtained.	• Evaluating social return on investment was not viable within the evaluation budget and timescales • A benefits-realisation model will be used to summarise this evaluation as a whole. Not measured **Lessons learned:** • Measuring social return on investment requires thorough planning as a dedicated project – it cannot be undertaken as a bolt on or as a rapid assessment • The complexity of a city-wide MECC means that considerable resource would be required to collect and collate the information required for SROI.

5 System Outcome:	Improved collaborative working arrangements across Salford organisations.	
Evaluation Measures:	(1) Factors enhancing or hindering collaborative working (2) Increased signposting to additional information of services	
Quantitative Indicators	**Qualitative Indicators**	**Conclusion**
(1) Knowing when to signpost or refer to a specialist service was high across all levels in staff who 'passed' the SAT (over 95%) but lower in those who 'failed' the SAT (65-77%). However, this increased to 97-100% in all three levels for these individuals following training. (2) Nearly two thirds of FLW (61%) said that referral pathways were about the same following MECC. One fifth (21%) said they were clearer now but 17% (one in 6) said they were not clearer. Signposting information was seen by the highest proportion of SL/LM (86%) as being likely to help in implementing MECC and a service directory/referral pathways as next most important (74%).	(1) The majority of FLW felt that collaborative working had stayed the same as they already had good relationships with partners; some were unsure; however, 6 felt there had been a change. 1 was seeing a benefit to her own organisation by virtue of having provided a stall at a MECC road show. **Enhancing -** Some FLW stated that MECC had resulted in them being more aware of other services that they can refer to. However, 5 FLW when asked about important factors for a successful rollout, suggested that there was a need for a directory of services or relevant service information. **Hindering -** Less than half of the FLW identified factors that get in the way. Factors included: • Lack of trust in other organisations • Inappropriate referrals • Poor referral information • Poor range of services to refer to • Organisational change and funding difficulties • Lack of agreed procedures.	• It is difficult to develop measures that truly measure collaborative working without detailed systems to record referrals • Signposting information and a directory of services /pathways were seen as the tools most likely to help FLW implement MECC • Overall the majority of interviewees felt that collaborative working had stayed the same, though some were unsure • Indicators were vague and difficult to develop. Traffic Light: Red **Lessons learned:** • Need better measures for collaborative work • Need for tools to support signposting e.g. up to date Directory of Services and referral information.

6 System Outcome:	Commitment and engagement of senior leaders across services to sustain the long term benefits and impact of behaviour change training.
Evaluation Measures:	(1) Number of organisations who have signed off Service Offers by quarter (2) Strategic and workforce plans demonstrate commitment to MECC (3) There is an effective communication strategy for MECC

Quantitative Indicators	Qualitative Indicators	Conclusion
(1) Internal monitoring data not available See system Outcome 2 (1) (2) The majority of SL/LM (57%) felt that MECC was embedded in their organisation's strategic and business plans. A quarter (26%) thought it was moderately embedded but 17% thought it was not embedded. (3) See System Outcomes 1&2. Over half (55%) of SL/LM said that MECC had been communicated well within their organisation. However, a third (31%) thought only moderately and 14 said it had been communicated little. Nearly half of SL/LM (45%) said that they were not using the MECC communications toolkit. A further 38% did not know if they were using it and only 17% (one in six) said that they were using it.	Also see Systems Outcome 1 (3/4). (2) Most of the SLs were not sure whether MECC is mentioned specifically in their organisation's strategic or business plans. All of these made reference again to the fact that MECC was something their organisations do already. One said it was mentioned. Some of them did mention it as happening through appraisals and job descriptions, but others acknowledged that it was not yet 'embedded' directly into their plans but might be in the future. None of those interviewed were able to answer the question – *'Does the organisation's current strategic workforce planning include or demonstrate commitment to MECC & in what way?'* *Interviews did not ask directly about a strategy but did about communication* (3) The majority of the SL/LM could recall how MECC had been communicated to them. Only 1 line manager reported that communication had relied solely on an e-mail from the SL which was sent out to all staff. The majority of the SL/LM were responsible for cascading the vision to staff within their organisation or team and were using existing mechanisms within their organisations. 2 of those interviewed cited examples of difficulties for non-core staff / volunteers / part time workers with no access to emails, staff meetings, and complicated information. Within the FLW, it was accepted that there was high-level engagement within their organisation. The level of commitment seemed less clear.	• Evidence that senior leaders are committed and engaged; however, this has not been transmitted through all levels of the organisations • SL/LM seemed less committed and cynical about MECC whereas staff seem more willing to be involved • There may not be the commitment to sustain MECC in the future • Effective communication of MECC within organisations was variable. Traffic Light: Amber Lessons learned: • Senior leads need to be held to account to the H&W Board for their stated commitments • Signing up to MECC may not means it is actually embedding it into practice • Develop measures to demonstrate that communication has filtered down and across organisations • Communication methods should be geared towards the needs of the individual organisations and appropriate support provided.

	There are a number of proxy measures that could be associated with how effective the communication strategy has been: • **How FLW felt about getting involved with MECC** Most FLW were generally happy to get involved; however, some were uncertain what it was about initially, but when they realised what it was, and they believed they were doing it already, they were quite happy. A light bulb moment when they realised that it was what they were doing already. Some reacted positively, that it was 'official' / gave what they were doing a 'label' and appreciated being recorded; they felt it was giving their work recognition and gave them something to base their work on. • **How FLW would describe MECC to someone** The vast majority appeared to understand the MECC concept in some way, but still believed it was something they did anyway. Many seemed to have a very narrow interpretation of it. • **How FLW saw MECC fitting with their organisation's core business** The majority of FLW seemed able to make a judgement about how they did or did not see it fitting, suggesting an understanding. The manner in which MECC was communicated was variable, including the following methods: e-mails, team meetings, attendance at launch events, MECC website. A minority of interviewees were critical of the communication process.	

7 Outcomes for staff:	Frontline staff who are skilled and equipped to confidently deliver effective behaviour change interventions to the Salford population.
Evaluation Measures:	(1) % staff at each level who have attained satisfactory levels of knowledge and skills, according to agreed competencies, to enable them to undertake behaviour change interventions with people using their service (2) % Staff feel 'satisfied' that the training received equips them to deliver behaviour change interventions (3) Quality indicators in terms of knowledge, confidence & skills, including staff competent to deliver

Quantitative Indicators	Qualitative Indicators	Conclusion
(1) Overall, 1,200 staff were MECC compliant without requiring training and of the 660 staff who 'failed' the SAT, 312 were trained, re-took the SAT and 'passed'. Therefore around 1,500 staff in Salford have the knowledge and skills to deliver MECC. (2) Only a third of FLW (31%) responding to the survey stated that the training equipped them to deliver MECC. A third said it equipped them little (though not statistically significant, 46% of Level 2 FLW thought it equipped them little compared with 26% of Level 1 FLW). Also, Level 2 FLW were more likely (43%; though not statistically significant) to say that the training equipped them little to deal with MECC situations, than Level 1 (31%) or Level 1 introductory FLW (9%). (3) The knowledge and skills required to deliver MECC were consistently higher in staff who 'passed' the SAT than in those who 'failed', regardless of level. After training, knowledge and skills were significantly increased.	Also see Outcome 3 (3). From the FLW interviews, it is difficult to assess the impact of the SAT and the MECC training on staff knowledge, confidence, skills and ultimately their level of competence. (1-3) All FLW had done the SAT, although 1 had not completed it. Generally there was quite a lot of confusion about the level that the interviewees were taking the SAT or training. 10 stated they were MECC competent – i.e. they 'passed' the SAT and did not need to go onto the training. Most of the FLW interviewed were somewhat concerned about the SAT – though the majority had taken it before the major changes had taken place in September 2012. Some found it straightforward / common sense. Others found it easy, but had cheated in the process. They admitted that if they had answered honestly, they would probably have 'failed' but if they played the game they could anticipate what answers should be / were expected. There was concern that the questions were not measuring a good level of competence and there were some suggestions that people were thinking of the SAT as an e-learning package and were unhappy about the way their learning was being assessed. Quite a few expressed concern of their initial feeling that they would 'fail' / feel stupid but that otherwise it was quite useful / not a problem and were pleased to have 'passed' it. However 1 of the interviewees, who expressed concern	• Around 1,500 staff in Salford have the knowledge and skills to deliver MECC. • Some (e.g. Level 2) frontline staff say they are equipped to confidently deliver effective behaviour change intervention to the Salford population (but this may not be due to MECC) • The majority of staff interviewed were confident but suggested that it was not to do with MECC • On the other hand, Level 1 staff are more likely to benefit from MECC training resulting in increased knowledge and confidence to deliver signposting interventions • The SAT may not be a reliable tool for assessing competencies (evidence of cheating). Traffic Light : Amber - Green **Lessons learned:** Also See Outcome 3 • MECC training should target FLW working at Level 1 as evidence suggests that Level 2 FLW do not benefit as much from MECC

	about 'failing', felt that she was constrained by the way in which the questions were asked. Some of the FLW that accessed the training clearly got some benefit from it, about learning different approaches, networking, clarifying MECC and the trainer's belief in the ethos of MECC. Most of the FLW interviewed were very unclear about what level of MECC they were operating at having done the SAT and MECC training.	• Consider alternative methods of assessing levels of competency • Danger of creating negative impact on confidence levels if tool is seen as 'pass' or 'fail'.

8 Outcomes for staff: Increased quality of end user and front line staff contact/ consultation experience.		
Evaluation Measures:	(1) % Staff feel confident in raising issues with clients (2) Staff can explain improved quality of experience of delivering interventions (3) Staff providing examples of good experiences of delivering interventions	
Quantitative Indicators	**Qualitative Indicators**	**Conclusion**
(1) Confidence was high (98%) in all staff who 'passed' the SAT, regardless of staff level but lower In those that 'failed' the SAT (68% of Level 1 and 85% of Level 2). After undergoing training and retaking the SAT, the proportion stating that they were confident increased to 100% in both levels. (2) Of FLW completing the survey, the majority (69%) felt it was easy to start a conversation with a person about their health and wellbeing/behaviour, 27% felt it neither easy or difficult and only 4% felt it was difficult. Although not statistically significant, 76% of Level 2 FLW felt it was easy to start a conversation with a person about their health and wellbeing/ behaviour compared with 70% of Level 1 and 51% of Level 1 introductory. (3) The majority of FLW (53%) never/rarely had uncomfortable or challenging conversation with people when raising the issue of health and wellbeing; around a third (35%) sometimes did so and 11% always/mostly did. A significantly higher proportion of Level 1 (56%) and Level 2 (65%) FLW reported always/mostly having positive conversations when raising issues of health/behaviour with the public compared with Level 1 introductory (26%).	(1-3) Though the majority of FLW felt confident, there were few examples of conversations that FLW could describe with which to make an assessment of the quality of the contact. The examples given were not seen as being linked to MECC. Only 1 FLW provided an explanation about why she felt her contact had changed – she felt that she now tunes in more for clues from clients. FLW found it difficult to respond when asked to describe difficult or successful interactions and how they responded to these. The majority (18) did not feel that they were seeing successes / difficulties as a result of / anything to do with MECC. There was one individual who could link her actions back to MECC, but she did not relate this to increased confidence. There was no direct evidence of increased quality of contact with end users.	• High proportions of FLW feel confident in raising issues with clients • Level 2 FLW showed less change due to the MECC process/training than Level 1 FLW, since they are already confident and skilled in behaviour change intervention • Interviewees say quality has not changed due to MECC and that they did it before. Traffic Light: Level 1 ; Level 2 **Lessons learned:** • The MECC program may not have been designed to achieve outcomes created –more realistic outcomes / targeted outcomes would have been beneficial • The MECC intervention should be based on underlying theory to help prevent the criticisms of those taking training – understand current behaviours, structures, and theory before creating a programme.

9 **Outcomes for staff:**	Increased number of behaviour change interventions: **a)** contributing to the achievement of organisational objectives and outcomes; and **b)** delivered by staff as part of their daily working practice
Evaluation Measures:	(1) Numbers of interventions delivered over time (2) Number of interventions delivered against the Action Plan target (3) Quarterly increase in number of behaviour change interventions delivered by staff as part of their daily working practice [incentivised organisations only] (4) Staff indicating an increase in the quality of interventions

Quantitative Indicators	Qualitative Indicators	Conclusion
(1) The majority of FLW (75%) said the number of conversations with people about their lifestyle/health and wellbeing had stayed the same. Around a fifth (19%) said there were more than before but 6% (one in 17) reported less than before MECC. (2) Monitoring altered after the evaluation indicators were developed, so this could no longer be measured (3) Monitoring altered after the evaluation indicators were developed, so this could no longer be measured (4) Two thirds of FLW (64%) said that the content of their conversations with the public had not changed since MECC. Only 15% (one in seven) said that they had changed but 21% (one in five) did not know.	(4) The interviews with FLW did not indicate that there was either an increase in the number of interventions, or a change in the conversations themselves. The majority stated that their daily working practice had not changed since the introduction of MECC, although there were a minority of FLW who made reference to new monitoring / performance targets in their organisations.	• The lack of monitoring data (due to changes in the MECC requirements) reduced the ability to evaluate against this outcome • It is difficult to draw any conclusions in relation to increased number of behaviour change interventions - the majority of those interviewed and surveyed found no increase in their interventions and no change in their daily working practice. Traffic Light: RED **Lessons learned:** • Quantitative monitoring of MECC is difficult & time consuming to undertake • A clear definition of what constitutes a MECC intervention is required • Being deemed to be 'MECC competent' does not guaranteed an increase in intervention activity • Develop appropriate measures to demonstrate increased number of behaviour change interventions.

10	**Outcomes for staff:**	Increased numbers of front-line staff are trained* to common core behaviour change competency standards (skills, knowledge and understanding) across multiple organisations.
Evaluation Measures:		(1) Specified increase in the number of trained/compliant staff (2) Staff identified for training (3) SAT undertaken (4) Training undertaken (5) Cumulative increase in Staff competent to deliver

Quantitative Indicators	Qualitative Indicators	Conclusion
**Analysis has not just focussed on trained staff but on the numbers of MECC-compliant staff who 'passed' the SAT and/or who 'failed' and were trained* (1) There was an average of 160 new registrations and 136 people completing the SAT each month from Dec 2011 to Dec 2012; with a total 1,200 compliant staff not requiring training and 312 compliant post-training. (2) 660 staff were identified for training by April 2013 (3) 1,800 staff had taken the SAT (4) By April 2013, 660 staff (36%) were identified as requiring training; 59 training courses have been undertaken which have trained 560 staff; 350 had completed the post-training SAT (5) Overall, 1,500 staff across Salford are competent to deliver MECC.		• Large numbers of staff from a range of organisations have been assessed and/or trained via the SAT process • SAT activity was high during 2012 but seems to have subsequently ceased in 2013 • Training data linked to the SAT were not available • The complexity of Version 1 of the SAT and subsequent modifications to Version 2 made it very difficult to assess the numbers going through the system. Traffic Light: Green **Lessons learned:** • The databases used for the SAT should take into account the monitoring outputs required and build them into the development • Training databases should link directly with the SAT database.

11	**Outcomes for staff:**	Staff commitment and understanding of the importance of delivering effective behaviour change interventions in achieving the organisation's core business: a) as well as utilising the skills for supporting positive behaviour change outcomes for end users.
Evaluation Measures:		(1) Quality indicators – staff understanding their role as advocates for health and wellbeing (2) Factors enhancing or hindering delivery of interventions (3) SL & LM engaged (4) Skills utilised with end users

Quantitative Indicators	**Qualitative Indicators**	**Conclusion**
(1) The majority of FLW (78%) see improving health and wellbeing as central to their usual job role. Significantly more Level 2 FLW (95%) thought this true than Level 1 FLW (78%) and significantly fewer Level 0 FLW (34%). However, whilst the majority of FLW (50%) were positive about getting involved with MECC, over a third (38%) were neutral and 12% were negative. (2) The majority of FLW (45 - 59%) thought that there should be no change to the information / support provided to help them deliver MECC. However, around a third (29-33%) stated more information on the practical skills for MECC and support outside of training would help; and around a quarter (22-27%) said more information on MECC principles and time for training would help. (3) Just over half of SL/LM (53%) were involved in their organisation's sign up to MECC; a third (31%) was not and 16% were somewhat involved. Two thirds (64%) were not involved in completing the Action Plan and only 30% were. Only a fifth (20%) had attended the line managers training session; 15% had booked; half (52%) planned to attend but 13% said they were not. Only a third of SL/LM (31%) thought staff would respond	Also see Outcomes 2 & 5. (1) The majority of FLW interviewed saw themselves as advocates for Health & Wellbeing (H&W). Some of the interviewees described the way in which they do this e.g. via holistic assessment, signposting. Many of the FLW also gave examples of how they talk to people about H&W; however, there was a clear indication that the majority of those interviewed (18) felt they were already doing this before the MECC project was implemented. (2) **Enhancing** (FLW): • Measuring success – make monitoring/recording easy – simple / timely / demonstrating/linking performance with feedback to show purpose • Push, direction and support from manager / leadership • Using Teamwork / having a cohesive team. **Hindering** (FLW): • Time / Money (x3) • Lack of information re services / inaccurate out of date info • Clients themselves – resistance to change; feeling bombarded with advice from multiple professionals; public having other priorities e.g. benefit changes • Being bombarded by too much irrelevant	• FLW generally have this commitment and understanding and they see health and wellbeing as part of their organisations' core business and central to their individual role • However, they do not attribute this to MECC - the majority interviewed felt that they were already using the principles of MECC in their everyday work and there was little or no evidence of change in practice • MECC training has enhanced knowledge or skills but this is related to level 1 FLW • There is a rational for targeting MECC at those working at level 0 (porters and receptionists) • Managers were not fully engaged, which is likely to hinder staff's commitment in some cases. Traffic Light: Amber **Lessons learned:** • Differentiating between level 0 and 1 may still be useful as there were differences evident in survey results • Targeting level 0 may well create the greatest added value for MECC.

positively to being involved in MECC. (4) Two thirds of FLW (64%) said that the content of their conversations with the public had not changed since MECC; one in seven said that they had changed but a fifth did not know. Listening to end users was high (95%) in level 1 FLW who 'passed' the SAT and lower in those who 'failed' (56%), which increased to 85% following training. Positive responses to questions about engaging with people were high (around 80%) in staff who 'passed' the SAT and much lower in those who 'failed' (around 30%). This did increase following training, but more so in level 2 staff (to 88%) than in level 1 staff (to 55%).	information re MECC. (3) All of the SL/LM interviewed had been involved in implementation in various capacities and to varying degrees. The majority thought it was relevant to their role and seemed quite happy to be involved. The SLs had all been involved in planning as well as implementation, whilst the LMs' involvement was directed more towards implementation and especially for making sure that staff had completed the SAT and training. There seemed uncertainty about when their organisations had become involved (i.e. the phase / wave) although the majority thought that it had been early on (i.e. November 2011 to June 2012). All of the SLs could recall attending launch events or stakeholder meetings at the very beginning of their involvement. None of the SLs or LMs had been involved in the initial sign up to MECC. (4) The answers given by the FLW interviewed about what particular knowledge or skills they felt they needed to interact with people, were not attributed to MECC. 100% of interviewees said that the skills had nothing to do with MECC – because they were referring to skills they have / already use i.e. they are not new. In the few examples given of MECC interventions, it would suggest that FLW are utilising a variety of skills, for example: good influencing skills, self-awareness, ability to accept that clients do not always take on board messages, recognising when to talk and when not to talk, listening, thinking outside the box, ability to engage, knowing your limitations.	

12	**Outcomes for staff:**	Effective system(s) in place to continually monitor the delivery and quality of service delivery.
Evaluation Measures:		(1) Monitoring systems developed and in place (2) Monitoring is relevant and appropriate

Quantitative Indicators	**Qualitative Indicators**	**Conclusion**
(1) Almost half of SL/LM (47%) said that their organisation was monitoring its success in implementing MECC. However, over a third (38%) did not know and 16% said there organisation wasn't monitoring its success in implementing MECC. In the SAT 97-100% of FLW stated that they record information about the content of the behaviour change interventions they provide. (2) Could not be assessed	Also see Systems Outcome 1 (2). **General -** The majority of FLW stated that MECC was nothing new and only a small minority referred to any new monitoring requirements. The question of what is a MECC intervention arose with a number of FLW – the feeling was that MECC had not been clearly defined and that this made it more difficult to determine when a MECC intervention (rather than what they would normally do) had taken place. (1) FLW were not asked directly about monitoring; however, a few referred to it, which would suggest that some organisations have developed and put in place monitoring systems. (2) 2 FLW who reported that there was a system in place were critical of the process - e.g. stating that it created extra work. 1 FLW when asked about factors for successful roll out of MECC, suggested that if staff are asked to record activity they should receive feedback and that this would have a positive impact.	• Systems for monitoring MECC are not systematic or consistent but they are in practice in some places • At the time of the interviews, the majority of the organisations that were not subject to a CQUIN, were doing some form of monitoring but it did not appear to be a formal requirement for MECC • Those organisations that were subject to a CQUIN had formal monitoring systems in place • There did not appear to be core performance indicators for MECC across all organisations - thus difficult to compare like with like. Traffic Light: Red - Amber **Lessons learned:** • An effective monitoring system for all participating organisations which is fed back officially to the Health & Wellbeing Board needs to be established • Monitoring systems should be developed in line with a small number of core measures but developed in ways sympathetic to each organisation • Greater feedback to FLW would be beneficial.

13	Outcomes for staff:	A reduction in inappropriate referrals to specialist services.
Evaluation Measures:	(1) Staff understanding difference between signposting and referrals (2) Staff stating that referral pathways are clearer (3) Staff stating that referrals are more appropriate	

Quantitative Indicators	Qualitative Indicators	Conclusion
(1) Knowing when to signpost/refer to a specialist service was high across all levels in staff who 'passed' the SAT (over 95%) but lower in those who 'failed' the SAT (65-77%). However, this increased to 97-100% in all three levels for these individuals following training. (2) Nearly two thirds of FLW (61%) said that referral pathways are about the same since MECC. One fifth (21%) said they were clearer now but 17% (one in 6) said they were not clearer. (3) The majority of FLW (72%) said the number of appropriate referrals had stayed the same since MECC. Only 15% (one in seven) said this had improved and 13% (one in eight) said it had not improved.	**General** The interviews were inconclusive about the impact of MECC on referrals to specialist services. When asked whether information for referrals has changed since the introduction of MECC, most felt that it had not changed (15). One felt that as a result of MECC she was now more aware of how to access information to assist referrals and this had been incorporated into her organisation's computer system. (1) Signposting and referral seemed to be used interchangeably which suggests that FLW do not understand the difference. (2) The majority suggested that the pathways had not changed. 5 did suggest that there was a need for a service directory so they would know who and where to refer to. (3) There was no evidence from the interviews to suggest that referrals are more appropriate – either from those who refer or those who receive referrals.	• Knowledge of signposting and referrals was generally high but did benefit from the training • FLW completing the survey suggested that the referrals pathways and appropriate referral had not altered since MECC Traffic Light: Red **Lessons learned:** • Appropriate monitoring systems of referrals need to be developed drawing on the experience of other projects • An up to date and accessible Service Directory needs to be developed and maintained.

Executive Summary of Additional Interviews with Delivery Team and Chief Executives

This is an Executive Summary of the findings from the refresh interviews which were undertaken with the Delivery Team (10 interviewed June – November 2012) and the Chief Executives / Heads of Service (6 interviewed June / July 2012). Interviews were undertaken at the request of the MECC Project Board and a report presented to them, which, informed some of the subsequent changes to the MECC Project.

These 2 sets of interviews were not specified in the original evaluation brief and have therefore been kept separate from the main summary document. Where possible, the findings have been linked to the agreed MECC system outcomes.

Table i.2. Summary of evaluation of MECC in Salford from additional data sources: a) interviews with delivery team (DT) members or b) participating organisations chief executives / heads of service (CE/HS)

	System Outcome:	Findings	Lessons learned
1	Organisations have embedded behaviour change interventions into service development through: **a)** the inclusion of behaviour change statements/ measures in job descriptions; **b)** change modules included as part of staff induction; and **c)** mandatory training programmes.	**DT -** Sustainability formed part of discussions between DT members and Service Leads (SLs) and incorporated into Action Plans & Service Offers. Some had a perception of an overly prescriptive approach to sustainability initially, which some organisations are resisting or finding too difficult / impractical to achieve e.g. job descriptions. There was a general consensus that there are real challenges and it seems uncertain whether MECC will survive in the next 3 to 5 years. Only 2 interviewees stated that their involvement with the DT and MECC was likely to continue beyond March 2013. Respondents were concerned about the loss of continuity and all felt that this would have a negative impact on sustainability. The future of training was a concern to many with a perception that MECC is seen first and foremost as a workforce training programme and that when the training provider withdraws from Salford this will cease. Also uncertainty about who will coordinate future training and deal with logistics. The lack of uptake and interest in train-the-trainer approach to future MECC training was a concern. Few commented on monitoring. Those that did felt that monitoring requirements should have been made clear at the start of the programme. **CE/HS -** CE/HS did not comment directly on this measure.	• Accreditation for those who have successfully completed SAT or training - to add value • Be flexible in how training is delivered, taking into account the varying structures and processes in the organisations and how training is delivered • Training to take account of non-core staff e.g. volunteers • Beware of being prescriptive about the approach to sustainability – emphasise the need to embed but provide guidance, support and examples of tools • Involve representative organisations in programme design – large, small, statutory and 3rd sector – so that a flexible, pragmatic approach can be developed for implementation

	System Outcome:	Findings	Lessons learned
2	Successful roll out of a comprehensive citywide behaviour change intervention programme.	**DT -** The majority of respondents from the DT were aware of the origins and rationale behind MECC. Some clear and distinct stages of MECC's development and implementation were identified – identification of need for MECC; examination of evidence from elsewhere; programme design; implementation; review and refinement. Some of the interviewees were critical of the approach adopted in Salford. These were people who had not been involved in the initial design and implementation phases. There was consensus amongst the DT that the principles and ethos of MECC were well received, viewed as sound and applicable to organisations across Salford, which resulted in them being receptive to become involved. There was a consensus that the DT has been and continues to be an important factor in ensuring MECC implementation and sustainability. Some were appointed with specific lead areas or specialist knowledge / skills e.g. training, IT (technical support and advice, website development), communication, HR, service provision, marketing. The roles of some had changed over time - developed Service Support Lead role for some of the DT members to provide tailored support in designated organisations. There was felt to have been over reliance on Service Leads (SL) to cascade / roll out MECC within their organisations and this had impacted on roll out. **CE/HS -** Although few CE/HS specifically discussed MECC using the terminology of Large Scale Change, there was evidence; implicit in their responses, that the concept itself was at least being adopted and also that the value of this approach was recognised at the level of the CE and SL. The ability of MECC to strengthen partnerships and the opportunities to have a more uniform approach across the city was recognised by all. Despite this, a 'one-size fits all approach' was regarded by most as unrealistic particularly for certain types of organisations. There was also a comment of the importance of keeping a local perspective as well as keeping it city wide. Others were concerned that MECC could increase their workload if the expectations of the organisation were not clarified.	• Need for DT or team of people operating at a senior management level who are able to engage with managers and also mentor frontline staff. Preferably those who have already developed strong relationships within organisations and know how they operate • Ensure strong and continuous leadership • Involve representative organisations in programme design • Tease out the unique selling points so that MECC stands out from other initiatives • Communication is key – requires different mechanisms, not solely reliant on IT or assumption that managers can cascade information.

	System Outcome:	Findings	Lessons learned
3	Development of a highly skilled, knowledgeable and motivated frontline workforce that is confident in delivering behaviour change interventions to the Salford population.	**DT -** The DT interviewees did not comment directly on the level of skill, knowledge or motivation of the workforce. There were some comments regarding communication re MECC, the SAT and training. There was a consensus that the majority of frontline workers who are involved in MECC view brief interventions as part of their role already and do not necessarily see a clear distinction between what they do normally and MECC. Comment was made by a minority that staff who do not normally undertake this type of work might gain more from the training and gain new skills / knowledge. **CE/HS -** The CE/HS did not comment directly on this measure.	• Be clear about what MECC is and the benefits for staff and the people of Salford • The aim should be to assimilate MECC into everyday practice so that it becomes part of core values.
4	Identified clear social return on investment and efficiency cost savings/outcomes.	**DT** The DT interviewees did not comment directly on this issue. **CE/HS** The CE/HS did not comment directly on this measure; however, they did raise the issues that some organisations were cognisant of the resources (staff time) invested thus far into the implementation of MECC and were therefore concerned about the possibility of a poor return on investment.	• See main Executive Summary.
5	Improved collaborative working arrangements across Salford organisations.	**DT -** The DT interviewees did not comment directly on collaborative working; however, it was suggested by the DT interviewees that the pathways for referral should be simplified and a service directory produced to assist staff. More opportunities for sharing good practice were also mentioned. These do not directly link to this outcome - they suggest, albeit indirectly, that action could be taken to improve collaborative working. **CE/HS -** The ability of MECC to strengthen partnerships and the opportunities to have a more uniform approach across the city was recognised by all CE/HS. Despite this, a 'one-size fits all approach' was regarded by most as unrealistic particularly for certain types of organisations. There was also a comment of the importance of keeping a local perspective as well as keeping it city wide. Others were concerned that MECC could increase their workload if the expectations of the organisation were not clarified. Although partnership working was frequently mentioned as a benefit from MECC, at least one commented on possible duplication of services and thus effort	• Try to anticipate other things that might be needed to support the programme • Have a clear plan regarding how these will be addressed e.g. service directory to aid referral, Way-to-Wellbeing Portal.

	System Outcome:	Findings	Lessons learned
6	Commitment and engagement of senior leaders across services to sustain the long term benefits and impact of behaviour change training.	**DT -** A few DT members gave examples of specific tools or approaches that they had used to encourage organisations to sign up and implement MECC in their organisations. Some were more "hands-on" than others (Service Support Leads). There were factors identified which respondents felt presented a risk to the future of MECC. A recurring one was the need for the DT or something similar to maintain the high level commitment from organisations at a time when many of them are going through significant change.In terms of factors for success, reference was made by the DT interviewees to senior level buy-in and a commitment to resource adequately – not just rhetoric, but the need to be firmer with organisations – place expectation on them to do it properly. There was consensus by the DT interviewees that communication was one of the keys to success and that there had been over reliance on SLs to cascade the key messages resulting in many staff not understanding why their organisation was becoming involved. **CE/HS -** CE/HS expressed there was strong sign up and commitment to MECC at the outset and, despite some initial reservations, staff had started to engage and understand the process and were *actually enjoying this*. For some this initial commitment towards MECC was in decline; some managers, for example, were *starting to question and doubt its implementation,* with some mention of this in relation to variable support available from the Delivery Team. Some organisations were cognisant of the resources (staff time) invested thus far into the implementation of MECC and were therefore concerned about the possibility of a poor return on investment. Reservations were linked to several factors, mainly internal communication and commitment and 'organisational fit'. Most of the CE/HS recognised that their organisations had introduced strategies for cascading information on MECC to staff, although one CE acknowledged that a large section of their staff were still not on board, particularly in the front-line staff or 'blue-collar staff' such as porters and ancillary staff. Despite this, most explained how their organisation was investing in MECC for the long term.	• Communication is key – being clear about what MECC is and why doing it. MECC is nothing to fear and it helps people do their jobs and to make people's lives better • Need properly resourced, designated support staff – preferably staff who already have established relationships with the organisations, to be engaged.
7	Frontline staff are skilled and equipped to confidently deliver effective behaviour change interventions to the Salford population.	**DT -** The DT interviewees did not comment directly on this measure; however, it was suggested that the approach for assessing competencies should be reviewed [the majority of the DT interviews took place before the changes to the SAT / training so those revisions may have addressed this comment]. **CE/HS -** The CE/HS did not comment directly on this measure.	• See main Executive Summary.

	System Outcome:	Findings	Lessons learned
8	Increased quality of end user and front line staff contact/ consultation experience.	**DT - *The DT interviewees did not comment directly on this measure.*** **CE/HS -** The CE/HS did not comment directly on this measure; however, some did express that they had high expectations of the benefits of MECC with Organisations benefiting (medium to long term) in a reduction on reliance of secondary care interventions – with expectations that patients would take increased responsibility for their own health.	• See main Executive Summary.
9	Increased number of behaviour change interventions: **a)** contributing to the achievement of organisational objectives and outcomes; and **b)** delivered by staff as part of their daily working practice	**DT -** The DT interviewees did not comment directly on this measure. Performance monitoring was viewed as a means of understating if there has been any change in practice. It was felt that this had not started soon enough and organisations needed support and guidance. **CE/HS -** Some CE/HS viewed MECC as providing a real opportunity for their staff with the provision of training, development of more effective systems and procedures, *another tool* that staff can use and the potential of better engagement of staff to patients / clients. Some CE/HS had high expectations of the benefits of MECC with Organisations benefiting (in the medium to long term), in a reduction on reliance of secondary care interventions – with expectations that patients would take increased responsibility for their own health.	• See main Executive Summary.
10	Increased numbers of front-line staff are trained to common core behaviour change competency standards (skills, knowledge and understanding) across multiple organisations.	Neither the DT interviewees nor the CE/HS commented directly on this measure.	
11	Staff commitment and understanding of the importance of delivering effective behaviour change interventions in achieving the organisation's core business: a) as well as utilising the skills for supporting positive behaviour change outcomes for end users.	**DT -** The DT interviewees did not comment directly on this measure. **CE/HS** Regarding factors enhancing or hindering delivery of interventions, the main challenges expressed by the CE/HS related to internal capacity, internal capability, access to the internet, training, data issues, recording & monitoring, changes and uncertainties.	• See main Executive Summary.

	System Outcome:	Findings	Lessons learned
12	Effective system(s) in place to continually monitor the delivery and quality of service delivery.	**DT -** ***The DT were not asked directly re monitoring; however, it was stated that this had not started soon enough and organisations needed support and guidance to introduce simple and manageable ways of monitoring.*** A clear definition of what constitutes a MECC intervention was suggested so that staff are able to identify when they have done one. Feedback was also felt to be important so that staff can see that they are making a difference. A minority of DT interviewees commented on the impact of contractual requirements such as CQUIN. 2 out of the 3 that did felt that financial incentives linked to performance was not an important factor. **CE/HS -** The CE/HS did not comment directly on this measure.	• Monitoring requirements should be considered as early as possible. These should be as simple / practical as possible • Mechanisms for providing feedback re monitoring should be put in place.
13	A reduction in inappropriate referrals to specialist services.	**DT -** The interviewees were not asked directly about this measure; however, it was suggested that there is a need to simplify the pathways and assist staff by producing a service directory. **CE/HS -** The CE/HS did not comment directly on this measure; however, there was mention of Organisations benefiting (in the medium to long term) in a reduction on reliance of secondary care interventions – with expectations that patients would take increased responsibility for their own health. Although partnership working was frequently mentioned as a benefit from MECC, at least one commented on possible duplication of services and thus effort.	• See main Executive Summary.

1. Background

Improving population health and wellbeing and reducing inequalities in health are key priorities for government, policy makers, and health professionals and as such remain at the heart of the NHS core business. The rationale for this is clear: the social and economic burden of increases in life expectancy and simultaneous rise in chronic or non-communicable diseases, resulting from an ageing population demographic, advances in health care technology and changes in the way people live and work.

The future threat of rising demand for health and social care against the backdrop of diminishing and finite resources, has forced successive governments to rethink the sustainability of the UK health care system. In 2004, the Wanless report[1] recommended that the future sustainability of the NHS would be best secured by turning towards an upstream fully engaged scenario. An approach characterised by high public engagement and increased emphasis on prevention and primary care would enable people to remain healthy and prevent ill health wherever possible. This scenario incorporated the need for the public to take greater responsibility for individual health-related behaviour and at the same time for social, economic and environmental policies to be at the heart of all disease prevention strategies. Some ten years on, progress towards achieving a fully engaged scenario is far from encouraging, with the exception of smoking prevalence (where legislature has driven population level smoking prevalence to a record low since the widespread availability of tobacco). As such pressure on finite NHS resources is increasing as a result of rises in lifestyle related illness, such as obesity (e.g. Diabetes) and alcohol related illness, and widening inequalities in health. In this year of the 65th anniversary of the NHS, there is a call for greater emphasis on keeping people healthy and well in order to lead longer, more illness-free lives: preventing rather than treating illness.[2]

In addition, increasing inequalities in health remain a growing concern for the UK government. On average, people living in the poorest neighbourhoods in England die seven years earlier than people living in the richest neighbourhoods, and spend 17 more years living with a disability[3]. The causes of inequalities in health are complex. As Sir Michael Marmot has described, they go far beyond medical issues:

> "The Commission on Social Determinants of Health concluded that social inequalities in health arise because of inequalities in the conditions of daily life and the fundamental drivers that give rise to them: inequities in power, money and resources. These social and economic inequalities underpin the determinants of health: the range of interacting factors that shape health and well-being. These include: material circumstances, the social environment, psychosocial factors, behaviours, and biological factors. In turn, these factors are influenced by social position, itself shaped by education, occupation, income, gender, ethnicity and race. All these influences are affected by the socio-political and cultural and social context in which they sit… Action is required across all these social determinants of health and needs to involve all central and local government departments as well as the third and private sectors. Action taken by the Department of Health and the NHS alone will not reduce health inequalities."[4]

Policy makers now appreciate that the causes of ill health and in particular health inequalities, are complex and as such cannot be fixed by the NHS alone. A broader, holistic and comprehensive multiagency approach is required where Health is 'Everybody's business'.

Everybody's business

There are finite resources to focus on prevention, and in the attempt to reorientate services upstream in order to address the wider socio-economic determinants of health there is a need to integrate environmental and organisational changes with individual level behaviour change approaches in order to

[1] Wanless D (2004) http://webarchive.nationalarchives.gov.uk/+/http:/www.hm-treasury.gov.uk/consult_wanless04_final.htm
[2] NHS England (2013) www.england.nhs.uk/wp-content/uploads/2013/07/nhs-belongs.pdf
[3] The NHS Future Forum (2012) www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_132024.pdf
[4] *Fair Society, Healthy Lives: A Strategic Review of Health Inequalities in England Post-2010* (Feb 2010) www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

maximise potential health gain. This requires a range of sectors across a 'health system' to collaborate in a synergistic and systematic way in order to influence individual behaviour (within the population) but also create more efficient ways of working across the system (e.g. improving referral pathways). The key challenge here is for all partners to agree to work towards a shared vision to improve population-level health and wellbeing and to genuinely engage in the process which requires political and organisational commitment (including investment of internal resources, organisational change and investment in staff).

There is overwhelming evidence that changing people's health-related behaviour can have a major impact on some of the main causes of premature mortality and morbidity[5]. The importance of preventative interventions in improving population health is also widely accepted although currently not invested in. People's behaviour and lifestyles however do not exist within a vacuum; lifestyle choices, like the foods we eat, are more than just a physiological necessity, they are a central part of the social and cultural fabric of society in which we live in. Moreover, people are *active consumers* in decisions affecting their health and lifestyle. As the World Health Organisation (WHO)[6] advocates, a critical role for health and social care organisations, and professionals, is to encourage, inform and enable people in making decisions that may enhance their health and well-being. This however also needs to take place against the enabling structures at the societal level to help *make the healthy choice the easy option*. This resonates with longstanding advice to incorporate upstream and downstream public health into all policies to improve population health and wellbeing. Such drivers of health change need to align and reinforce each other if health gain is to be maximised at population level.

The recent public health White Paper (2010:29)[7] sets out the vision of the current government to improve population health and wellbeing, and acknowledges the importance of addressing health at different levels of the system:

- Strengthening self-esteem, confidence and personal responsibility;
- Positively promoting 'healthier' behaviours and lifestyles; and
- Adapting the environment to make healthy choices easier.

The importance of working across the whole system for health gain has been acknowledged (see chapter 2) in public health but is still a contested issue[8] however the evidence base with respect to large-scale population based interventions in the UK is limited. As such this evaluation report adds important insight to this evidence.

Population-level Behaviour Change for Health Gain: Systems Approaches

There has been a growing awareness that in order for intractable, complex community health problems to be tackled effectively, more 'joined-up' approaches to intervention and service delivery are required. Consequently, movements such as Healthy Cities and ways of working such as Whole Systems approaches[9] have been gaining in popularity and application, Pratt et al., (1999) described Whole Systems working as:

> *"… a radical way of thinking about change in complex situations: a combination of theory and practical methods of working across boundaries. At its simplest level it is a way of thinking about and designing meetings that help people to express their different experiences, to identify possibilities for action and commit to change"* (p3).

[5] NICE (2007) *Behaviour Change at Population, Community and Individual Levels*. http://www.nice.org.uk

[6] World Health Organisation Ottawa Charter for Health Promotion [internet] In: First International Conference on Health Promotion, Ottawa: WHO; 1986. Available from: http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf

[7] Public health White Paper (2010:29) Department of Health, 2010, Healthy Lives, healthy people: our strategy for public health in England.

[8] Adams J and White M (2005) When the population approach to prevention puts the health of individuals at risk" International Journal of Epidemiology, Vol 34 No 1, pp40-43.

[9] Pratt J, Gordon P and Plamping D (1999) Working Whole Systems: putting theory into practice in organisations. King's Fund Publishing; London.

Systems approaches often target neighbourhoods and use a variety of practical techniques to get large groups of people working together differently in order to solve problems. Whole Systems working recognises that some problems cannot be solved by dealing with discrete 'sections' of the system. Instead it emphasises the necessity of getting as many of the players within a system together, to try and find different and innovative ways to solve the problem by working together: these intractable problems are more likely to be solved by thinking of them as part of *"an interconnected system to tackle together"* [10]
The purpose of Whole System working is about radical change in terms of service redesign, community mobilisation or organisational operation and relies on all players in the system working together on an equal footing in the decision-making process, including the public. In practice the Whole Systems approach is conceptually positive but can be difficult to implement against a backdrop of existing structures and processes which are mainly governed by professionals.[11]

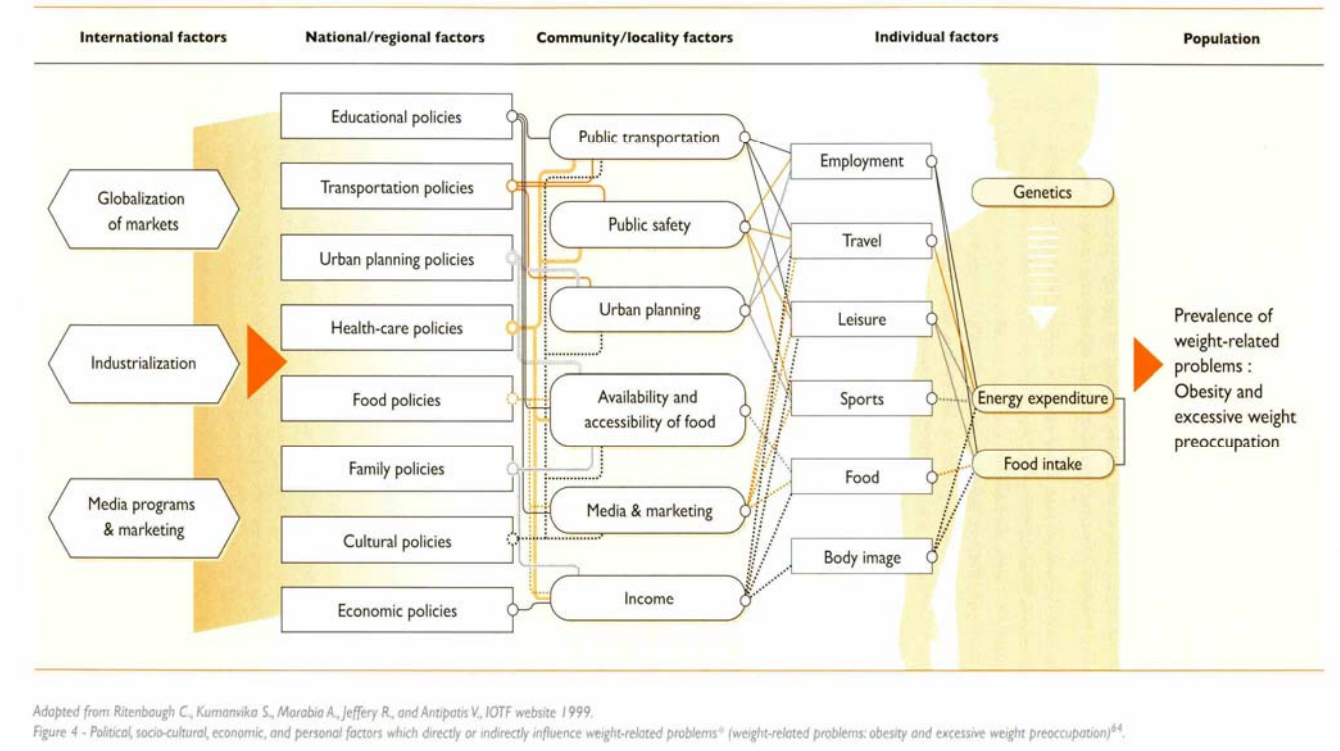
Socio-ecological theory emphasises the interconnectedness of levels within a system. This interconnectedness and complexity is exemplified by Salford Primary Care Trust's model of health improvement, based on Nutbeam's Categories of Health Promotion Activities[12], to tackle health inequalities[13]. The model uses six different approaches to developing health improvements which are implemented at different levels of the system (individual, family, community, organisation, and environment). The six different approaches include:

- **Awareness raising:** encouraging individuals to change behaviour by provision of information. This strategy is unlikely to be effective if used alone however it can be vital for making people aware of factual information such a service provision.
- **Education:** developing knowledge and skills in a population can enable behaviour change to take place. The challenge here is to enable people to learn to transfer the behaviours into their own environment and then sustain them for themselves rather than relying on a professional intervention.
- **Social support:** this approach utilises the benefits that can be drawn from social networks within communities which enhances health and well-being especially mental health. Peer support can often be favoured as it is thought to be less judgemental and more empathic.
- **Capacity building:** this approach builds, from the 'bottom up', the skills and the confidence within a community to make health changes that are relevant to them. It encompasses principles of community development, such as empowerment, which encourage communities to take charge of change processes.
- **Clinical Intervention:** this approach focuses on evidence-based medical interventions which are known to improve health status within a population e.g. the prescribing of Statins to reduce blood pressure. Health behaviour/public health interventions which are also known to work in certain situations should also be considered here.
- **Policy change:** this focuses on the necessity to create healthy public policy which generates a joined-up health agenda across areas such as transport, education, housing, the environment, employment etc.

The term 'health improvement' is used to convey a progression to a neighbourhood-focused, community development approach to health gain[14]. Socio-ecological theory recognises the importance of alignment within a system, whereby maximum health gain is achieved by ensuring the upstream policy and environmental context reinforce community and individual opportunities for positive health choices. The nested and interconnected relationships between the factors that influence health are illustrated using the example on obesity in figure 1.1 For individual's to make healthier food choice they require access to affordable food, which in turn is influenced by urban planning (e.g. type of food outlets in a locality); regional and national pricing strategy; government policy on food advertising and labelling; agriculture subsidies which may influence pricing and availability of various foodstuffs.

[10] Pratt et al cited in Heller, Muston, Sidell and Lloyd, 2001, p358): Pratt J, Gordon P and Plamping D (2001) Chp 36 Working Whole Systems, in Heller T Muston R, Sidell M and Lloyd C (eds) Working for Health. OUP/Sage; London.
[11] Dugdill L, James K, Cliff E and Powell E (2001) Developing Whole Systems: Theory to Practice. Liverpool Community Health Council.
[12] Nutbeam, D., and Harris, E. (1998) Theory in a Nutshell: A Practitioner's Guide to Commonly Used Theories and Models in Health Promotion. Sydney, Australia: National Centre for Health Promotion
[13] Salford PCT, 2008.
[14] Ibid

Figure 1.1. Causal web of factors influencing weight-related problems



Adapted from Ritenbaugh C., Kumanvika S., Marabia A., Jeffery R., and Antipatis V., IOTF website 1999.
Figure 4 - Political, socio-cultural, economic, and personal factors which directly or indirectly influence weight-related problems (weight-related problems: obesity and excessive weight preoccupation)[64].*

The current evidence for achieving population level behaviour change for health gain suggests that the following general principles are followed when implementing programmes of behavioural change at population/community level in any population:[15]

- Base interventions on an assessment of the target group which takes into account their locality and the behaviour/s to be changed
- Work with both the community and other local organisations to design and develop the intervention programme
- Build on the existing skills, knowledge and social networks (assets) within the community
- Understand the barriers to behaviour change and attempt to take account of this e.g. costs of accessing leisure facilities
- Base all interventions on a knowledge of what is known to work
- Train staff to help people to change their behaviour
- Evaluate all interventions

Evaluating the factors that contribute to population level health gain is very difficult due to the complexity and interconnectedness of each factor, thus disentangling cause and effect is very difficult[16];[17],[18]

The NHS's role in system-wide population health gain

The NHS, as the biggest healthcare workforce in Europe, is in a unique position to influence the health and wellbeing of the population in the UK. For many staff working in the NHS interacting with the public and talking about health with them, is an inherent part of their daily working life. In 2012 The NHS Future

[15] (NICE, 2007): NICE (2007) *Behaviour Change at Population, Community and Individual Levels*. http://www.nice.org.uk
[16] Coote A, Allen J and Woodhead D (2004) Finding Out What Works: Understanding Complex, Community-based Initiatives. King's Fund; London.
[17] Medical Research Council MRC (2006) Developing and evaluating complex interventions: new guidance. MRC. 2006
[18] Jee M, Popay J, Everitt A and Eversley J (1999) Evaluating a Whole Systems Approach to Primary Health Care Development. King's Fund Publishing; London.

Forum[19] outlined how the preventative health agenda might be enhanced further and placed at the heart of all NHS activity, improving health of individuals and communities and reducing inequalities in health; the potential opportunities for health gain through staff in the NHS, interacting with the public in a systematic way in order to promote health, was highlighted[20]:

> "*Millions of people talk with a member of NHS staff every day, spanning a diverse range of professions: from doctors and nurses to pharmacists and midwives, from optometrists and dentists to physiotherapists and health visitors – and far beyond. Each day, GPs and practice nurses see over 800,000 people and dentists see over 250,000 NHS patients. There are 31,000 NHS sight tests, while approximately 1.6 million people visit a pharmacy. We can encounter healthcare professionals in our schools, at home and in practices, surgeries and hospitals. Outreach activities by many also means we can meet the NHS in less traditional locations: on high streets, at sports grounds and at supermarkets…There are millions of opportunities every day for the NHS to help to improve people's health and wellbeing and reduce health inequalities, but to take this opportunity it needs a different view of how to use its contacts with the public*" (page 10)

The concept of **Making Every Contact Count** is about realising this potential in everyday encounters between staff and the public within the NHS system, and beyond in the wider public sector workforce.

[19] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_132024.pdf
[20] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/152170/dh_132114.pdf.pdf

2. Making Every Contact Count (MECC)

Making Every Contact Count (MECC) implements the NICE guidance (PH6, 2007) using large scale change methodology to 'industrialise' the delivery of behaviour change into the workforce. It was described as "an innovative whole system response to enable a sustainable commissioner led approach to promoting healthy lives[21]"

The original programme objectives were to:

- Be patient/client focused and 'start where the community/individual is'
- Be simple and flexible adding value to current good practice
- Support the system to change and be generic enough to be added into current services i.e. reinforce commissioning of services
- Support responsive and accountable appraisal processes and procedures to enable the Workforce to succeed
- Address and align the 'Good Business' agenda of the Black Report (2007), Health and Wellbeing Review (2010) and Boorman Review (2009) regarding Health and Well-being at work along with 'Staying Healthy'
- Support the development of measureable outcomes and the effectiveness/efficiency gains required within the current public sector environment
- Support capacity building across the whole workforce so all can respond to opportunities to support or instigate lifestyle behaviour change but not necessarily be experts i.e. be aware of, able and confident to signpost to other appropriate practitioners or services.
- Build a whole system, responsive to health and wellbeing and prevention, not just a programme or illness service.
- Take into account behaviour change[22] focused roles sometimes take responsibility for the totality of the change process when in reality, the contribution to enabling an individual to take the decision to change is made by a chain of contacts with health and social care staff, family and friends.

The concept of MECC as an intervention sits best within socio-ecological theory at the level of community/organisation and group/individual i.e. at the lower end of the systems spectrum. The theoretical component of MECC is about supporting individuals to change behaviour through the use of techniques such as brief advice, brief interventions or motivational interviewing[23]. In evaluating the effectiveness of different interventions it is important to understand the theoretical design, including specific theoretical elements adopted, by the behaviour change intervention as NICE[24] state:

> "*Successful behaviour change interventions or programmes employ effective behaviour change techniques and principles and have a theoretical basis for the design and evaluation – this ensures better outcomes, and helps in understanding why an intervention is effective*"

When developing interventions for individual level behaviour change NICE Guidance[25] recommends that they are designed in such a way as to motivate and support people to:

- understand the short, medium and longer-term consequences of their health-related behaviours, for themselves and others
- feel positive about the benefits of health-enhancing behaviours and changing their behaviour
- plan their changes in terms of easy steps over time
- recognise how their social contexts and relationships may affect their behaviour, and identify and plan for situations that might undermine the changes they are trying to make
- plan explicit 'if–then' coping strategies to prevent relapse
- make a personal commitment to adopt health-enhancing behaviours by setting (and recording) goals to undertake clearly defined behaviours, in particular contexts, over a specified time
- share their behaviour change goals with others.

[21] www.nice.org.uk/usingguidance/sharedlearningimplementingniceguidance/examplesofimplementation/eximpresults.jsp?o=516
[22] Taken from: www.nice.org.uk/usingguidance/sharedlearningimplementingniceguidance/examplesofimplementation/eximpresults.jsp?o=516
[23] NICE (2007) *Behaviour Change at Population, Community and Individual Levels*. www.nice.org.uk
[24] http://publications.nice.org.uk/behaviour-change-phb7 (NICE PhB7, Local Government briefing, 2013
[25] Ibid

Behaviour change theory[26,27] also highlight a number of key components that are fundamental to successful sustained behaviour change processes within individuals, such as:

- Goal setting
- Action planning
- Reinforcement
- Self monitoring
- Habit formation
- Family support/social support
- Preventing relapse

Abraham and Mitchie's taxonomy of behaviour change in discussing the relevant merits of these different elements, refer to – passive components (leaflet giving) – less likely to lead to change - compared with more active forms, such as motivational interviewing; key to successful behaviour change is to enable behaviours to be practised in the relevant environment (community/home); some but not all front line workers are able to reach out to people in the community/home. Others have referred to the nature of the therapeutic relationship as essential in facilitating behaviour change; in particular the use of people who may be socially and culturally similar to the communities served (Kennedy, 2011). This resonates with the work around Health Trainers. The British Psychological Society developed the Health Trainer National behaviour change Competency Framework and training manual.[28] This includes 4 tiers of training, 3 of which are identified as useful for the development of frontline capacity in behaviour change and health gain:

- Health Trainer 1: make relationships with communities
- Health Trainer 2: Communicate with individuals about promoting their health and wellbeing
- Health Trainer 3: Enable individuals to change their behaviour to improve their own health and wellbeing

The potential for frontline workers located within the NHS, and related organisations, to make a difference, to a community's health and wellbeing has also been highlighted as a cost effective means of supporting existing initiatives in other parts of the system.[29]

> "*Engaging the population employed by the public sector in health gain will have a positive impact on population health. This will be achieved by not only raising awareness and positively influencing health behaviours of staff and their families but also by the provision of consistent frontline advice delivered by competent and confident staff to support health-seeking behaviour. This will only be achieved through empowerment of staff and implementation of change management approaches to workforce and organisational development*".

Addressing health gain with system and scale responds to the direction set out in the NHS White Paper, *Equity and Excellence: Liberating the NHS*[30] calling for Workforce development to implement MECC (training support and organisational development)[31]
This mandate also outlines the importance of shared decision-making - 'no decision about me without me' - the partnership approach required between the public and the NHS[32]. Moreover, there is a clearly evidenced link between staff health and wellbeing and patient experience, safety and effectiveness of care (ibid). The case for implementing system-wide approach to behaviour change and health gain – MECC - is strongly provided by this report.

[26] Abraham and Mitchie, 2008
[27] NICE Obesity Guidance, 2006
[28] British Psychological Society Health Psychology Team (2008). Improving health: changing behaviour - NHS health trainer handbook. Department of Health. England
[29] Department of Health (2011). www.gov.uk/government/uploads/system/uploads/attachment_data/file/147344/dh_127728.pdf.pdf
[30] Department of Health (2010). www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353
[31] ibid
[32] www.phorcast.org.uk/document store/1302777427_NJmd_how_...

3. MECC in Salford

Despite decreases in all-cause mortality for most indicators of health, Salford is worse than the national (England) average including with respect to life expectancy. Deprivation is higher than the England average: with the life expectancy gap between least and most deprived areas of Salford being 1.1 years for men and 8.2 years for women.[33] Mortality from heart disease, stroke and cancer are considerably higher than the England average, as are lifestyle related issues such as healthy eating, smoking (including in pregnancy) and sexually transmitted infections. In young people obesity is a key concern with 23.1% of year 6 children being classified as obese. In addition GCSE attainment, teenage pregnancy and alcohol-related hospital stays in the under 18s all indicate are all worse than average. Key public health priorities for action in Salford include reducing harm (including early mortality) from smoking and drinking and improving breastfeeding rates.

The health and wellbeing of people living in Salford is improving, but not sufficiently fast enough to reduce the gap in inequalities between the city and the rest of England. Behaviour change interventions are evidenced to impact on wider public health outcomes through encouraging healthier behaviours and supporting people to maintain their own and their family's wellbeing. Also, individuals with average or above average levels of wellbeing have been shown to demonstrate higher levels of social capital and community belonging.

There are a number of services already delivering behaviour change interventions across Salford. However, this is patchy and uses different approaches and rarely measures outcomes effectively. This programme will provide a systematic and consistent approach to behaviour change in order that the citizens of Salford will receive comparable interventions with any contact with front line staff across the City.

Salford MECC Project objectives:
According to the original documentation Salford MECC[34] set out to deliver

- a city wide front line workforce, skilled and confident to deliver behaviour change interventions
- single monitoring and audit systems consistent across services
- processes for the systematic integration into core organisational business: to include making every contact count into commissioning contracts, staff job descriptions, appraisal processes and mandatory training within organisations across the City
- Promotion of wellbeing through every contact between front line staff and citizens across the City.

Strategic Fit
Salford MECC was focused on individual behaviour change, and aligned with the social marketing programme for Salford, which aimed to shift the cultural context for behaviour change. It reflected current national policy and supported Salford's neighbourhood reform programme, including the Way to Wellbeing Service and the Prevention and Early Intervention Service. Improving the public's health had been identified as a priority in the strategic objectives of key local partners including those for Hundreds Health Salford, Salford Royal NHS Foundation Trust's Public Health Strategy, the Salford City Council Cabinet work plan and the NHS Salford Strategic Commissioning Plan.

The project was strategically aligned with NHS Salford's Vision Statement of;

> "*NHS Salford will work with its partners to improve the health, well being and social care of the people of Salford, commissioning a movement of resources from hospitals to communities and preventative services*"

The project was also strategically aligned with Salford City Council's Vision Statement of:

[33] Salford Health Profile (2012)
[34] Salford Project Initiation Document (PID)

"*In 2016, Salford will be a beautiful and welcoming city, driven by energetic and engaged communities of highly skilled, healthy and motivated citizens, who have built a diverse and prosperous culture and economy, which encourages and recognises the contribution of everyone, for everyone*"[35].

Benefits
The project (Salford MECC) objectives were developed to result in the summary benefits of:

- increased use of self care and positive behaviour change choices
- consistent core messages provided to individuals with signposting into appropriate services
- appropriate referrals into specialist services
- greater efficiencies across the City through shared processes
- increased health and wellbeing for the citizens of Salford.

Method of Approach
Salford MECC was developed as a partnership initiative with NHS Salford and Salford City Council providing the leadership and programme management. City wide services were involved in the co-production of the programme from both the public, independent and voluntary and community sectors. This included housing providers, environmental health, children's services, Citizens Advice Bureau, the Fire Service as well as NHS providers and social enterprises.

The Salford MECC programme consisted of 2 work streams (components):
Workstream 1 - Workforce training to ensure that frontline staff are trained to the same set of competencies and are supported to deliver quality behaviour change interventions by their managers. Included within the scope of this work stream:

- Commissioning of a training provider to develop and deliver phase 1 training for key staff groups in both the public, voluntary/community and independent sectors against a set of competencies
- Commissioning of a training provider to train a core team of trainers to deliver phase 2 of the training
- Development of a self assessment audit tool for services to undertake workforce audit for behaviour change across the 3 levels
- Development and use of a single assessment tool and impact monitoring tool
- Consultation by the training provider with service users and frontline staff and managers in the development of materials and modules

Work stream 2 – Sustainability to ensure a systematic, consistent city wide application, where feasible using shared resources and systems. Included within the scope of this work stream:

- Leadership and co-ordination using change management approaches across all levels of the partnership
- Engagement of managers to support delivery of behaviour change interventions
- Core competencies for levels 1, and 2 to be included in relevant job descriptions and assessed through appraisal systems
- Mandatory and induction training programmes to include behaviour change modules
- Commissioning and contracting to include behaviour change intervention indicators
- Organisations to have staff behaviour change interventions in place
- For service effectiveness to include monitoring and governance

The Commissioners - also agreed to develop a number of tools for services to:

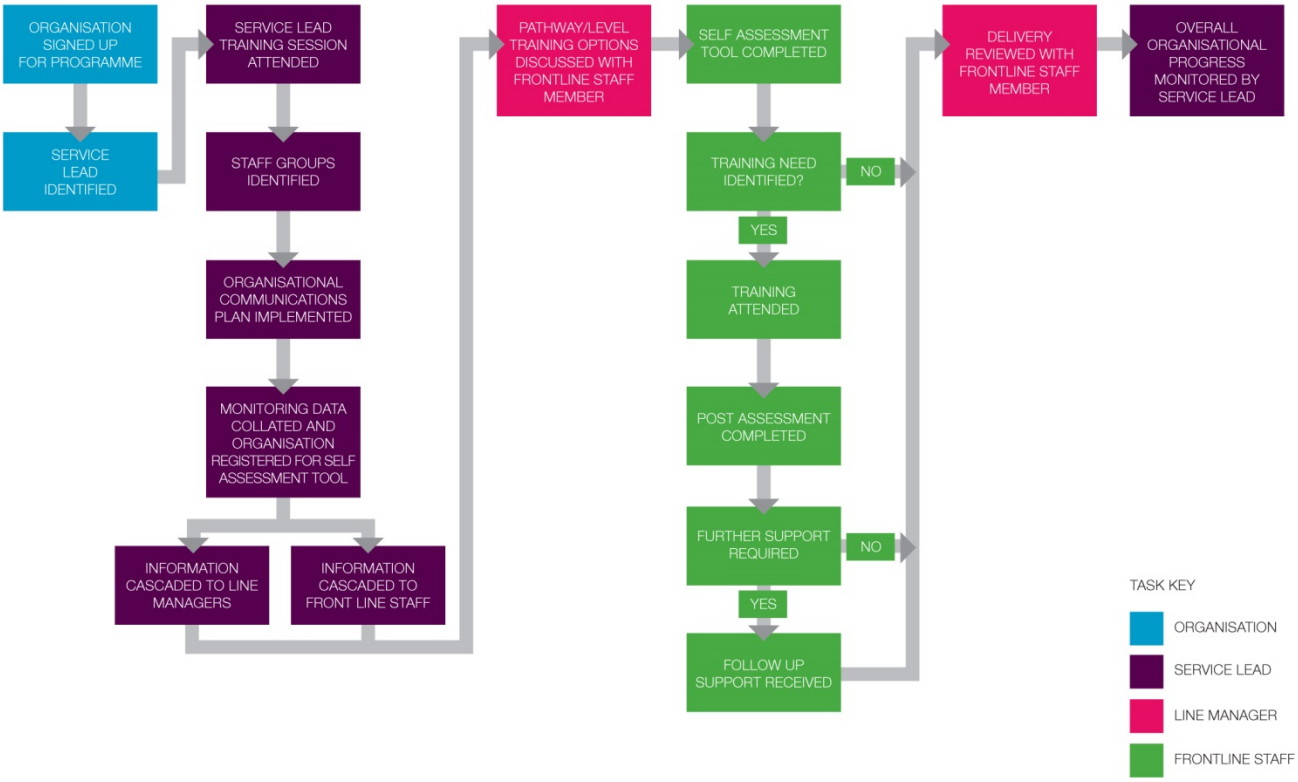
- Assess their frontline workforce against the competencies drawn from national and regional sources and tested locally
- Monitor delivery of behaviour change interventions
- A single services information database

[35] (The Salford Plan)

The Process

Details of the process for MECC can be found within the online Communication Toolkit. [36] In summary (Figure XXX), once an organisation is signed up to MECC, a service lead is identified who implements and oversees delivery of the training programme within their organisation. Line managers will then support staff to complete the assessment and training and help them embed Making Every Contact Count into practice. Front line staff are the prime beneficiaries of the programme.

Figure XX.MECC in Salford pathway (@ January 2012)



Training

Following an evidence review,[37] the training element of the MECC programme was developed focusing on how staff need to appreciate the range of lifestyle and other factors that can influence health and wellbeing.[38] 10 key topics in which staff need basic knowledge were identified: Housing, Employment, Welfare Benefits and Tax Credits, Money and Debts; Smoking, Weight Management, Substance Misuse (including Alcohol), Physical Activity, Emotional Health & Wellbeing and Sexual Health. Crucially, staff also need to be able to quickly assess a person's need and motivation to change and be confident to encourage people to take small steps along the stages of change journey by, where appropriate, strengthening self-care, delivering brief advice or a brief interventions, signposting to other sources of help, or by making a quality referral.

The training events were held across a range of venues, times and locations across the city and consisted of:

- Level 1 Introductory (2 ½ hours) - engagement, self-care & signposting
- Level 1 Intermediate (3 ½ hours) - delivering brief advice
- Level 2 (1 day) - supporting behaviour change, brief interventions & specific topic-based learning

[36] MECC in Salford (2012). Communications Toolkit
[37] Behaviour Change Consortium (2011). NHS Salford Health Gain Programme Literature Review: Report to Client
[38] Hope M, McArthur A, Herne D (2013). MECC in Salford – presentation at the World Social Marketing Conference, Canada. http://wsmconference.com

Outcomes Framework

The programme was designed to deliver outcomes for end users, for the front line workforce and assist services in achievement of their delivery targets. Staff would be trained to engage and provide consistent core messages, signposting and referral to specialist services, enabling people to find it easier to self care, and make choices early about their behaviours which will impact on their own and their family's health and wellbeing.

The **outcomes framework** consisted of the 3 critical strands of

1. System Outcomes,
2. Organisational Outcomes and
3. End User Outcomes.

Systems Outcomes:

- Organisations have embedded behaviour change interventions into service development through the inclusion of behaviour change statements/ measures in job descriptions, behaviour change modules included as part of staff induction and mandatory training programmes
- Successful roll out of a comprehensive citywide behaviour change intervention programme
- Development of a highly skilled, knowledgeable and motivated frontline workforce that is confident in delivering behaviour change interventions to the Salford population.
- Identified clear social return on investment and efficiency cost savings/outcomes.
- Improved collaborative working arrangements across Salford organisations
- Commitment and engagement of senior leaders across services to sustain the long term benefits and impact of behaviour change training

Outcomes for organisations including frontline staff:

- Frontline staff who have attended the behaviour change training are skilled and equipped to confidently deliver effective behaviour change interventions to the Salford population.
- Increased quality of end user and front line staff contact/ consultation experience
- Increased behaviour change interventions contributing to the achievement of organisational objectives and outcomes.
- Increased numbers of front-line staff are trained to common core behaviour change competency standards (skills, knowledge and understanding) across multiple organisations.
- Staff commitment and understanding of the importance of delivering effective behaviour change training in achieving the organisation's core business as well as utilising the skills for supporting positive behaviour change outcomes for end users.
- Increased number of behaviour change interventions delivered by staff as part of their daily working practice
- Effective system(s) in place to continually monitor the delivery and quality of service delivery.
- A reduction in inappropriate referrals to specialist services.

Outcomes for end users:

- End users' concerns/issues are discussed and raised sensitively, timely and solution focused
- Increased confidence in one to one consultations to discuss multiple issues
- Increased opportunities in receiving behaviour change interventions at a time and location that are more suitable and convenient.
- Increased proactive action planning, advice, information and support received by a range of services
- Improved motivation to change health and wellbeing behaviours due to ongoing quality client /professional interactions/ relationships

The above outcomes framework was used by the Evaluation Partnership to develop the evaluation strategy and inform the development of evaluation indicators and data collection tools outlined in the following section (chapter 4).

4. Evaluation Strategy: Aims, Methodology & Approach

In December 2011 The Evaluation Partnership (EP) was commissioned by NHS Salford to design an independent, prospective evaluation to assess whether the original objectives of Salford MECC were achieved and to identify what can be improved for the future. This was achieved through consideration of (a) the inputs i.e. what went into the activity, in terms of time, materials and resources (b) was it delivered according to plans (c) how well was it delivered and (d) what has been achieved (Outcomes). The evaluation was commissioned by Salford NHS and was therefore external and independent. Having said this, the tender was specific and prescriptive in outlining the broad expectations for the evaluation strategy. The Evaluation Partnership liaised closely with the MECC Evaluation Commissioning Group and relevant stakeholders to ensure the design of the evaluation could meet these expectations through an iterative design (Figure 1.2)

Figure 1.2. Double-helix iterative approach to evaluation

The iterative design was recognised as a defining feature of the evaluation strategy. As such the evaluation was flexible and responsive, acknowledging the evolving nature of the Salford MECC initiative, in a complex and changing social and organisational environment. As such, as detailed in this chapter, certain aspects of the evaluation strategy and data collection were adapted as necessary.

The **overall aim of the *evaluation*** of Salford MECC was:

> *To assess whether the implementation of the Salford MECC Programme has been successfully embedded in organisational procedures in relevant organisations in Salford and has been effective in terms of training front-line staff to deliver behaviour change interventions and benefiting service users health and wellbeing.*

The **objectives** for the evaluation of Salford MECC were:

1. To assess impact of the MECC Programme on services, beneficiaries' (frontline staff) and end users (public)
2. To review the approach used for scaling up a systematic behaviour change intervention across the City.
3. To assess whether the MECC Programme provides value for money
4. To review the sustainability of the approach used to embed the behaviour change interventions into service delivery across service providers

Methodology

The methodological approach underpinning the Evaluation is Stakeholder Evaluation.[39] This emphasises the involvement of the different Stakeholders in the design and/or implementation of the evaluation. Key stakeholders for evaluations of public health programmes fall into three major groups:

1. Those involved in programme operations: Management, programme staff, partners, Organisations involved in delivery, funding agencies.
2. Those *served* by *or affected* by the programme: Patients or clients, community members, Organisations and staff responsible for delivery.
3. Those who are intended *users* of the evaluation findings: Persons in a position to make decisions about the programme, such as partner organisations, funding agencies.

Stakeholder Evaluation is a process of individual and collective learning and capacity development through which people and organisations involved become more aware and conscious of their strengths and weaknesses, and their visions and perspectives of development outcomes. This learning process creates conditions conducive to change and action: it can (i) emphasise varying degrees of participation (from low to high) of different types of stakeholders in initiating, defining the parameters for, and conducting Monitoring & Evaluation (M&E); (ii) is a social process of negotiation between people's different needs, expectations and worldviews; and iii) is a flexible process, continuously evolving and adapting to the programme specific circumstances and needs.[40] Secondly, we know that an approach delivered in one context does not necessarily replicate or suit subjects in another context in the same way. So learning from the evaluation rightly focuses on what works, for whom and in what circumstances. The development of Salford MECC also benefited from a detailed analysis of the relationship between original programme objectives and mechanisms at a system-wide level and how these translate into the way the intervention operates on the ground. This was informed by 'Theories of Change[41]', the MRC guidance on evaluating complex interventions[42] and systems theory[43] .

Evaluation Design

The Evaluation adopted a longitudinal design, incorporating process data and outcome measures. The Evaluation was designed over a longitudinal (20 month) period, pre and post-test mixed method study, utilising Process and Outcome forms of evaluation.

(i) Process Evaluation

Process evaluation data was collected in consultation with stakeholders, using information collected as part of self-assessment and monitoring. This was collated and supplemented with Primary data collected from individuals, namely beneficiaries of the training front line workers (FLW) and other staff employed within the organisations with responsibility for implementing the Programme (Service Leads and Line Managers). It had been intended to collect data, via on-line surveys, focus groups and case studies.

The final objectives relating to the evaluation of organisational systems and processes were agreed in consultation with key stakeholders during the initial 'familiarisation' phase (months 1-4). It was anticipated from the outset that key questions addressed by the evaluation would focus on Organisational Preparedness, Delivery of the Programme, Equity and Efficiency.

(ii) Outcome Evaluation

The Impact/Outcome evaluation utilised:

[39] Robert Wood Johnston Foundation (2009). www.rwjf.org/content/dam/web-assets/2009/01/a-practical-guide-for-engaging-stakeholders-in-developing-evalua

[40] (Estrella, 1997).

[41] (Pawson 2002[41]),

[42] Medical Research Council MRC (2006) Developing and evaluating complex interventions: new guidance. MRC. 2006

[43] Coote A, Allen J and Woodhead D (2004) Finding Out What Works: Understanding Complex, Community-based Initiatives. King's Fund; London.

(a) primary date collected through interviews and on-line surveys. It was originally intended to also utilise case studies and focus groups.
(b) health related knowledge and behaviour questions from two Salford Surveys (if available) to assess trends in the population.

The data tools utilised for each of the evaluation measures developed against the projects outcomes are listed below in (Table 1.1).

Table 1.1. Evaluation measures developed for the programme Outcomes, with proposed collection tools for each measure (signed off 7th July 2012)

Systems Outcomes (MECC Programme)	**Evaluation Measures** (EP team)	**Measurement Tools** (various sources)
1. Organisations have embedded behaviour change interventions into service development through:	• SL & LM state that there is increased inclusion of MECC in staff induction and performance targets	SL/LM interviews
a) the inclusion of behaviour change statements/ measures in job descriptions;	• SL & LM state that there is increased inclusion of MECC in job descriptions for relevant staff groups	SL/LM interviews
b) behaviour change modules included as part of staff induction; and	• SL & LM state that appraisal programmes include review of appraisees performance in MECC • SL and LM state that the organisation completed a sustainability plan?	SL/LM interviews
c) mandatory training programmes.	• There is a communication strategy for MECC	SL/LM interviews
how has the organisation communicated the vision of MECC and does this fit with the organisations vision? Question 6 in SL and LM Interview Schedule Etc	• % of organisations' where MECC is mandatory part of staff training; including training for Managers of frontline staff • Inclusion of MECC in the CQUIN, LES or contracts as a stimulator	SL/LM survey
2. Successful roll out of a comprehensive citywide behaviour change intervention programme.	• Number of organisations who have signed off Service Offers • Number of organisations with Action Plans in place • Increasing numbers of staff have completed the SAT • Increasing numbers of staff attended MECC training • Increasing numbers of staff completing the MECC training (incl post assessment) • Factors enhancing or hindering provision, implementation and uptake by staff; for example capacity to undertake this work * also by indicators of staff outcomes See 7-13	Profile of Organisations MECC OF Performance reports MECC OF Performance reports SAT (pre- & post- training) Training provider data SL/LM interviews / case studies & survey

3. Development of a highly skilled, knowledgeable and motivated frontline workforce that is confident in delivering behaviour change interventions to the Salford population.	• % staff at each level who have attended MECC training who are confident to use the approach advocated by MECC	
	• Quality indicators in terms of knowledge, confidence & skills	SAT (pre- & post- training)
	• Appropriate referral	Staff interviews & survey
	* also by indicators of staff outcomes	See 7-13
4. Identified clear social return on investment and efficiency cost savings/outcomes.	• Ratio of costs (MECC inputs) to benefits (at workforce and population level)	tbc - look at NCSM tool for VfM and see if that can be adapted
	• Comparison between cost of this intervention and comparable interventions	tbc - NICE to discuss
5. Improved collaborative working arrangements across Salford organisations.		
	• Factors enhancing or hindering collaborative working	Staff interviews & survey
	• Increased signposting to additional information of services	MECC Delivery metrics
6. Commitment and engagement of senior leaders across services to sustain the long term benefits and impact of behaviour change training.	• Number of organisations who have signed off Service Offers by quarter	MECC OF Performance reports
	• Strategic and workforce plans demonstrate commitment to MECC	SL/LM interviews & survey
	• There is an effective communication strategy for MECC	SL/LM interviews & survey Plus review of a sample of: • Strategic documents • communication briefings
		Dependent on external data sources

Outcomes for frontline staff:	Evaluation Measures	Measurement Tool
7. Frontline staff who have attended the behaviour change training are skilled and equipped to confidently deliver effective behaviour change interventions to the Salford population.	• % staff at each level who have attained satisfactory levels of knowledge and skills, according to agreed competencies, to enable them to undertake behaviour change interventions with people using their service	SAT (pre- & post- training)
	• % Staff feel 'satisfied' that the training received equips them to deliver behaviour change interventions	Staff interviews & survey
	• Quality indicators in terms of knowledge, confidence & skills, including staff competent to deliver	Staff interviews & survey
8. Increased quality of end user and front line staff contact/ consultation experience	• % Staff feel confident in raising issues with clients	Staff interviews & survey SAT (pre- & post- training)
	• Staff can explain improved quality of experience of delivering interventions	Staff interviews & survey
	• Staff providing examples of good experiences of delivering interventions	Staff interviews & survey
9. Increased number of behaviour change interventions: **a)** contributing to the achievement of organisational objectives and outcomes **b)** delivered by staff as part of their daily working practice	• Numbers of interventions delivered over time	MECC Delivery metrics
	• Number of interventions delivered against the Action Plan target	MECC OF Performance reports
	• Quarterly increase in number of behaviour change interventions delivered by staff as part of their daily working practice [incentivised organisations only]	MECC Delivery metrics
	• Staff indicating an increase in delivery of interventions	Staff interviews & survey

10. Increased numbers of front-line staff are trained to common core behaviour change competency standards (skills, knowledge and understanding) across multiple organisations.	• Specified increase in the number of trained staff • Staff identified • SAT undertaken • Training undertaken • Cumulative increase in Staff competent to deliver	SAT (pre- & post- training) ; Training provider data SAT (pre- & post- training) ; Training provider data SAT (pre- & post- training) ; Training provider data SAT (pre- & post- training) ; Training provider data
11. Staff commitment and understanding of the importance of delivering effective behaviour change training in achieving the organisation's core business a) as well as utilising the skills for supporting positive behaviour change outcomes for end users.	• Quality indicators – staff understanding their role as advocates for health and wellbeing • Factors enhancing or hindering delivery of interventions • SL & LM engaged • Skills utilised with end users	Staff interviews & survey Staff interviews & survey Staff interviews & survey Staff interviews & survey
12. Effective system(s) in place to continually monitor the delivery and quality of service delivery.	• Relevant and appropriate Monitoring systems developed and in place	MECC Performance reports
13. A reduction in inappropriate referrals to specialist services.	• Staff understanding difference between signposting and referrals • Staff stating that referral pathways are clearer • Staff stating that referrals are more appropriate	SAT (pre- & post- training) Staff interviews & survey Staff interviews & survey
		Dependent on external data sources

Outcomes for end users:	Evaluation Measures	Measurement Tool
14. End user's concerns/issues are discussed and raised sensitively, in a timely and solution focused way	• [Unable to develop]	
15. Increased confidence in one to one consultations to discuss multiple issues	• [Unable to develop]	
16. Increased opportunities in receiving behaviour change interventions at a time and location that are more suitable and convenient.	• % Increased levels of participation in health related behaviour services locally • Changes over time in designated service utilisation	Lifestyle survey
17. Increased proactive action planning, advice, information and support received by a range of services	• [Unable to develop] • % Increase in local people's awareness of the need for behaviour change	Lifestyle survey
18. Improved motivation to change health and wellbeing behaviours due to ongoing quality client /professional interactions/ relationships	• % Increase in participants' knowledge of opportunities for health related behaviour change	
19. Improved user experience	• [Unable to develop]	Dependent on external data sources

5.a. MECC in Salford Project & Evaluation Timeline

The MECC in Salford evaluation was intended to be iterative and formative with on-going review and modification based on feedback (see double-helix above). Table 5.a.1 summarises the project timeline as defined by the original project plan and by changes identified during the evaluation.

A Phase 1 closure report[1] covering September 2011 to March 2013 was produced in early April 2013 when the project entered Phase 2.

Modifications to the evaluation

As a result of 1) changes to the MECC project overall and 2) iterative development of the evaluation tools, several major changes were made to the original evaluation plan. These are detailed in the sections below but in summary consisted of:

1. Self-assessment tool (SAT) – many of the evaluation measures were designed around agreed access to the database underpinning the SAT. During the feedback/revision of the MECC process in July-Sept 2012, the database was overhauled and modified. How these changes affected the evaluation are documented in Section 5.b.
2. Additional interviews – in May 2012 the evaluation team were asked to support a refresh review by interviewing Chief Executives and Heads of Services as well as members of the MECC Delivery Team. These were done at the request of The Delivery Team to provide them with an insight into the implementation of MECC, which subsequently resulted in some changes to the approaches being taken. These also provided additional qualitative information for the evaluation (see Section 5.d iv).
3. Case studies – to add depth and detail to the main evaluation findings, case studies were originally proposed as longitudinal stories. However, participants were not forthcoming and the MECC project also requested case study data as an adapted monitoring process. In agreement with the MECC Evaluation Commissioning Group (see Section 5.e), case studies were not carried out.
4. End User evaluation – this was originally proposed as a possible part of the evaluation, with reservations about how realistic it would be to deliver, and indeed how meaningful it would be within the timescales in relation to behaviour change. In the end (see Section 5.f), end user evaluation was not carried out as agreed by the Delivery Team.
5. Social Return on Investment – the original evaluation plan included a proposal to identify data that could be used for economic analysis. Discussions with the delivery team identified that this was not achievable within the scope and timescales of the evaluation (see Section 5.g).
6. Performance Monitoring data - Several of the evaluation measures were designed around the proposed collection of monitoring data. Following difficulties in collection of such data and changes to how organisations were monitored[2], these indicators could not be achieved.
7. Given difficulties in recruitment for interviews and case studies as well as iterative discussions around end user/SROI evaluation, the evaluation team were awarded an extension to the contract to enhance communications and recruitment and to include additional time for write-up of the final report.

[1] Anderton R (2013). Making Every Contact Count in Salford: end stage report.
[2] MECC in Salford (Oct 2012). Monitoring for Impact.

Table 5.a.1. Timeline summary

	Stage	Time	Consisting of:
1	Project Initiation	May'11 to Jan'12	Project Board Stakeholder Reference Group Project Delivery Team Business Case
2	Documents & Assessments	Jan'12 to May'12	Project Initiation Document Intellectual Property Rights Equality Impact Assessment Privacy Impact Assessment
3	SAT development & testing	Aug'11 to Mar'12	Design Development, Testing User Acceptance Review, Amendments
4	SAT redesign	Jun'12 to Sep'12	User feedback Training review Development, Testing Launch
5	SAT revision	May'13 to Sep'13	Stakeholder Review Ongoing …
6	Stakeholder engagement	Sept'11-Mar'12	Early Implementors
7	& roll-out	Mar'12-Sep'12	Wave 2
8	& roll-out	Aug'12-Mar'13	Wave 3
9	& roll-out	Apr'13 -	Waves 4+ ongoing …
10	Training development	Sept'11-Mar'12	Early Implementors
11	& delivery	Mar'12 -	Wave 2
12	revisions & re-launch 2012/13	Sept'12 -	Wave 3
13	revisions & re-launch 2013/14	Apr'13 -	Waves 4+ ongoing …
14	Marketing & Communications	May'11 to Aug'13	Planning Toolkit development Briefings & Newsletters Email lists & Logistics Website development Sharepoint site
15	Sustainability	Jan-Jun'12	Consultation workshops
16	Monitoring	Jun-Jul'12	Agree tasks, PI's and Monitoring
17	Train the Trainer	Jul-Aug'12	Develop content & Deliver
18	Communities of interest	Jun'13 -	Stakeholder led with support ongoing …
19	Evaluation - main project	Jan'12 to Jun'13	Familiarisation Development of outcome measures & tools Data collection Reporting
20	Executives/ Del Team	Aug-Sep'12	Additioinal interviews for review/refresh
21	Enhanced comms & extension	Oct-Dec'12	Communication & Recruitment boost

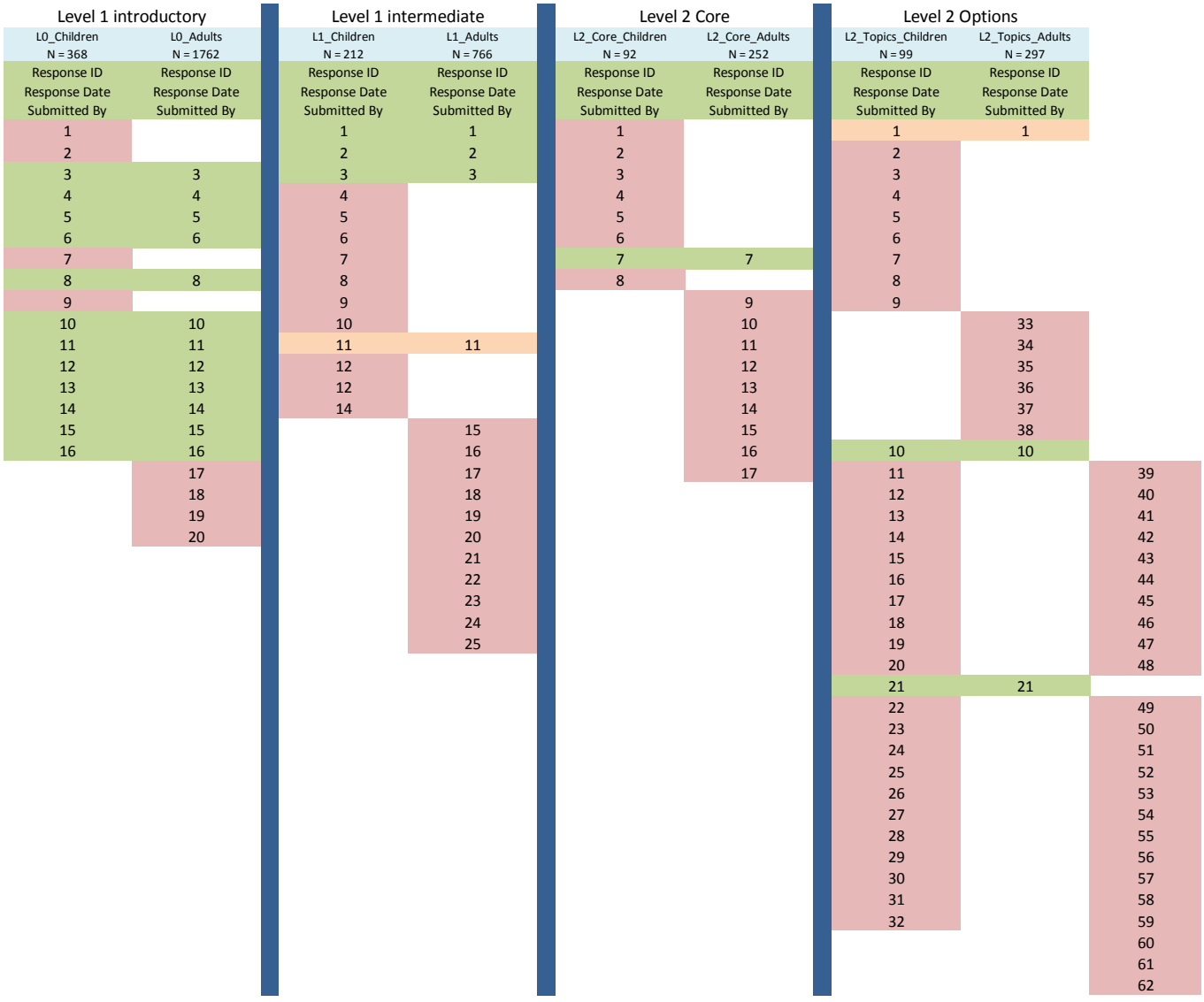
5. b. Self-Assessment Tool (SAT) Analysis

Methods

The entire self-assessment tool (SAT) database was obtained from Salford Council by secure SFTP data transfer. This included a list of 'users' and resonses to the SAT questionnaire for both pre- and post-revision of the SAT. Inclusion criteria for analysis of the SAT were all records designated as 'Active Users'. Records were excluded if they were coded as 'Assessment not required', email prefixed with 'DELETED…' and/or they were labelled as 'Test'.

- The initial SAT database comprised 3 different MECC delivery levels and 4 sets of questions:
    - Level 1 introductory
    - Level 1 intermediate
    - Level 2 core
    - Level 2 topic options
- In addition each level had the options of 'Children & Young People' (C&YP) and 'Adults' and the SAT questions for these differed in details
- Questions were compared and reconciled and Figure 1 shows a summary of the complexity of Version 1 of the SAT
- Data from C&YP and Adults SAT were merged into the four Level SAT tables for analysis
- In addition to these, the same questions were also asked in a post-training Version 1 SAT at each level for staff who 'failed' the initial SAT and who underwent training

Figure 5b.1. Summary of identical (green), similar (orange) and unique (pink) questions for SAT Version 1



- The revised Version 2 SAT (September 2012) was developed to help simplify the MECC training process and Figure 2 shows the simplification of the SAT questions as a result.
- Level 1 and Level 2 responses were merged into one table for analysis
- In addition to these, the same questions were also asked in a post-training Version 2 SAT at each level for staff who 'failed' the initial SAT and who underwent training

Figure 5b.2. Summary of identical (green) and unique (pink) questions for Version 2 of the SAT

Level 1		Level 2	
L1 N = 843		L2 N = 455	L2	L2
Response ID Response DateTime Submitted By		Response ID Response DateTime Submitted By		
1		1	33	65
2		2	34	66
3		3	35	67
4		4	36	68
5		5	37	69
6		6	38	70
7		7	39	71
8		8	40	72
9		9	41	73
10		10	42	74
11		11	43	75
12		12	44	76
13		13	45	77
14		14	46	78
15		15	47	79
16		16	48	80
17		17	49	81
18		18	50	82
19		19	51	83
20		20	52	84
21		21	53	85
22		22	54	86
23		23	55	87
24		24	56	88
25		25	57	89
26		26	58	90
27		27	59	91
28		28	60	92
29		29	61	93
30		30	62	94
31		31	63	95
32		32	64	96
				97
				98
				99
				100
				101

1. Overview – SAT Users

- The number of active registrations on the Self-Assessment Tool (SAT) increased rapidly during the launch and testing phase, which continued at a steady pace throughout 2012, with:
    - an average of 160 new registrations added each month from Dec 2011 to Dec 2012
    - a slight hiatus in August 2012 (with just 80 new registrations added) during the time of the revision and re-launch
    - a subsequent halt in new registrations during the first 4 months of 2013

- By 23rd April 2013, there were 2,214 active registrations:
    - Just over 1,600 (73%) were level 1 and around 600 (27%) were level 2 staff
    - Level 1 introductory (listed as Level 0) ceased in August 2012, when both Level 1 categories were merged
    - Around 1,300 registrations were NHS staff, nearly 600 were Council staff and 350 were from other organisations
    - The Council were engaged in the SAT early on (with 80% of their users registered by April 2012) and NHS/Other organisations involved more slowly
    - There was a big boost in new registrations from Other organisations in June 2012 and a big boost from NHS staff in December 2012

- There were registrations from 26 different Organisations on the SAT by April 2013; each with varying proportions of Level 1 and Level 2 staff. The total number of unique staff registered was (because staff had to enter again to undertake post-training assessment).
    - As well as the Council and Salford Royal, there were staff from 7 smaller NHS and 16 other organisations registered

- Overall, 64% of staff (1,200) taking the SAT 'passed' – ie. they were already MECC compliant and 36% 'failed' (660) – ie. were identified as requiring training. However, 350 active users still had not taken the SAT by April 2013.
    - the average number of SAT completions between Dec 2011 to Dec 2012 was 136 per month

- It is not possible to accurately identify the numbers of staff that had been trained from within the SAT database, but according to the SAT records:

    - a total of 450 staff had set a training date
    - around 400 staff had completed the post-training questions (to 12th April 2013)
    - therefore analysis of post-training is based upon responses to the post training questionnaires at the different levels
    - Around one in 10 of trained staff (11%) 'failed' the post-training assessment – a total of 43 staff

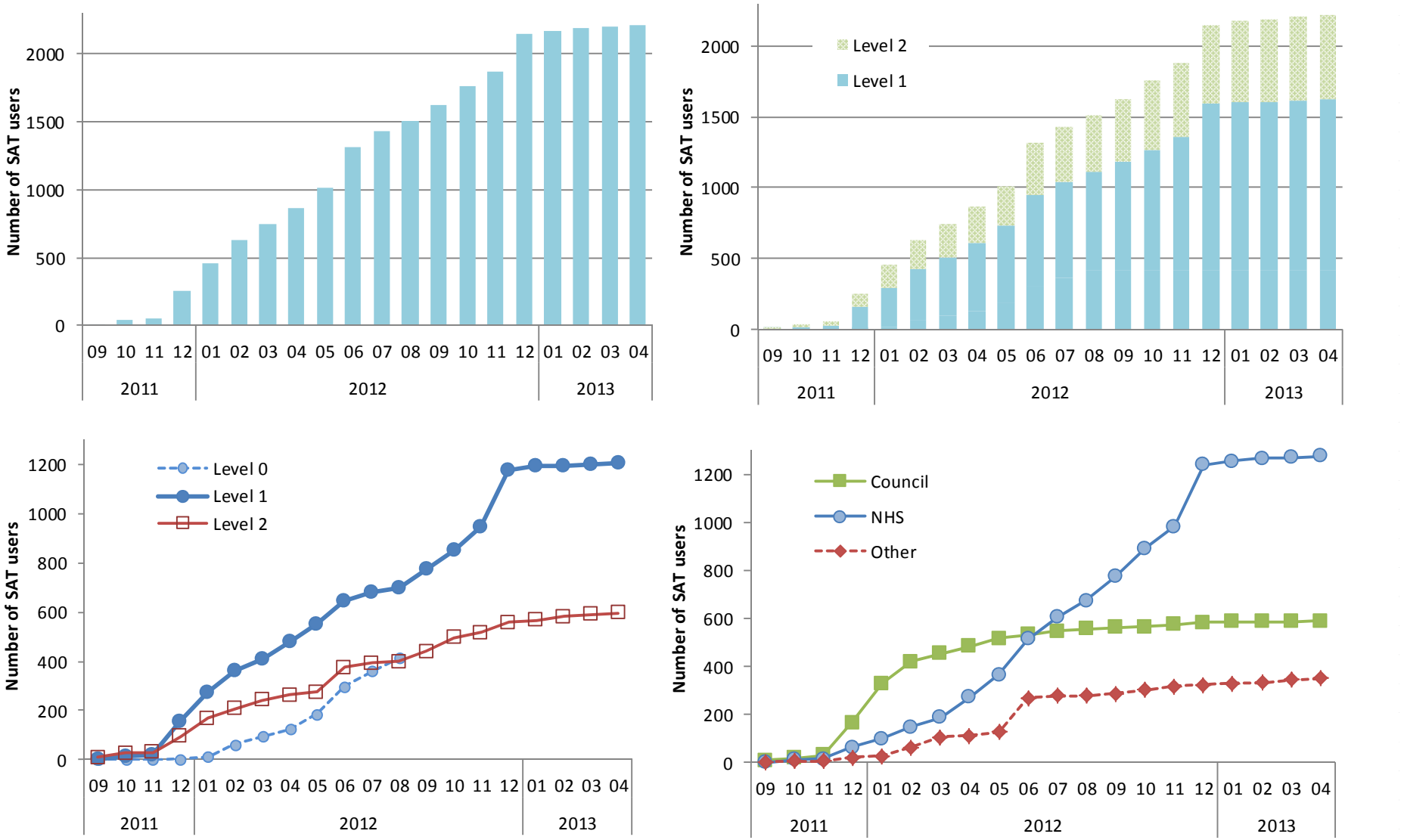


Figure 5b.3. Summary of cumulative numbers of SAT users overall and by level and organisation.

Table 5b.1. Summary of SAT users by organisation.

Name	Total	Level 1	Level 2
Council			
Salford City Council	589	71%	29%
NHS			
Blackfriars Medical Practice	4	75%	25%
Chapel Medical Centre	5	80%	20%
Langworthy Cornerstone	9	100%	0%
Lifeline	12	8%	92%
Oaklands Hospital	82	98%	2%
Salford Foundation	18	61%	39%
Salford Heart Care	5	40%	60%
Salford Royal	1130	80%	20%
Other			
Age Concern Salford	41	51%	49%
Big Life Centres	10	70%	30%
CAB	13	92%	8%
City West Housing Trust	12	92%	8%
GMFRS (Salford)	8	100%	0%
Heart Start Salford	3	100%	0%
Prince's Trust - Fairbridge Programme	1	0%	100%
Salford Care Centre	7	71%	29%
Salford City College	141	42%	58%
Salford Community Leisure	19	74%	26%
Salford Police	22	82%	18%
Salix Homes Ltd	11	82%	18%
Six Degrees Social Enterprise	23	13%	87%
Social Adventures	12	58%	42%
Unlimited Potential	24	8%	92%
Work Solutions	3	67%	33%
Unknown	15	67%	33%

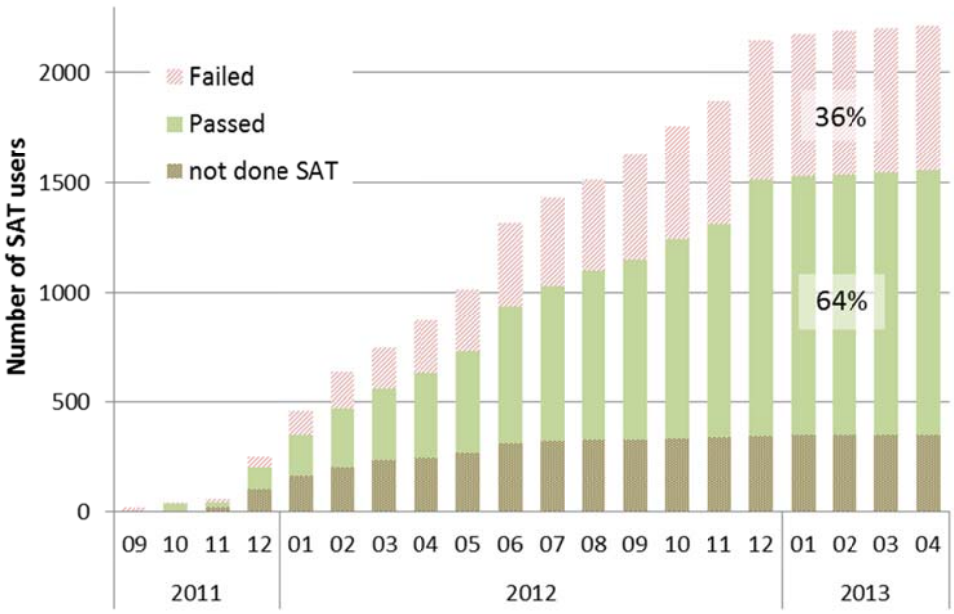
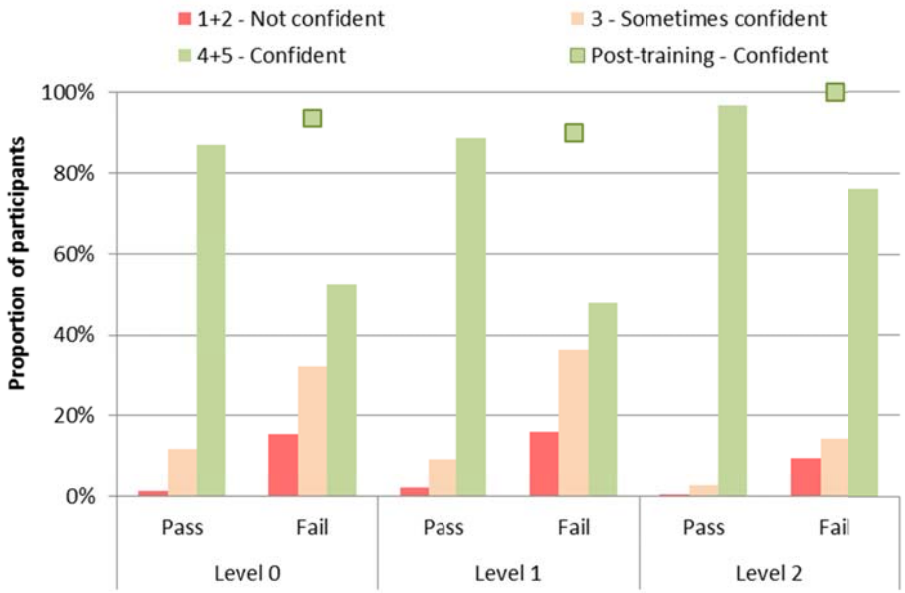


Figure 5b.4. Summary of cumulative numbers of SAT users by outcome status.

2. Staff confidence

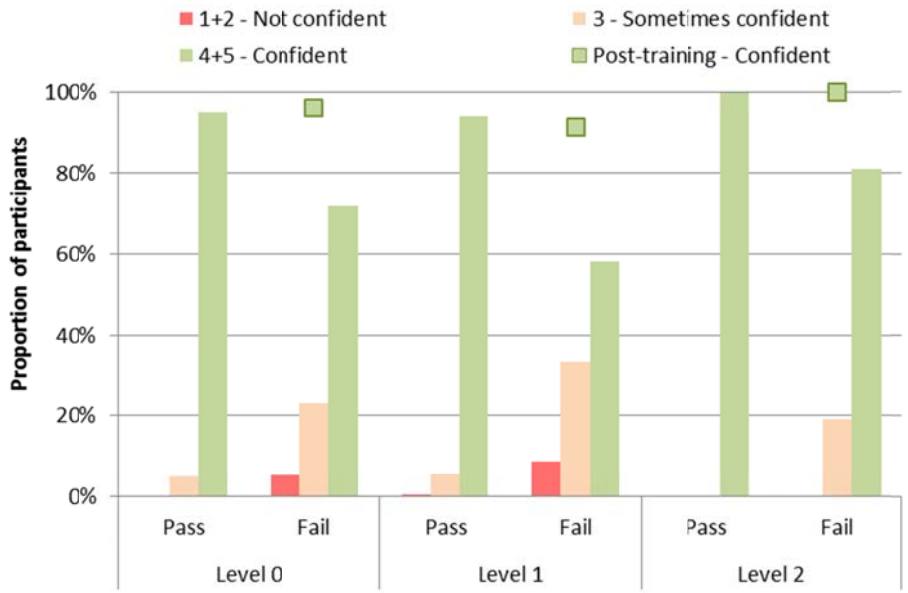
a) Confidence was asked from all users in Version 1 of the SAT by:

Figure 5b.5. How confident do you feel raising issues relating to a service users lifestyle factors that are causing you concern? E.g. You are concerned about the service users debt problems / sexual health behaviour / housing situation.



Confidence was similarly high (over 87%) in all staff who 'passed' the SAT, regardless of staff levels but lower In those that 'failed' the SAT (50% of Level 0/1 and 75% of Level 2). After undergoing training and retaking the SAT, the proportion stating that they were confident increased to almost everyone in all three levels.

Figure 5b.6. Are you confident in chatting to people about how they are feeling? i.e. Can you hold an open and comfortable conversation with someone about their experiences of issues affecting their wellbeing?



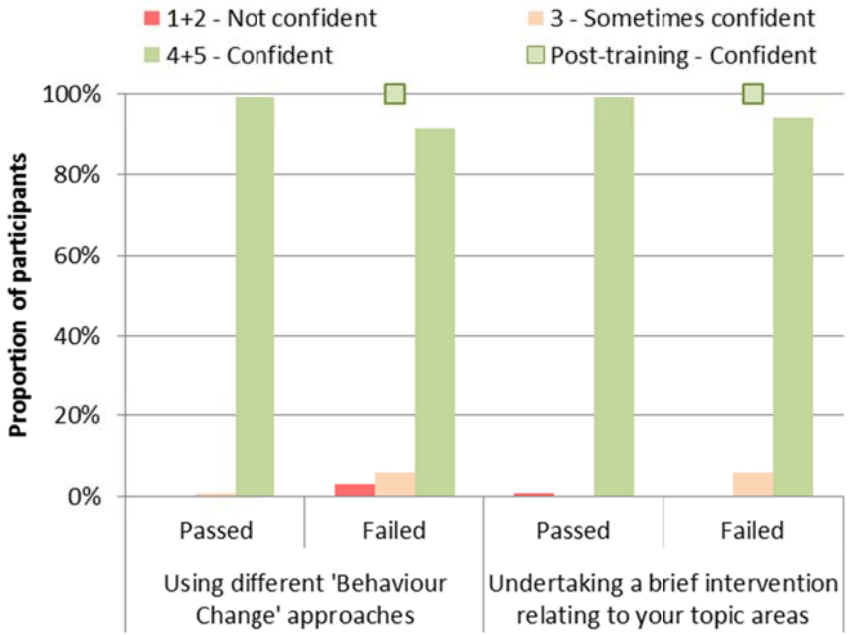
Confidence was similarly high (over 94%) in all staff who 'passed' the SAT, regardless of staff levels but lower In those that 'failed' the SAT (60% - 80%). After undergoing training and retaking the SAT, the proportion stating that they were confident increased to almost everyone in all three levels.

b) For Level 2 staff in Version 1, confidence was asked by:

Figure 5b.7. Do you feel confident about using different 'Behaviour Change' approaches? A 'Behaviour Change approach' is a collection of strategies for structuring a conversation with a client / patient that guides and enables the person to talk and consider behaviour change and where the client /patient's concern are central. Behaviour Change approaches are based on theories of how and why people make changes to their behaviour.

And

Do you feel confident to undertake a brief intervention relating to your identified Level 2 optional topic areas?



Confidence was high across the board and only marginally lower in those who ‘failed’ the SAT. However, this increased to 100% for these individuals following training.

3. Confidence was asked in Version 2 of the SAT by:

Figure 5b.8. How confident do you feel talking openly to people about elements of their lifestyle that are causing concern? This includes both issues of concern to you and those of concern to the person E.g. You are concerned about the persons debt problems / sexual health behaviour / housing situation or they indicate that it is becoming an issue for them

Confidence was similarly high (98%) in all staff who 'passed' the SAT, regardless of staff level but lower In those that 'failed' the SAT (68% of Level 1 and 85% of Level 2). After undergoing training and retaking the SAT, the proportion stating that they were confident increased to 100% in both levels.

Figure 5b.9. Are you confident in being able to provide clear, up-to-date and relevant information to people about what they can do to improve their wellbeing?

Confidence was similarly high (99%) in all staff who 'passed' the SAT, regardless of staff level but lower In those that 'failed' the SAT (74% of Level 1 and 88% of Level 2). After undergoing training and retaking the SAT, the proportion stating that they were confident increased to 100% in both levels.

4. For Level 2 staff in Version 2, confidence was asked by:

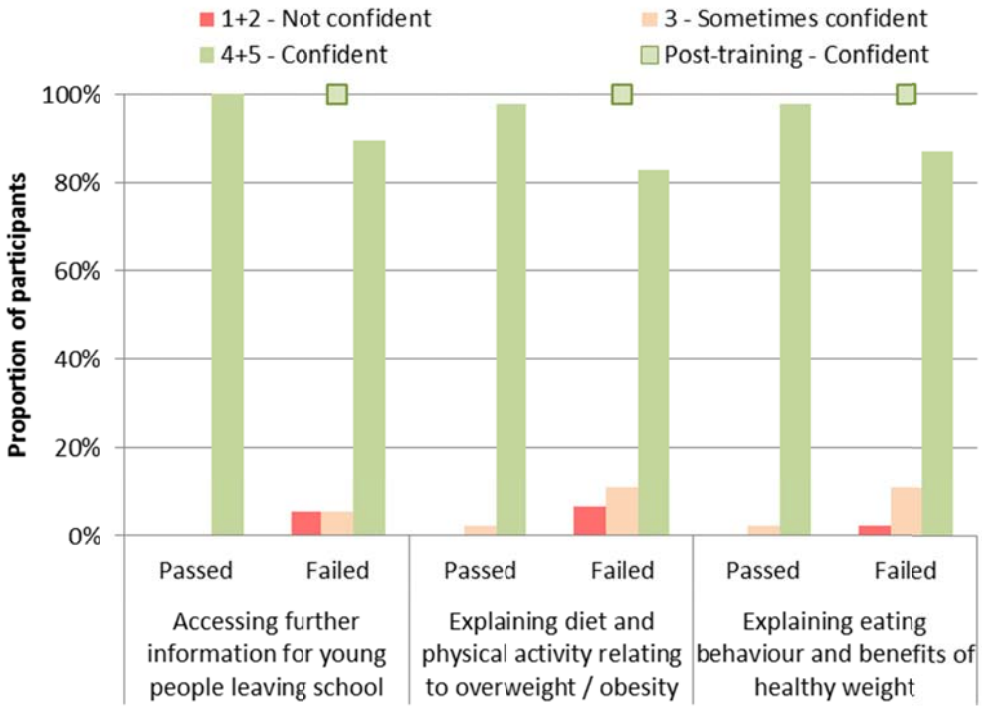
Figure 5b.10. Are you confident you can access information on training, education and employment opportunities locally and nationally, including those for young people leaving school?

And

Do you feel confident in being able to explain the role of diet and physical activity in helping to modify overweight / obesity to the people you work with?

And

Do you feel confident that you can explain the health risks and determinants of eating behaviour and benefits of maintaining a healthy weight to the people you work with?

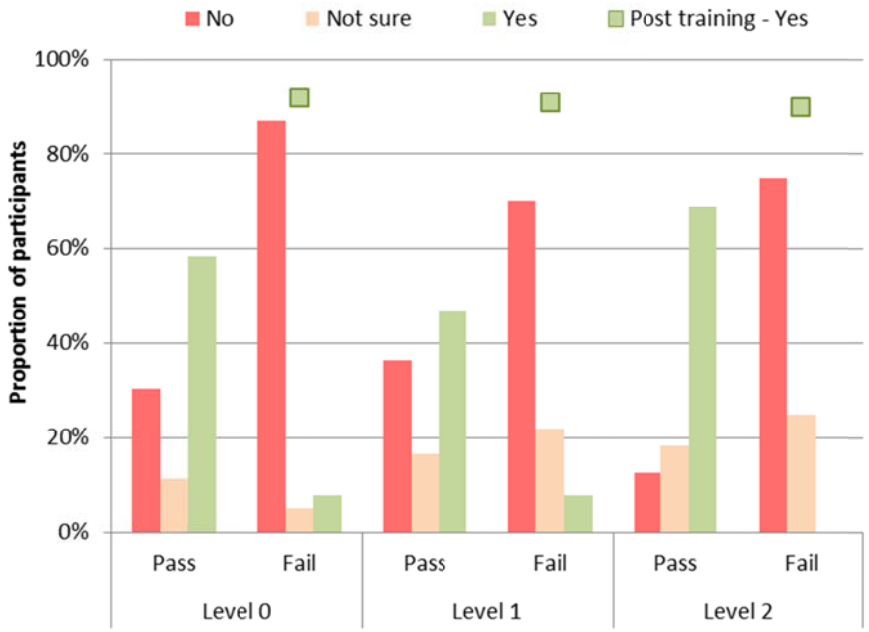


Confidence was high across the board and only marginally lower in those who 'failed' the SAT. However, this increased to 100% for these individuals following training.

5. Skilled Workforce

a) Skills relating to the MECC evaluation were asked in Version 1 of the SAT by:

Figure 5b.11. Making Every Contact Count is based on a model of a personal change called the Prochaska and Diclemente Cycle of Change. Are you familiar with this?



Familiarity with the Prochaska and Diclemente cycle of change model was not high even in those staff who 'passed' the SAT, but it was marginally higher in Level 2 staff (69%) than Level 0/1 (<60%). High proportions (70-87%) of staff who 'failed' that SAT were unfamiliar with the model. However after training this had increased to over 90%.

This is illustrated right by the proportions of staff which named the six stages in the correct order and the least ready to change first. Of the Level 2 staff who were trained, half failed to get the least ready to change first but they all (100%) got them in the correct order).

Figure 5b.12. Can you put them in order? Starting with the least ready to change and progress through the changed behaviour.

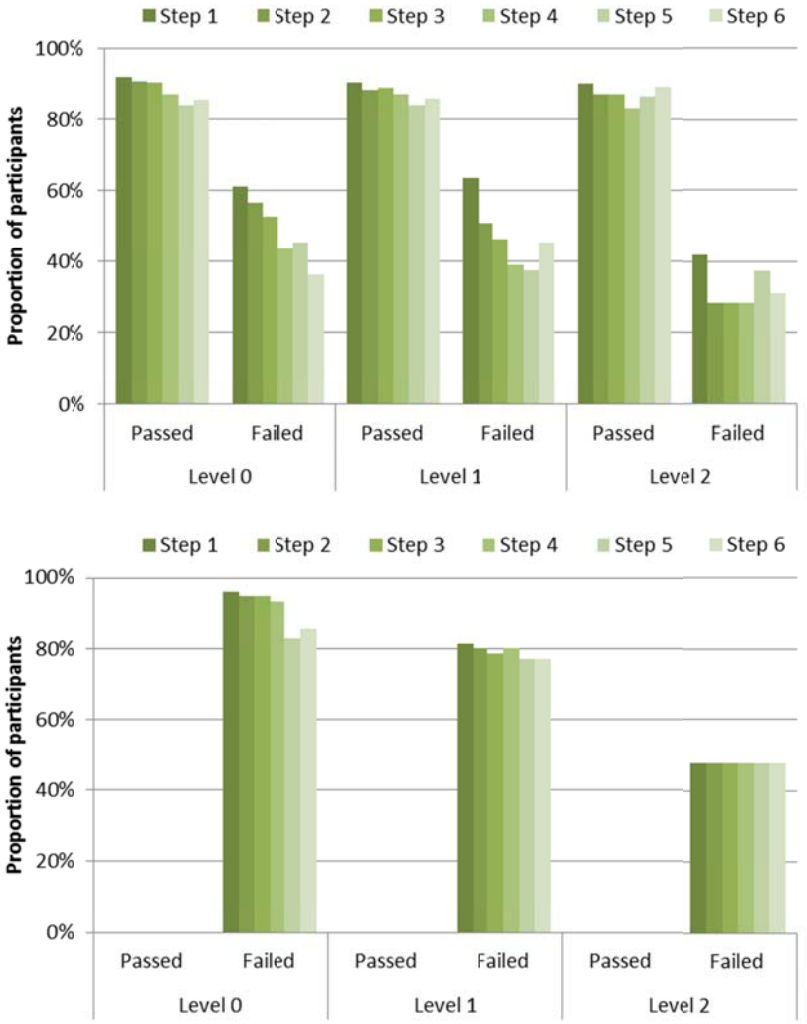
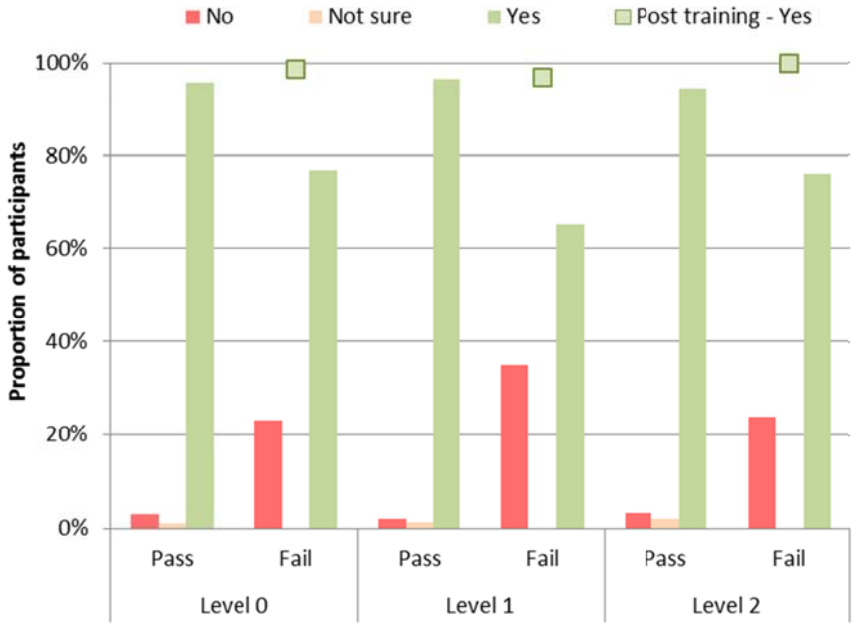
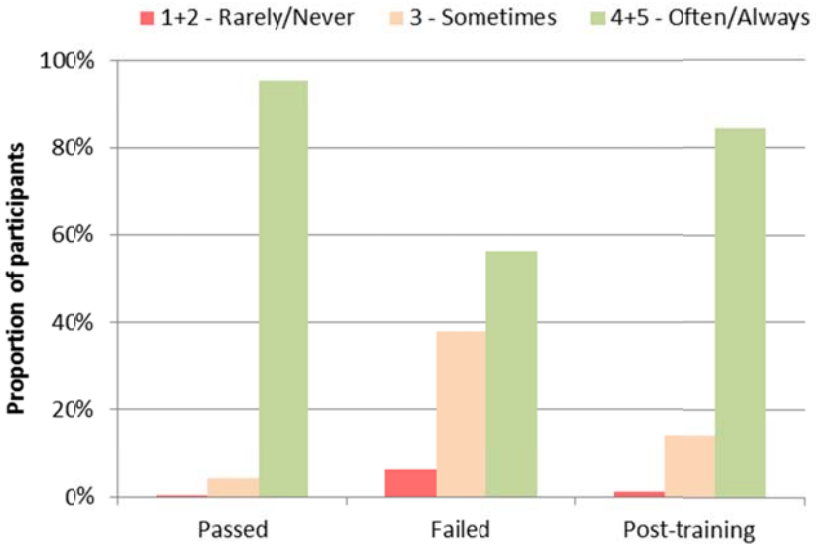


Figure 5b.13. Do you know when to signpost someone to a specialist service? L0



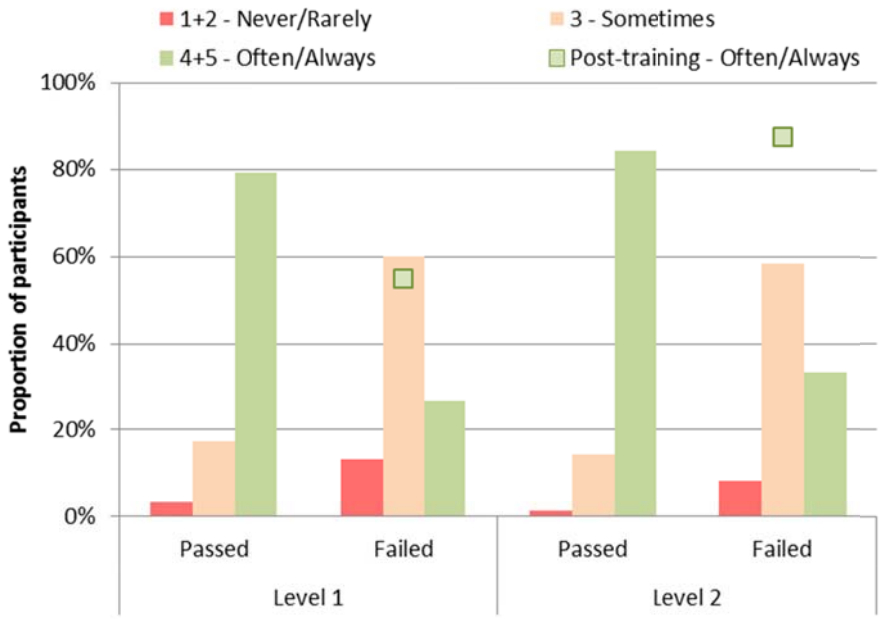
Knowing when to signpost to a specialist service was high across all levels in staff who 'passed' the SAT (over 95%) but lower in those who 'failed' the SAT (65-77%). However, this increased to 97-100% in all three levels for these individuals following training.

Figure 5b.14. Do you listen to service users to find out the things that are affecting their wellbeing? The term wellbeing can be defined as: The subjective state of being healthy. L1



Listening to users was high (95%) in level 1 staff who 'passed' the SAT and lower in those who 'failed' the SAT (56%). However, this increased to 85% for these individuals following training.

Figure 5b.15. When engaging with people, do you explore their role in influencing the behaviour of those close to them - i.e. their family? L1

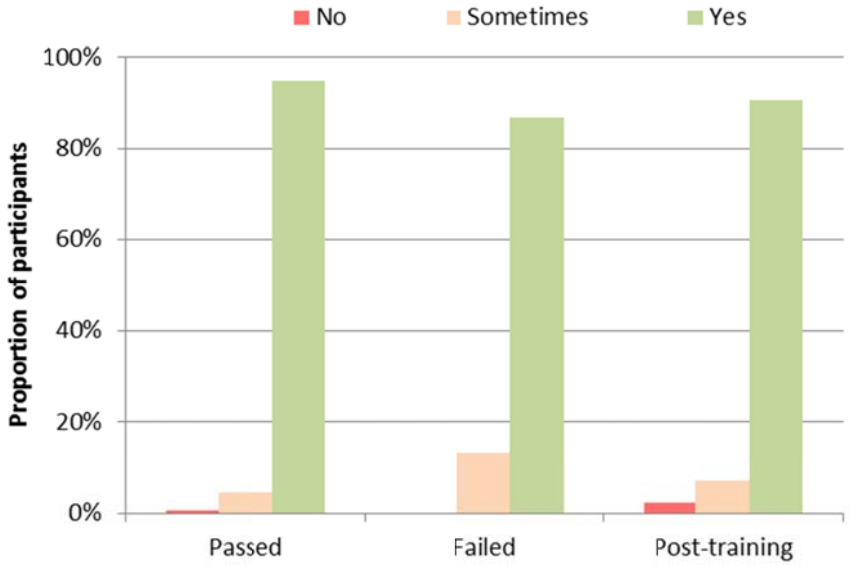


Exploring people's influencing roles was high (around 80%) in staff who 'passed' the SAT and much lower in those who 'failed' the SAT (around 30%). This did increase for these individuals following training, but more so in level 2 staff (to 88%) than in level 1 staff (to 55%).

Other questions, such as 'What would you do if a conversation with a service user became uncomfortable or challenging for you? For example, a person begins discussing personal details with you that you feel are outside the scope of your role' were answered correctly by 97-100% of respondents whether they passed or failed the SAT.

b) For Level 2 staff only, skills were determined by:

Figure 5b.16. Do you provide a summary of the information the service user has received and prompt confirmation about decisions or commitments they have made?

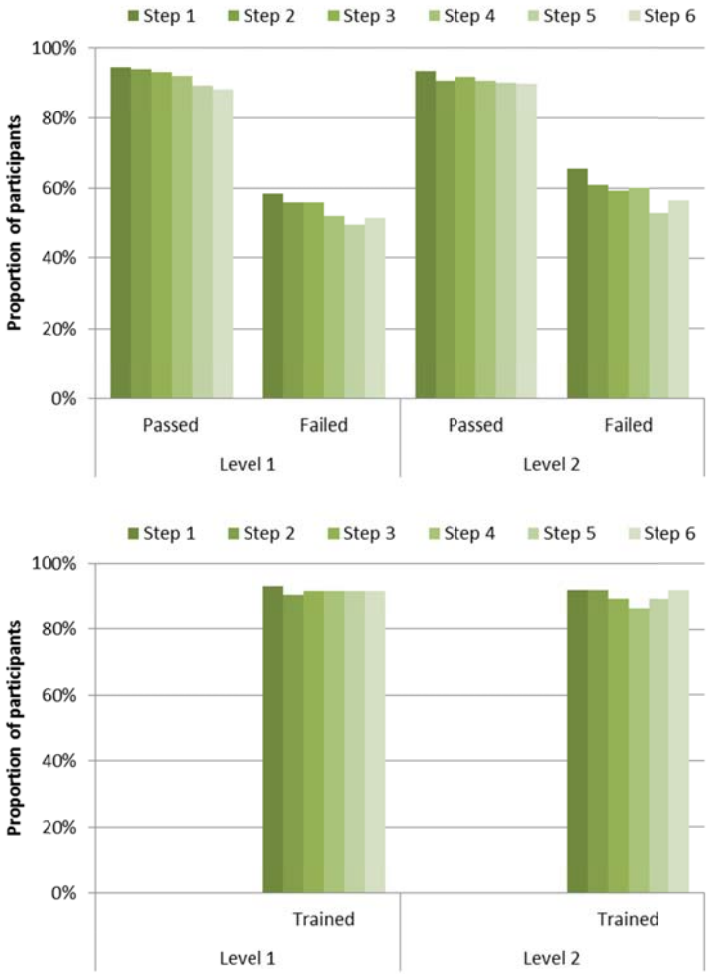


This skill was high (95%) in level 2 staff who 'passed' the SAT and only marginally lower In those that 'failed' the SAT (87%). After undergoing training and retaking the SAT, this increased to 91%.

Other questions, such as 'Do you record information about the content of the behaviour change interventions you provide?' were answered correctly by 97-100% of respondents whether they passed or failed the SAT.

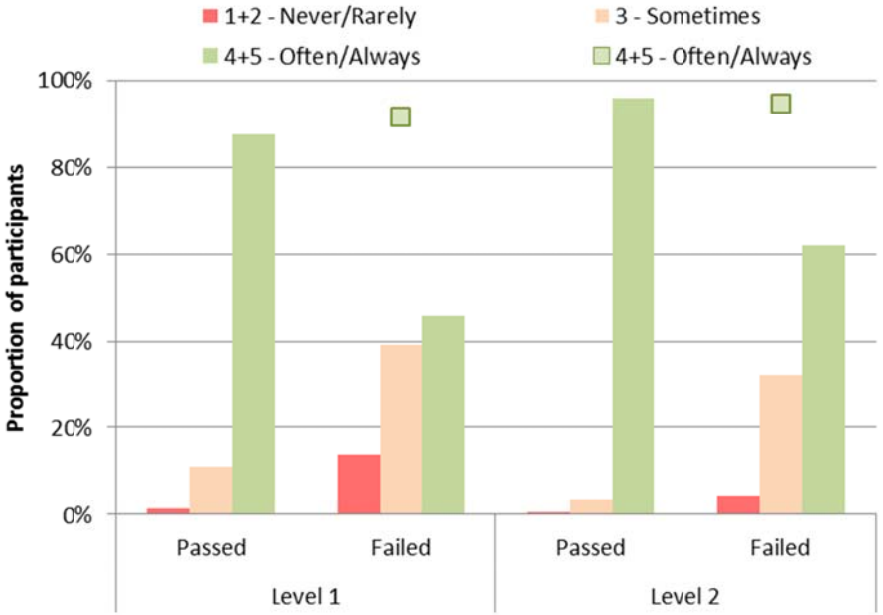
c) Skills relating to MECC were asked in Version 2 of the SAT by:

Figure 5b.17. The stages of change theory has 6 steps to changing behaviour. Can you put them in order? Starting with the least ready to change and progress through the changed behaviour.



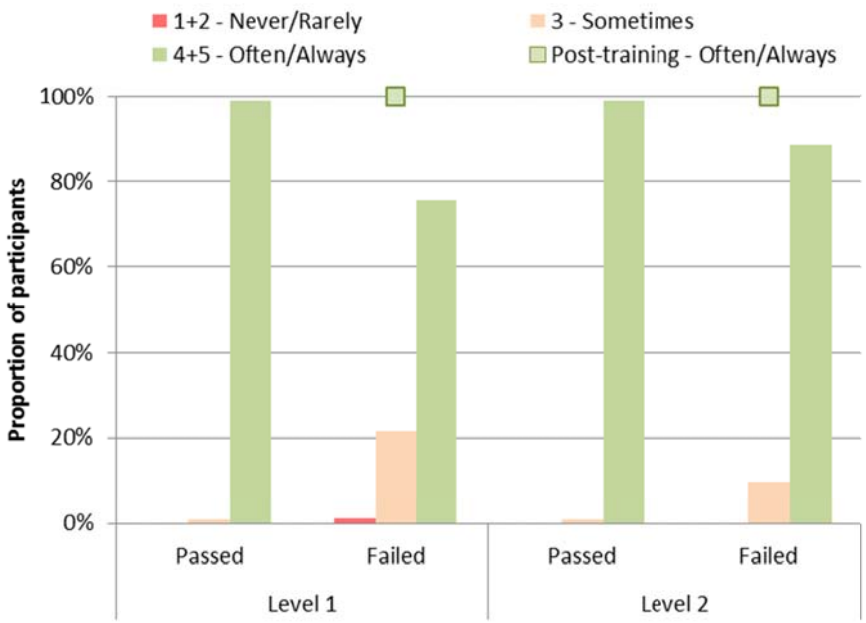
The proportions of staff which named the six stages in the correct order and the least ready to change first were almost identical to in Version 1 of the SAT. After training, knowledge of the behaviour change cycle increased to over 90%.

Figure 5b.18. When engaging with people, do you explore their role in influencing the behaviour of those close to them i.e. their family?



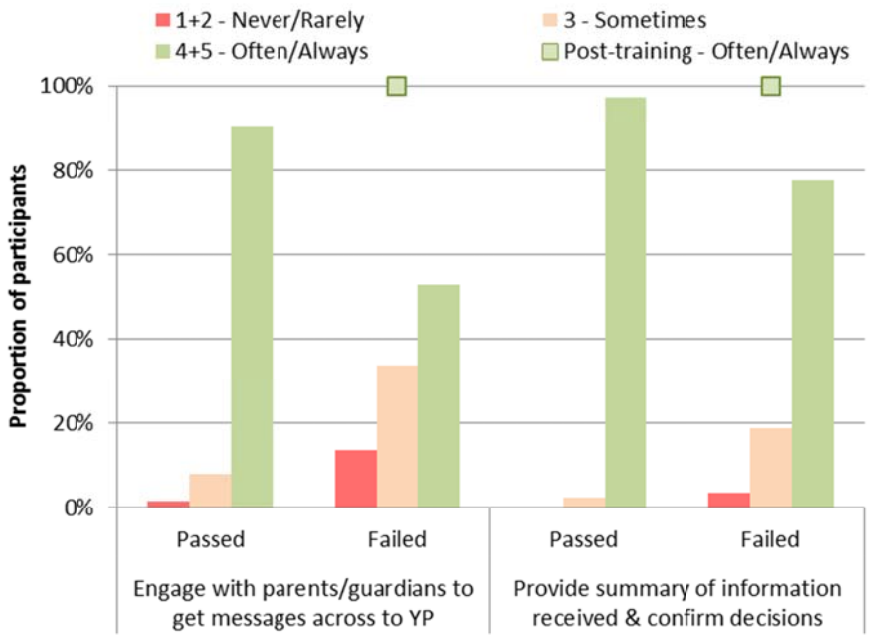
Exploring people's influencing roles was high (88-96%) in staff who 'passed' the SAT and much lower in those who 'failed' the SAT (46% for level 1 and 62% for level 2 staff). This increased to over 90% for these individuals following training.

Figure 5b.19. Can you summarise the main concerns that a person talks to you about and summarise them back?



Summarising a person's concerns was high (99%) in all staff who 'passed' the SAT, regardless of staff level but lower In those that 'failed' the SAT (76% of Level 1 and 88% of Level 2). After undergoing training and retaking the SAT, the proportion stating that they were confident increased to 100% in both levels.

Figure 5b.20. Do you try to engage with parents/guardians to get messages across to young people and involve them in the decision making process?; and
Do you provide people with a summary of the information they have received and prompt them to confirm the decisions or commitments they have made?



These skills were high (90-97%) in staff who 'passed' the SAT and much lower in those who 'failed' the SAT (53% for level 1 and 77% for level 2 staff). This increased to 100% for these individuals following training in both levels.

Overall numbers of MECC-compliant staff

By mid-April 2013, there were around 2,400 front line staff in Salford who were MECC-compliant. The majority of these (2,015; 85%) 'passed' the SAT without requiring training and the remainder (354; 15%) had undertaken training and subsequently 'passed'. However, at the date of analysis (12th April 2013 for the post-training assessments) there were still over 300 staff who had 'failed' the SAT and who were either yet to book training, awaiting training or not yet retaken the SAT.

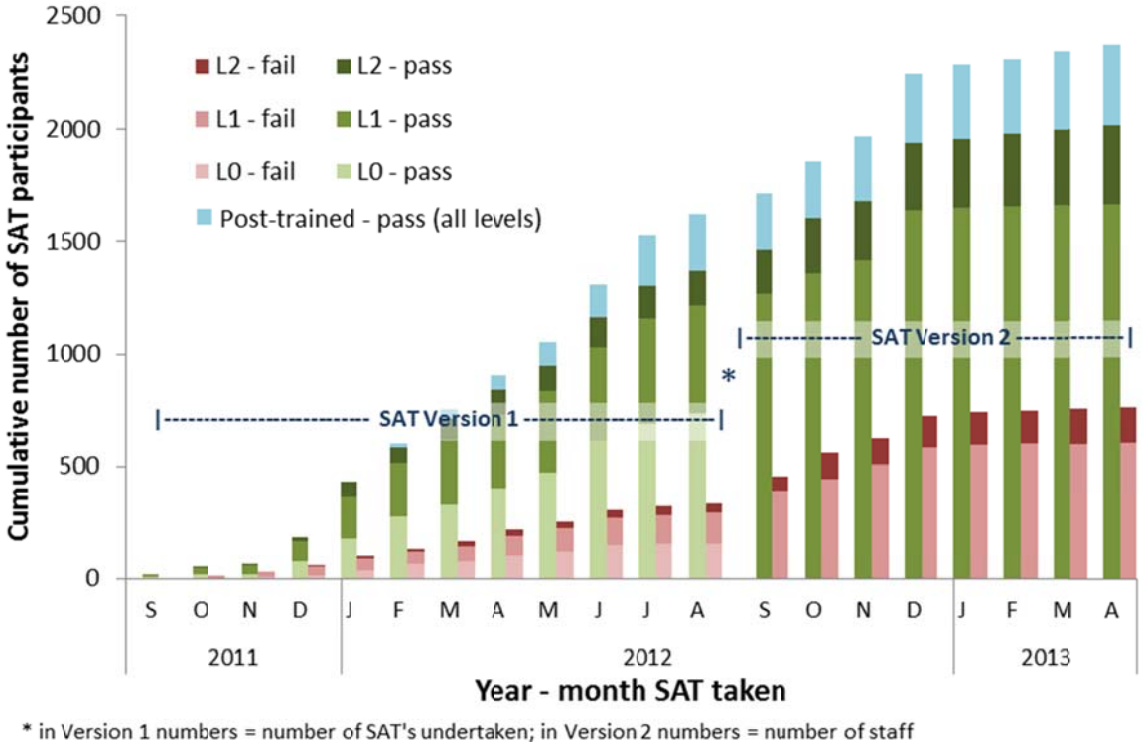


Figure 5b.21. Summary of cumulative numbers of SAT users by 'pass' status, level and post-training.

5.ci. Survey of Service Leads & Line Managers

Methods

A set of survey questions were developed to gain information on the System Outcomes identified in the development phase of the evaluation. System Outcomes measures were to be collated from service leads and line managers (SL/LM). A web-based survey was developed using the Glyndwr University account with Bristol Online Survey (www.survey.bristol.ac.uk).

Details of the survey were emailed to SL/LM in organisations participating in MECC and a follow-up email was sent approximately two months later. Two phases of the survey were carried out corresponding to pre- and post- revision of the SAT and training in August/September 2012.

Analysis

There were a total of 58 responses from Service Leads/Line Managers (SL-LM) over the two 4 month phases – Phase 1 (Sep-Dec 2012), 32 responses and Phase 2 (Jan – April 2013), 25 responses. There was no change to the SL-LM questionnaire between phases and the data were combined.

Summary of respondents

There were 28 responses from NHS SL-LM, 22 from Council SL-LM and 8 from other organisations. Other organisations ware combined with Council data for analysis. However, there was no statistical difference between responses from the NHS and Council/other, except for Question 5 where separate responses are presented.

5ci.1.	How/why were you selected to support MECC in your organisation?
Overall	The majority of SL-LM (60%) said they were selected to support MECC because it's part of their role. Nearly half (47%) also stated that they were selected because their line manager told them to. Only 3.4% stated 'personal development' and only one person stated that they requested it.

Fig 5ci.2.	How did you feel about doing this at the time?
By Org	Significantly more SL-LM from the Council/other organisations difference in response to this question by organisation type
Overall	The majority of SL-LM (50%) were neutral about getting involved with MECC. Just over a third (38%) were happy/positive and 12% were unhappy/negative.

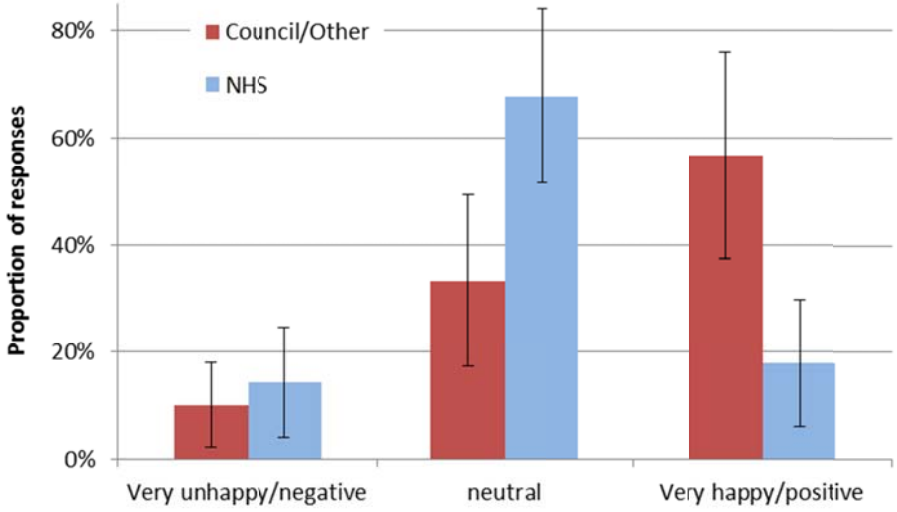


Fig 5ci.3. How do you see MECC fitting with your organisation's vision (goals)?

Overall The majority of SL-LM (78%) thought that MECC fitted well with their organisation's vision/goals. Around 17% thought it fitted neither well nor not well and only 5% thought it didn't fit well.

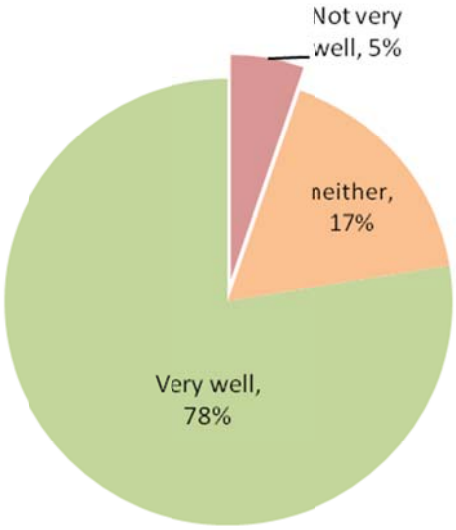


Fig 5ci.4. To what extent have you been involved in your organisation's sign up to MECC?

Overall Just over half of SL-LM (53%) were involved in their organisation's sign up to MECC. A third (31%) was not and 16% were somewhat involved.

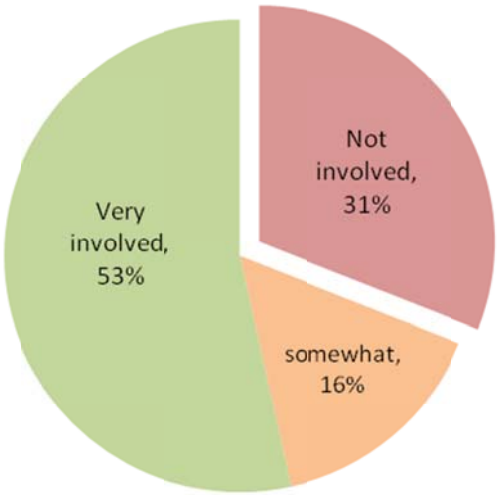


Fig 5ci.5.	Were you involved in completing the Action Plan?

Overall Two thirds (64%) of SL-LM were not involved in completing the Action Plan. Only 30% were involved and 6% didn't know.

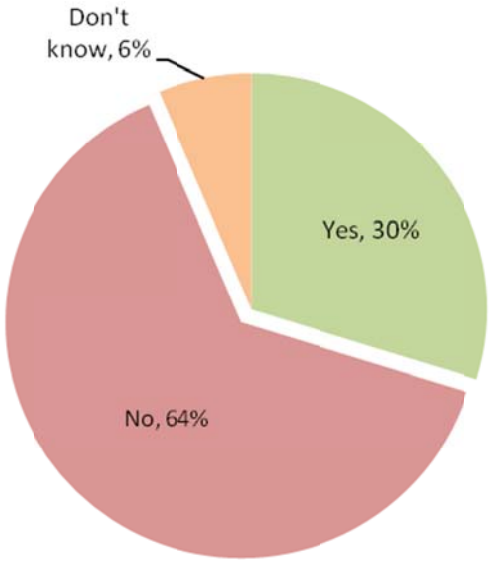


Fig 5ci.6.	Did you or are you planning to attend the line manager's training session?

Overall Only a fifth (20%) of SL-LM had attended the line managers training session but 15% had booked to attend. Around half (52%) were planning to attend but 13% said they were not.

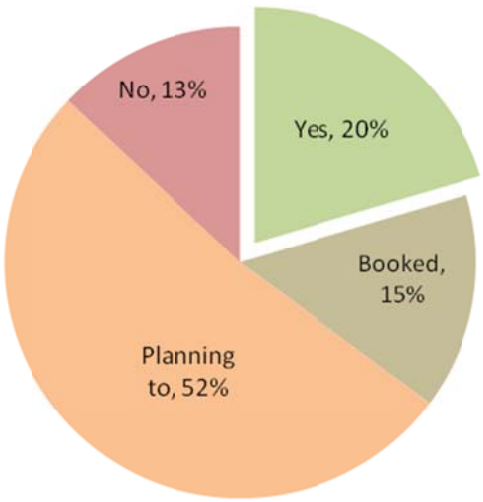


Fig 5ci.7. How well has MECC's vision been communicated (cascaded) within your organisation?

Overall

Over half (55%) of SL-LM said that MECC had been communicated well within their organisation. However, a third (31%) thought only moderately and 14 said it had been communicated little.

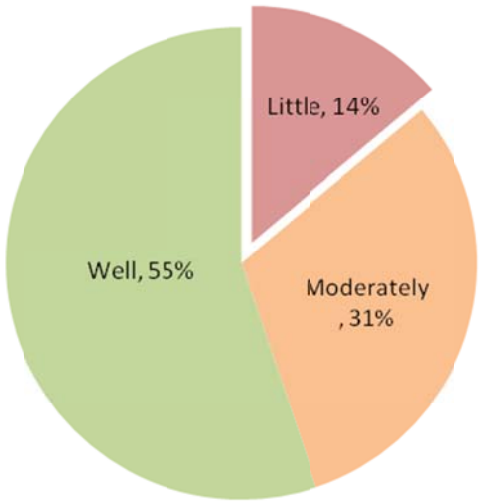


Fig 5ci.8. How do you think people using your service will respond to MECC?

Overall

Less than half of SL-LM (49%) thought that people using their service would respond positively to MECC. Over a half thought response would be neutral and just 2% thought people would be negative about MECC.

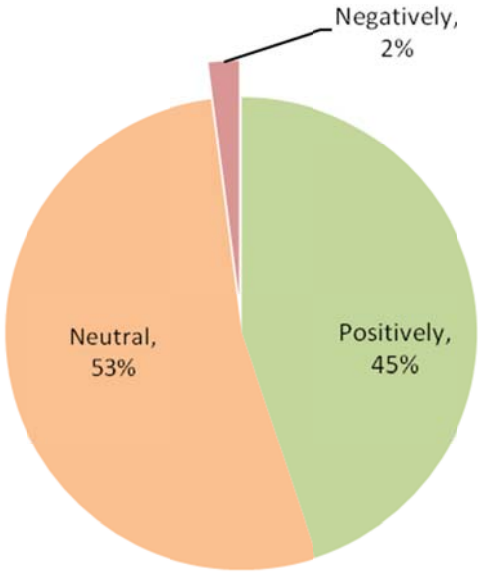


Fig 5ci.9.	How did staff respond to being involved with the MECC programme? LINE MANAGERS ONLY

Overall

Only a third of SL-LM (31%) thought staff would respond positively to being involved in MECC. Around a half were thought staff would be neutral but 17% felt staff would respond negatively.

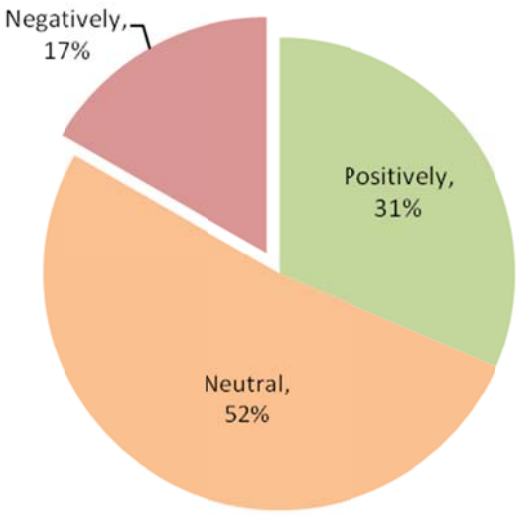


Fig 5ci.10.	To what extent is MECC embedded in your organisation's strategic and business plans?

Overall

The majority of SL-LM (57%) felt that MECC was embedded in their organisation's strategic and business plans. A quarter (26%) thought it was moderately embedded but 17% thought it was not embedded.

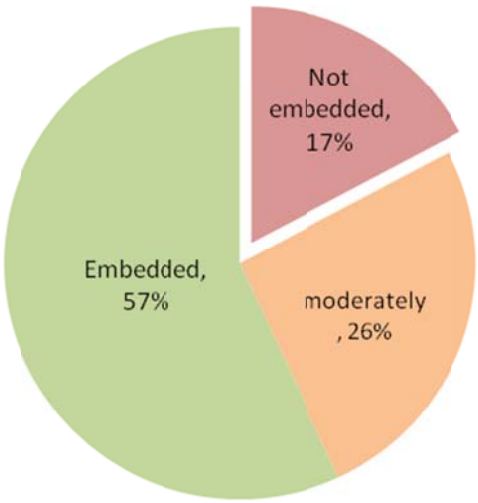


Fig 5ci.11.	Is there sufficient support 'within your organisation' for implementing MECC?

Overall The majority of SL-LM (61%) thought there was good support. A quarter (28%)thought it was average and 11% thought there was poor support .

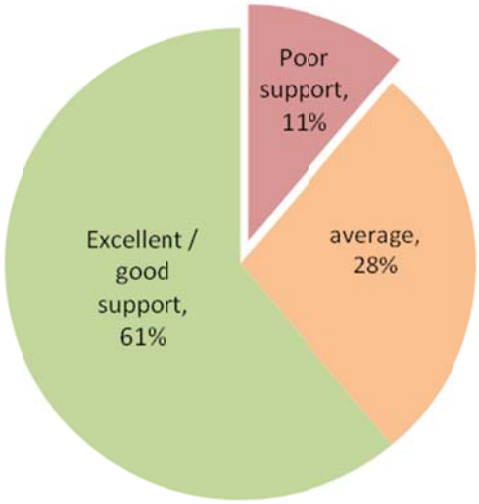


Fig 5ci.12.	Do you have support from the Salford MECC 'delivery team'?

Overall Just under half of SL-LM said that they did have support (45%) from the Salford MECC delivery team; the same said they didn't know and 10% said they didn't.

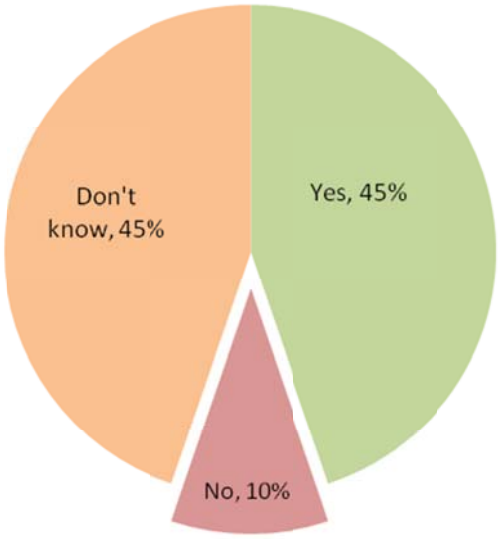


Fig 5ci.13. Does MECC benefit the way your staff interacts with clients/users/patients?

Overall Just over a third of SL-LM (38%) said that MECC benefits the way staff interacts with clients/users almost always and 41% said it does sometimes. However, a fifth (21%) said that MECC never benefits the way staff interacts with clients/users.

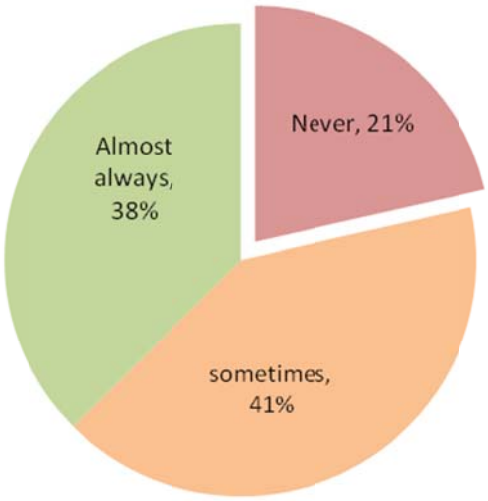
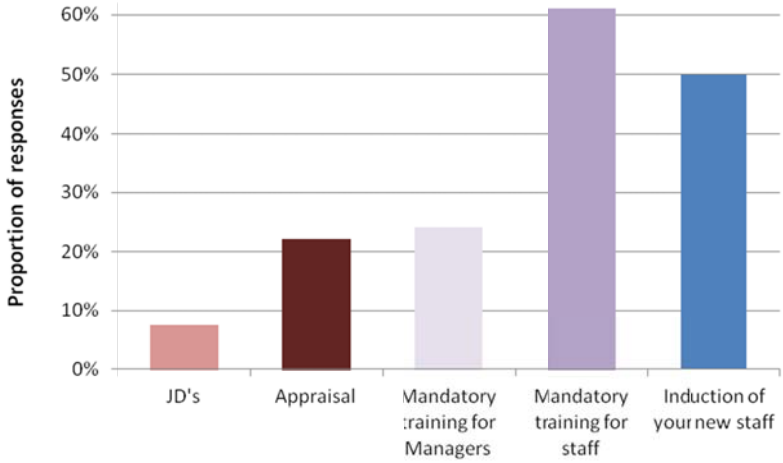


Fig 5ci.14. Is MECC currently linked into:

Overall The majority (60%) of SL-LM said that MECC is linked to mandatory training for staff and a quarter (24%) said it is linked to mandatory training for managers. Also half (50%) said it is linked to induction of new staff. However, only 7% said that MECC is linked to job descriptions and a fifth (22%) that it is linked to appraisals.



*responses to this question were removed where the SL-LM commented that boxes could not be unchecked.

Fig 5ci.15.	Do you think the MECC programme will be operating in your organisation over the next 5-years?

Overall The majority of SL-LM (51%) weren't sure if MECC will be operating in their organisation over the next 5 years. Only 4 in 10 (41%) thought that it would and 7% thought that it wouldn't.

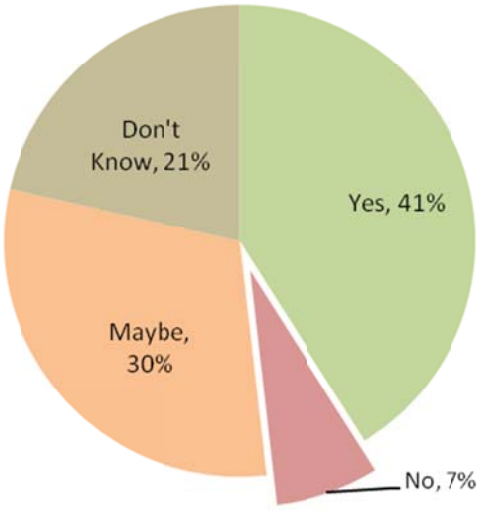


Fig 5ci.16.	Do you envisage any challenges in the roll out of MECC in your organisation?

Overall Around equal proportions of SL-LM responded yes, no or didn't know to whether they envisaged challenges in the roll out of MECC.

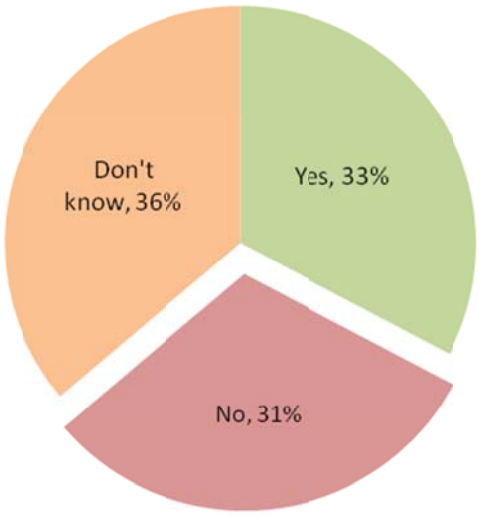


Fig 5ci.17. Would any of these help you and your staff to implement MECC?

Overall

Signposting information was seen by the highest proportion of SL-LM (86%) as being likely to help in implementing MECC and a service directory/referral pathways as next most important (74%). The W2W portal and an events directory were still seen as a help by the majority of SL-LM (59-62%). However, a fifth to a third were not sure if anything other than the signposting information would help and a few SL-LM (5-10%) thought these things would not help.

What might change:	Yes	No	Don't know
Way 2 Wellbeing Portal	59%	9%	33%
Service directory	74%	3%	22%
Events directory	62%	10%	28%
Referral pathways information	74%	7%	19%
Signposting information	86%	5%	9%

Fig 5ci.18. Are you using the MECC communications toolkit?

Overall

Nearly half of SL-LM (45%) said that they were not using the MECC communications toolkit. A further 38% didn't know if they were using it and only 17% (one in six) said that they were using it.

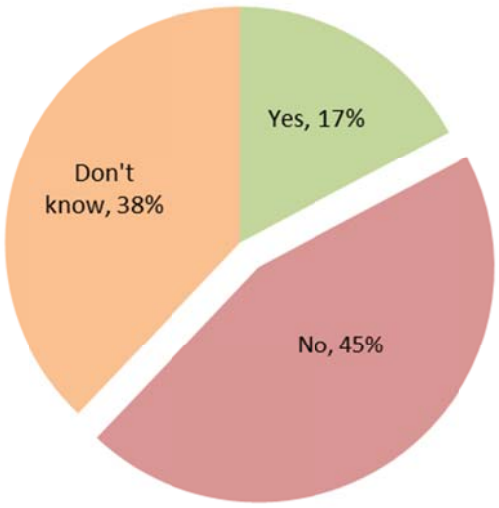


Fig 5ci.19.	Are there any differences in how staff undergoing the training are delivering MECC compared with those 'not' undergoing training?

Overall

Half of SL-LM (50%) said there were never any differences in how staff who had undergone training were delivering MECC and those that did not require training. Around 40% said there were differences sometimes and 10% said there were almost always differences.

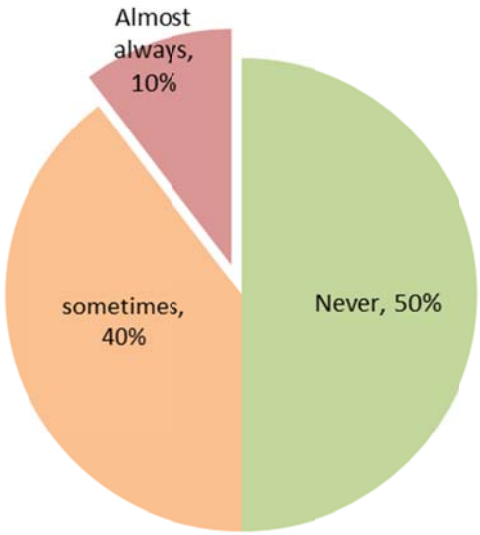
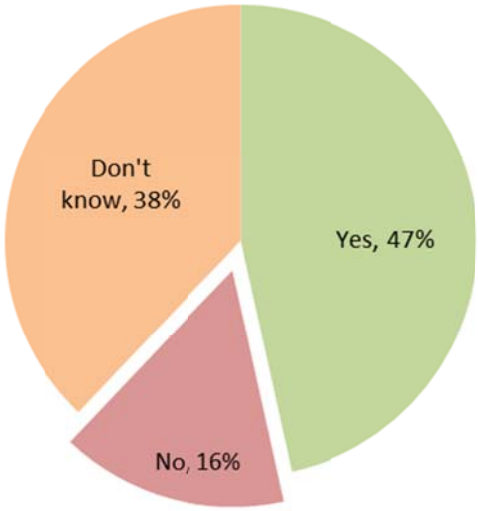


Fig 5ci.20.	Is your organisation monitoring its success in implementing MECC?

Overall

Almost half of SL-LM (47%) said that there organisation was monitoring its success in implementing MECC. However, over a third (38%) didn't know and 16% said there organisation wasn't monitoring its success in implementing MECC.



5.cii. Staff Survey Analysis

Methods

A set of survey questions were developed to gain information on the Staff Outcomes identified in the development phase of the evaluation. These measures were to be collated from front line workers (FLW). A web-based survey was developed using the Glyndwr University account with Bristol Online Survey (www.survey.bristol.ac.uk).

Details of the survey were emailed to FLW who were registered on the SAT and a follow-up email was sent approximately two months later. Two phases of the survey were carried out corresponding to pre- and post- revision of the SAT and training in August/September 2012, with minor revisions to two questions to take into account the revision and feedback from the first phase.

Analysis

There were a total of 249 responses over two 4 month phases – Phase 1 (Sep-Dec 2012), 138 responses and Phase 2 (Jan – April 2013), 111 responses. The main change between these phases was a simplification of the competency levels, which only affected two questions in the questionnaire. The data from the two phases were combined taking these changes into account. Analysis was first undertaken on data disaggregated by:

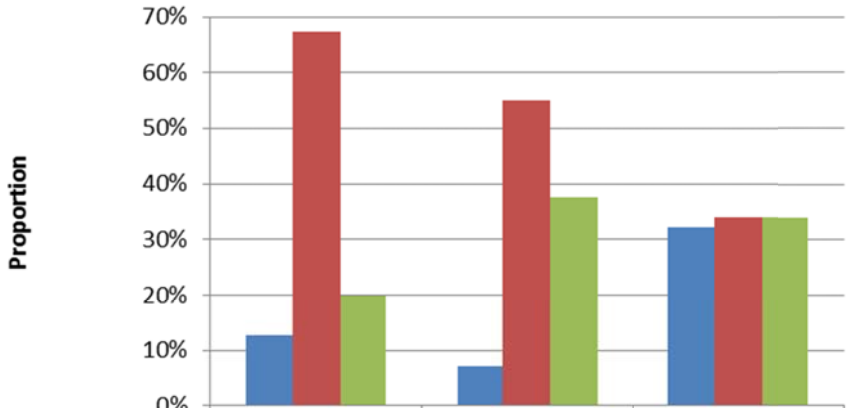
- Organisation type (NHS, Council and Other)
- Competency Level (Level 1 introductory (Phase 1 only); Level 1 intermediate; Level 2)

Where there was a significant difference in responses by Organisation or Level, these are presented. Where there was no significance between Organisation or Level, the responses are presented combined.

> * in some cases, sample sizes preclude statistical significance but there is an apparent trend in the responses. In these cases, the trend has been presented for completeness.

Summary of respondents

Overall, there were 55 responses from the Council, 138 from the NHS and 56 from Other organisations [See section 5b]. There was a greater proportion of Level 1 respondents from the Council than from the NHS and Other organisations, with significantly more Level 2 respondents from NHS/Other. This reflects the expected distribution of competencies across organisation types.



	Council	NHS	Other
Level 1 (intro)	13%	7%	32%
Level 1	67%	55%	34%
Level 2	20%	38%	34%

Figure 5cii.1. Proportions of respondents by staff level and organisation type

Figure 5cii.1. What is your usual job/current role

The differences in competency levels across organisation are reflected in the descriptions of the usual job role. The NHS staff have more specialist health roles involving nursing, therapy and treatment of patients, whilst Council staff have more support, population and wellbeing roles. The other organisations describe roles more like Council staff but have a higher proportion of Level 2 staff, more like NHS roles.

Council (54 responses)

NHS (118 responses)

Other (55 responses)

Figure 5cii.2.	How central is improving health and wellbeing of Salford residents to your 'usual role'?
By Org	NS - there was no significant difference in response to this question by organisation type
By Level	Significantly more Level 1 staff (78%) thought that improving health and wellbeing was central to their 'usual role' than Level 1 introductory staff (34%). Significantly more Level 2 staff (95%) thought that improving health and wellbeing was central to their 'usual role' than Level 1 staff (78%).
Overall	The majority of staff (78%) see improving health and wellbeing as central to their usual job role.

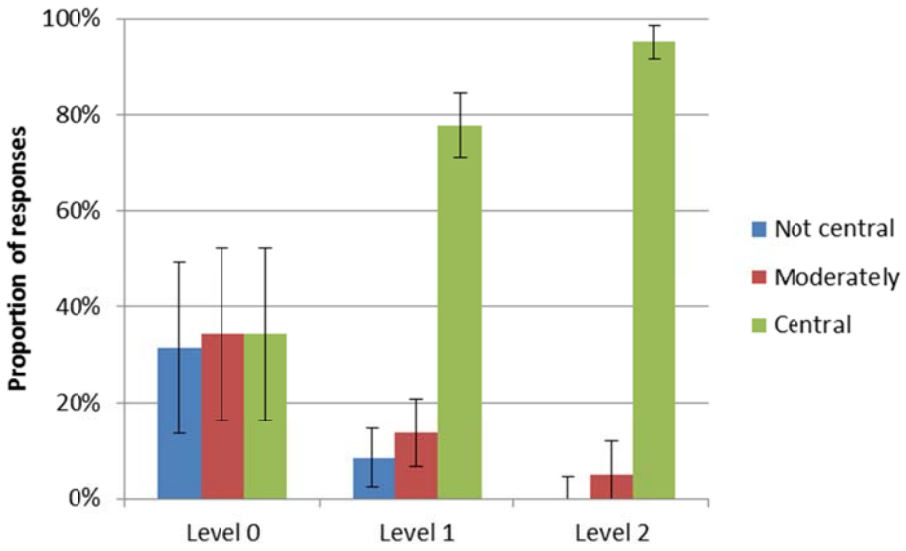


Figure 5cii.3.	How/why did you get involved in the MECC programme?
By Org	NS - there was no significant difference in response to this question by organisation type
By Level	Significantly more Level 1 staff (40%) got involved in MECC because it was part of their job role than Level 1 introductory staff (14%). Level 2 and Level 1 staff had similar responses.
Overall	The majority of staff (72%) get involved with MECC because their line manager told them to. Around a third (34%) did so because it is seen as central to their role.

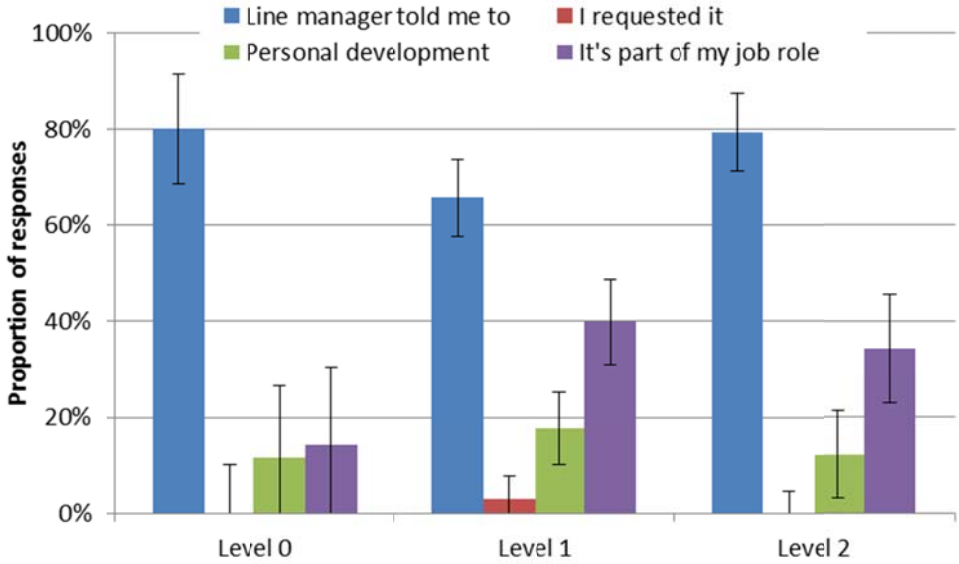
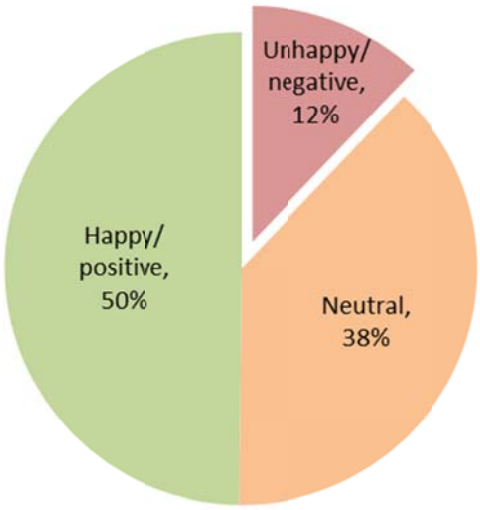


Figure 5cii.4.	How did you feel about doing this at the time?
By Org	NS - there was no significant difference in response to this question by organisation type
By Level	NS - there was no significant difference in response to this question by competency level

Overall

The majority of staff (50%) were happy/positive about getting involved with MECC. However, 38% were neutral and 12% were unhappy/negative.



Text comments

Many participants felt this was a waste of time and resources due to the fact that it was something they were already doing or irrelevant to their job. Other participants felt the rational for completing this was unclear and that it was just another exercise to be completed and nothing new was added to their knowledge as the information was too basic. For those participants whose job did not include MECC principles, they felt this program gave valuable knowledge, the confidence to share this information and streamlined what staff were already being advised across the organization. These respondents were interested in learning about services available and felt it complimented the work they were already doing and could only further benefit their patients.

"I feel that the learning outcomes/information are already a requisite element of my specialist role, and a raft of previously attained qualifications and/or training address these."

"It is always good to get updated with new knowledge and skills to enhance my role and help me deliver better care to patients and carers.

Figure 5cii.5.	How do you see MECC fitting with your organisation's core business?
By Org	NS - there was no significant difference in response to this question by organisation type
By Level	NS - there was no significant difference in response to this question by competency level

Overall

The majority of staff (68%) thought that MECC fitted well with their organisation's core business. Around a quarter thought it fitted neither well nor not well and only 6% thought it didn't fit well.

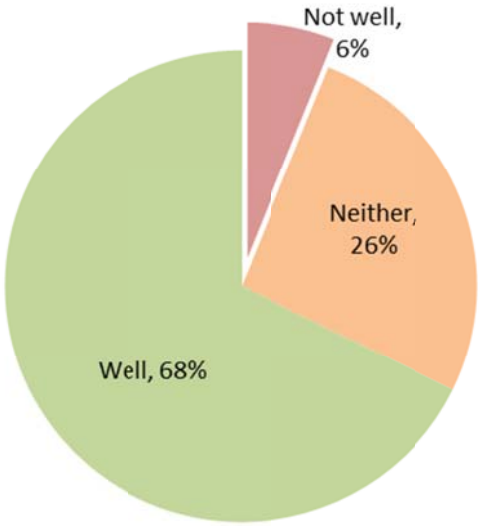


Figure 5cii.6.	How was it decided what 'level' of MECC you should operate at - level 1 or level 2?
By Org	NS - there was no significant difference in response to this question by organisation type
By Level	NS - there was no significant difference in response to this question by competency level

Overall

For the majority of staff (77%) their line manager decided the level at which they should operate. Only 14% stated that the level was part of their usual job.

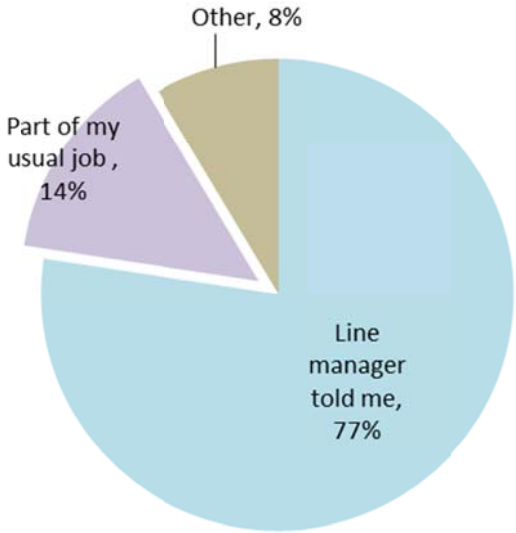
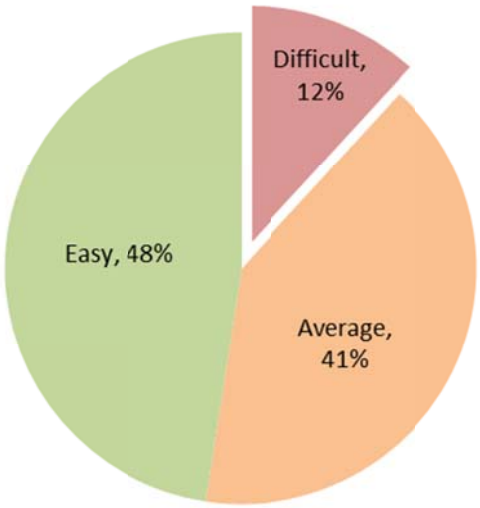


Figure 5cii.7.	How easy was it to complete the SAT tool?
By Org	NS - there was no significant difference in response to this question by organisation type
By Level	NS* - there was no significant difference in response to this question by competency level *However, 55% of Level 2 found it easy, compared with 45% of Level 1 and 40% of Level 1 introductory.

Overall

Around half of staff (48%) found completing the self-assessment tool (SAT) easy but almost the same proportion found it average. In all 12% (one in eight) found completing the SAT difficult.



Text comments

The majority of participants had difficulty accessing the tool and filling out the question forms due to unclear or poorly worded questions involving jargon and not reflecting the different levels. Some participants used Google, alongside completion of the SAT, to obtain answers; others felt it was not an appropriate measure of skills and that the time limit was not conducive to completing the SAT tool on the job.

"Organisation around filling in self-assessment and registering online was extremely difficult and inefficient. It also failed on a number of occasions"

Figure 5cii.8.	Did the SAT result recommend you needed training?
By Org	NS* - there was no significant difference in response to this question by organisation type *However, 68% of NHS staff did not need training compared with 50% of Council/other (combined).
By Level	NS* - there was no significant difference in response to this question by competency level *However, 65% of Level 2 did not need training compared with 54% of Level 1 (combined).
Overall	In the survey sample, 59% of staff did not require training after taking the SAT and 41% did require training.
Text comments	There was a divide in response to training amongst participants based on what appeared to be level of training and their current job role. Participants already trained in this area (particularly health advice role; level 2) felt MECC training was a waste of time, boring, frustrating and patronising ("insulting"). Overall, the training was viewed by most as inefficient, confusing, too theoretical and lacked connection to the SAT or the answers to questions they had previously failed on testing. There was a lack of consistency around the delivery of the training, for example, in terms of capacity, some sessions were too full while others contained too few participants; some trainers were "excellent" while others "lacked basic information". Participants with little background knowledge felt the training was beneficial and informative and they appreciated the interdisciplinary nature of the training. These participants appreciated the broad knowledge about MECC but felt they needed more information on signposting opportunities/options for referrals and on reference materials to implement MECC in the future. Overall, future training should be better tailored to meet the needs of different participants and their previous knowledge and job roles/qualifications, to ensure better engagement by participants and relevance to their learning needs, without overstepping their job/role requirements. "Beneficial for everyone for reflecting, gaining theoretical knowledge, however didn't assist with answering questions that were failed on the online 'test' since no-one was informed what question they got wrong(???). I already deliver interventions on a daily basis so hasn't changed my delivery/work. Training doesn't really assist you with answering SAT questions, SAT was very vague and answers dependent upon your interpretation of the question i.e. resilience factors - do you mean to positive effect or negative?? Not specific enough."

Figure 5cii.9.	To what extent has the training equipped you to deliver a MECC intervention?
By Org	NS - there was no significant difference in response to this question by organisation type
By Level	NS* - there was no significant difference in response to this question by competency level *However, 46% of Level 2 staff thought it equipped them little compared with 26% of Level 1 (combined).

Overall There was an even split between all staff as to whether the training equipped them little, moderately or much to deliver MECC.

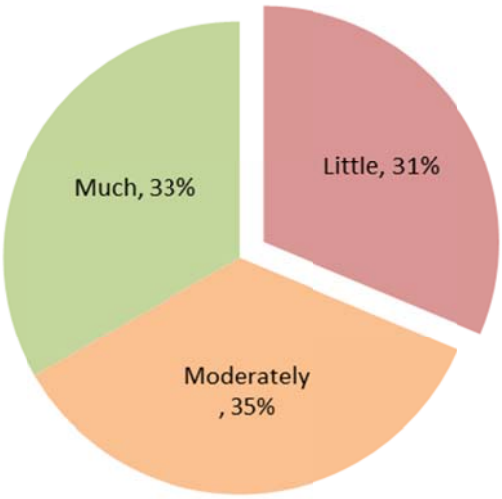


Figure 5cii.10.	What has been your experience of implementing MECC principles into your usual role?
By Org	NS - there was no significant difference in response to this question by organisation type
By Level	A significantly higher proportion of Level 1 (60%) and Level 2 (71%) staff found implementing MECC easy compared with Level 1 introductory (31%).

Overall The majority of staff (69%) found implementing MECC easy, whereas a third (33%) found it average and 8% found it difficult.

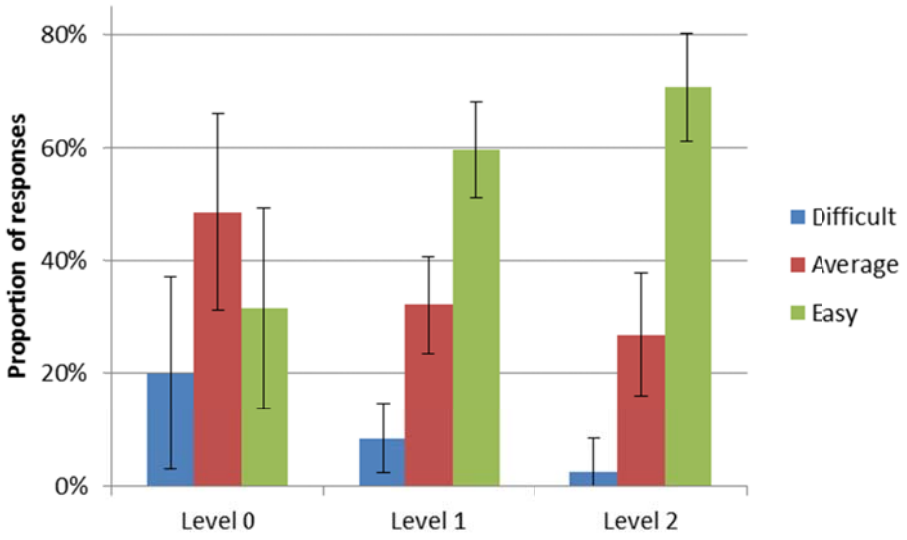


Figure 5cii.11.	Do you feel fully equipped to deliver MECC?
By Org	NS - there was no significant difference in response to this question by organisation type
By Level	NS* - there was no significant difference in response to this question by competency level *However, 82% of Level 2 staff felt fully equipped to deliver MECC compared with 76% of Level 1 and 69% of Level 1 introductory.

Overall

Over three quarters of staff (77%) felt fully equipped to deliver MECC, 16% were unsure and 7% did not feel equipped.

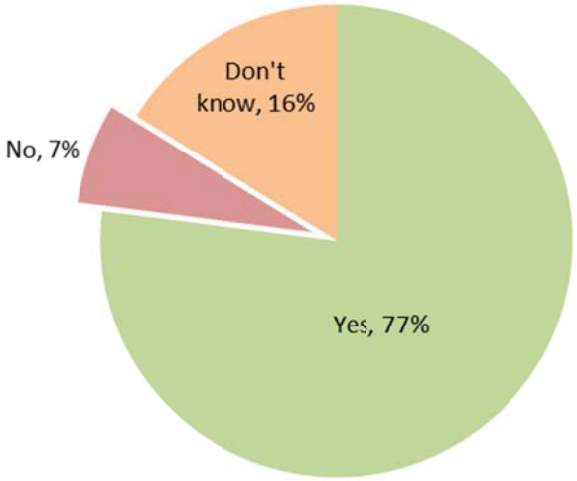


Figure 5cii.12.	Since the introduction of MECC, how easy do you find starting a conversation with a person about their health and wellbeing /behaviour?
By Org	NS - there was no significant difference in response to this question by organisation type
By Level	NS* - there was no significant difference in response to this question by competency level *However, 76% of Level 2 staff felt it was easy to start a conversation with a person about their health and wellbeing/behaviour compared with 70% of Level 1 and 51% of Level 1 introductory.

Overall

The majority of staff (69%) felt it was easy to start a conversation with a person about their health and wellbeing/behaviour, 27% felt it was average and only 4% felt it was difficult.

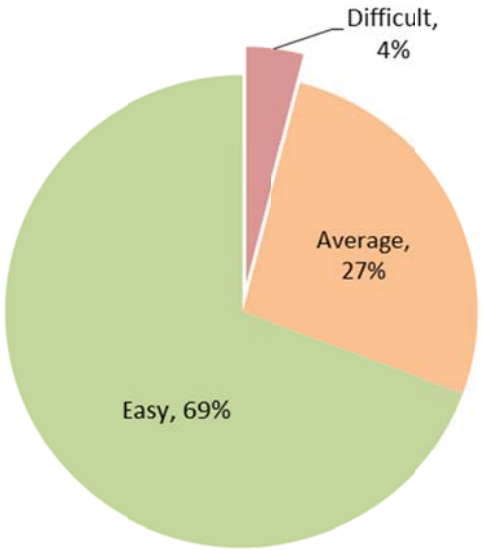


Figure 5cii.13.	How do you match your conversation (content) to the needs of the people who use your service?
By Org	X – responses were too few to analyse by organisation
By Level	X – see below
Overall	X – responses were analysed by competency level
Level 0	Many participants felt the training has not affected the way they approach clients in terms of MECC as they "already do this" as part of their routine assessments and incorporate this into conversations with all clients. However, several participants described how they used client-centred communication style, where they take time to check health records and observe clients in order to tailor their conversations to the individual's needs. Other participants rely solely or predominantly on signposting to other services and leaflets; these participants felt they would benefit greatly from having a current list of agencies and their services offered to assist with appropriate referrals. "Conversation raised as part of clinical assessment/treatment process - as it always has been, this programme has not changed the way general health issues have always been covered." "I noticed a client's needs were changing and I felt able to address the situation and have a chat about what services they needed and assist them to get the information required.
Level 1	Participants take a client-centred approach and treat patients with respect, providing information to make informed decisions rather than impose their opinion of what the client needs. Providing this information was considered by the majority in this participant group as part of usual conversations and client-centred assessments undertaken already and most of these participants see opportunities to raise these issues as part of their usual and broad, holistic approach to health and wellbeing. In general, participants asked questions, listened to clients, observed and looked for clues, and tried to understand goals and expectations. Providing general advice and information about services, signposting, or referrals followed up this approach. Interestingly, a minority of the Participants here, whose core role (job) did not typically include addressing these issues, said their clients saw this as an intrusion. "Ask Questions, Listen, advise, refer or signpost- Follow up"
Level 2	All the same as listed in Level 1. "I feel I ask the right questions once I have given the person time to talk, listening is as important as advice. I feel more able to understand and not be judgemental, to calm a situation and offer assurance that our establishment will help where possible"

Figure 5cii.14.	Have you had any uncomfortable or challenging conversations with people when raising the issue of their health and wellbeing?
By Org	NS - there was no significant difference in response to this question by organisation type
By Level	NS* - there was no significant difference in response to this question by competency level *However, 16% of Level 2 staff always/mostly had uncomfortable or challenging conversation with people when raising the issue of health and wellbeing compared with 10% of Level 1 and 6% of Level 1 introductory.

Overall — The majority of staff (53%) never/rarely had uncomfortable or challenging conversation with people when raising the issue of health and wellbeing; around a third (35%) sometimes did so and 11% always/mostly did.

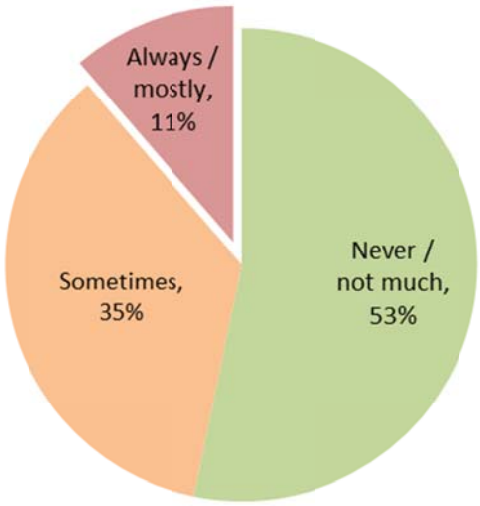


Figure 5cii.15.	Did you have support to deal with this?
By Org	Significantly less NHS staff (44%) said that they did have support for this than Council/other staff (62%).
By Level	NS - there was no significant difference in response to this question by competency level

Overall — Around half of staff said that they did have support (52%) for this and half said they didn't (48%).

Text comments — Participants received advice or input from others including peer support, colleagues, managers, or referred/signposted to others with experience in that area. Many participants felt they had enough experience and training to deal with these situations as it was 'part of their usual job'.

"If I'm not making progress with a client, I would usually say I'm not sure of the full facts and that I need to speak to another member of staff for their input."

Figure 5cii.16.	Have you had any positive conversations with the public when raising the issue of their health/behaviour?
By Org	NS - there was no significant difference in response to this question by organisation type
By Level	A significantly higher proportion of Level 1 (56%) and Level 2 (65%) staff reported always/mostly having positive conversations when raising issues of health/behaviour with the public compared with Level 1 introductory (26%).

Overall Just over half of staff (55%) reported always/mostly having positive conversations when raising issues of health/behaviour with the public. Around a third (29%) reported only sometimes doing so and 16% (one in six) said never/not much.

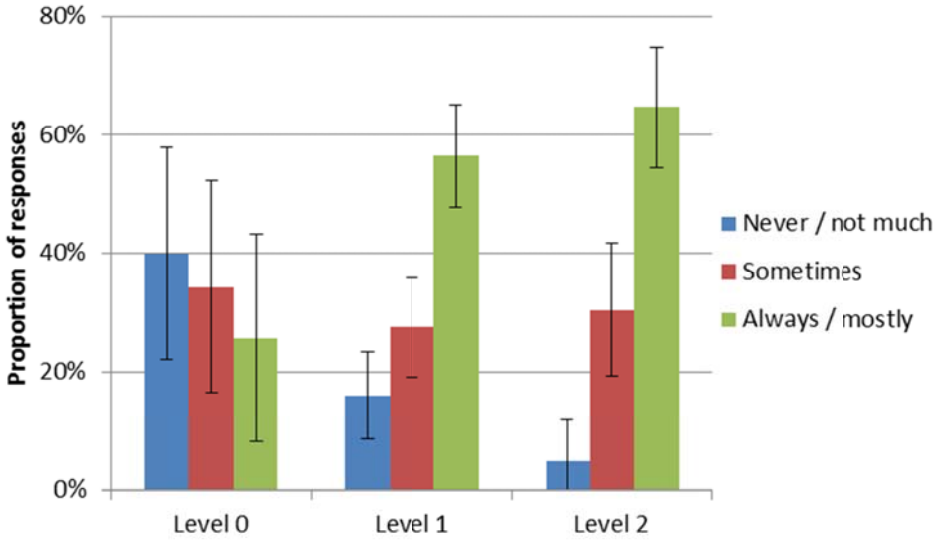
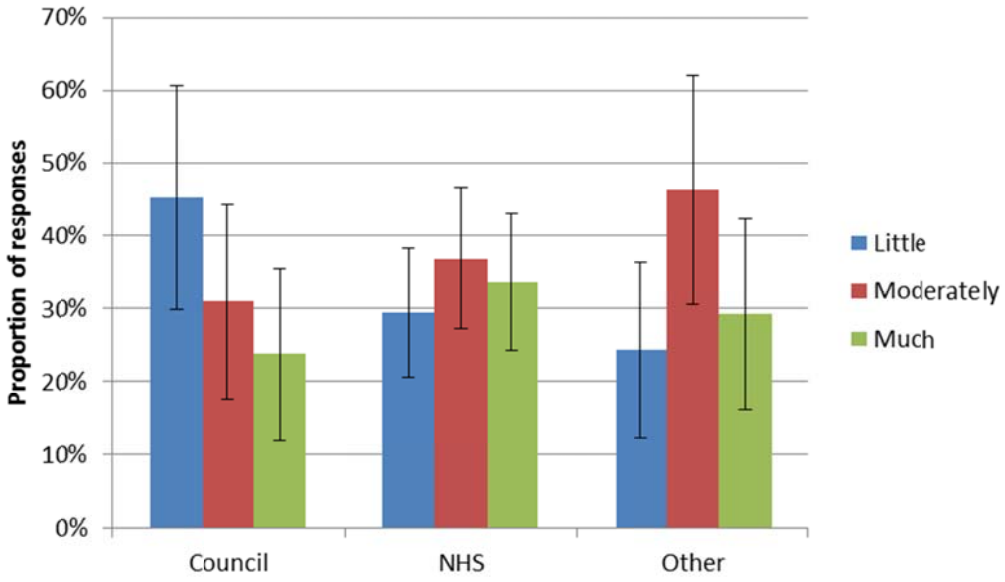


Figure 5cii.17.	If you participated in the MECC Training, did the training equip you with skills to deal with those uncomfortable and/or positive situations?
By Org	NS* - there was no significant difference in response to this question by organisation type * However, Council staff were more likely (45%) to say that the training equipped them little to deal with these situations, than NHS (29%) or Other staff (24%).
By Level	NS* - there was no significant difference in response to this question by competency level * However, Level 2 staff were more likely (43%) to say that the training equipped them little to deal with these situations, than Level 1 (31%) or Level 1 introductory staff (9%). NB – this is not statistically significant even when Level 1 are combined.

Overall

There was an even split between all staff as to whether the training equipped them little (32%), moderately (37%) or much (31%) with the skills to deal with uncomfortable and/or positive situations.



Text comments

In general participants who had experienced negative or uncomfortable interaction felt that the MECC training had given them some confidence, understanding, and useful tips for approaching and raising the issue of health in this situation. Participants were more aware of services and had access to necessary information to signpost clients. For many the training was seen as a refresher course that gave people with less experience, specific strategies to use, the confidence to start conversations, and aided in quicker recognition of people to be approached or targeted for more intensive support.

"I had the skills already but recognise this training is for all levels of staff and may have been useful to others."

Figure 5cii.18.	What changes (if any) would improve the training in order to help you deliver MECC better?
By Org	NS - there was no significant difference in response to this question by organisation type
By Level	NS - there was no significant difference in response to this question by competency level

Overall

The majority of staff (45 - 59%) thought that there should be no change to the information / support provided to help them deliver MECC. However, around a third (29-33%) stated more information on the practical skills for MECC and support outside of training would help; and around a quarter (22-27%) said more information on MECC principles and time for training would help.

One in 6 or 7 didn't know what change might help and a range of comments were offered up about what changes might help.

	Level of change			
What might change:	More	No change	Less	Don't know
Information about the principles of MECC	22%	59%	5%	14%
Information on the practical skills for MECC	33%	49%	4%	14%
Time for training	27%	50%	7%	16%
Support outside of training	29%	48%	5%	18%
Other (please specify)	12%	45%	4%	39%

Text comments

Mixed range of responses was received around the training. Some participants felt that the MECC programme was a waste of time. However, others felt it provided good support and would prefer more information about services available, local training, and more practical skills and scenarios. Participants felt that the SAT was not an accurate measure as they failed the test but do this in their job already.

Figure 5cii.19.	Since MECC has there been any change in the number of conversations with people about their lifestyle/health and wellbeing?
By Org	NS - there was no significant difference in response to this question by organisation type
By Level	NS - there was no significant difference in response to this question by competency level
Overall	The majority of staff (75%) said the number of conversations with people about their lifestyle/health and wellbeing had stayed the same. Around a fifth (19%) said there were more than before but 6% (one in 17) reported less than before MECC.

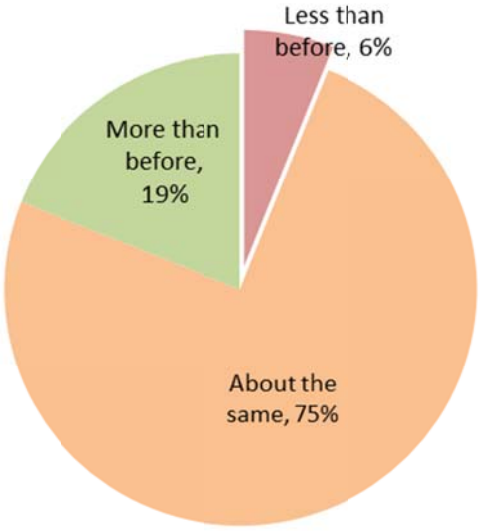
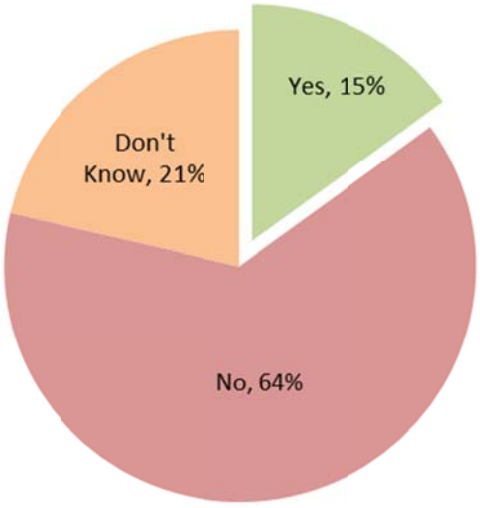
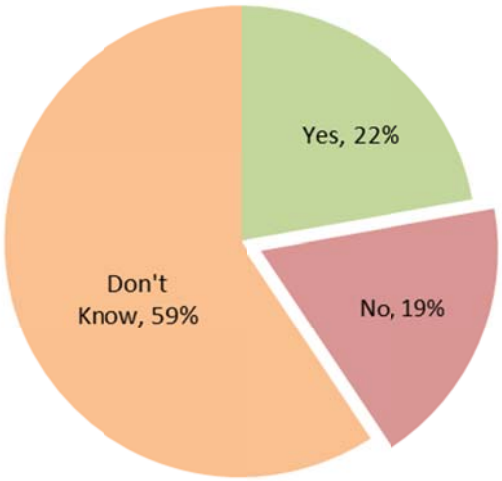


Figure 5cii.20.	Since MECC has the content of your conversations with the public regarding their health/behaviour changed?
By Org	NS - there was no significant difference in response to this question by organisation type
By Level	NS - there was no significant difference in response to this question by competency level
Overall	Two thirds of staff (64%) said that the content of their conversations with the public had not changed since MECC. Only 15% (one in seven) said that they had changed but 21% (one in five) didn't know.



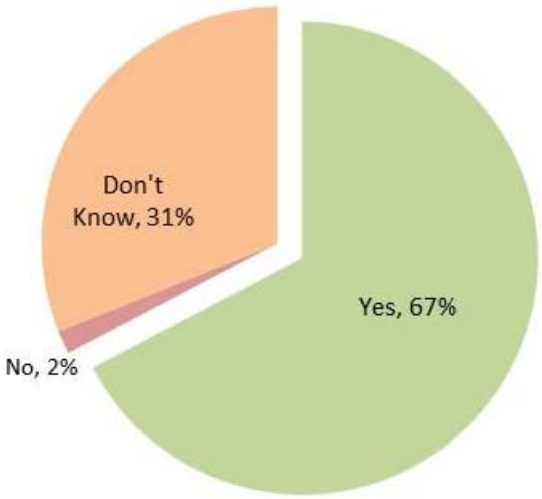
Text comments	Many participants were more aware of services and felt more confident starting conversations about health and behaviour change following MECC.

Figure 5cii.21.	Is there any on-going support to help you deliver MECC in the next 5 years?
By Org	NS - there was no significant difference in response to this question by organisation type
By Level	NS - there was no significant difference in response to this question by competency level
Overall	The majority of staff (59%) didn't know if there was any on-going support to help them deliver MECC in the next 5 years. Around a fifth (22%) said that there was but nearly the same proportion (19%) said there wasn't and on-going support.



Text comments	Participants wanted to hear about implementation in other organizations and were aware of newsletters currently delivering monthly updates. There was a desire amongst some participants to continue taking courses about similar topics or a refresher course in the future.

Figure 5cii.22.	In your opinion/experience does your organisation demonstrate a long term commitment to MECC?
By Org	NS - there was no significant difference in response to this question by organisation type
By Level	NS - there was no significant difference in response to this question by competency level
Overall	The majority of staff (67%) believed that their organisation demonstrates a long-term commitment to MECC. Most of the remainder (31%) said that they didn't know.



Text comments	Participants felt this was "something already being done and a key part of health promotion anyway", therefore, not something to be sustained long term. "MECC has demonstrated commitment to the program NOT the workforce." "This is a very loaded question... MECC feels forced in every way. Making a 'long term commitment to MECC' means nothing. MECC is a gimmick. No doubt an expensive one.

Figure 5cii.23.	Do you have annual appraisal?
By Org	NS - there was no significant difference in response to this question by organisation type
By Level	NS - there was no significant difference in response to this question by competency level

Overall Nearly all staff (95%) have an annual appraisal and only 5% either didn't know or said that they didn't have one.

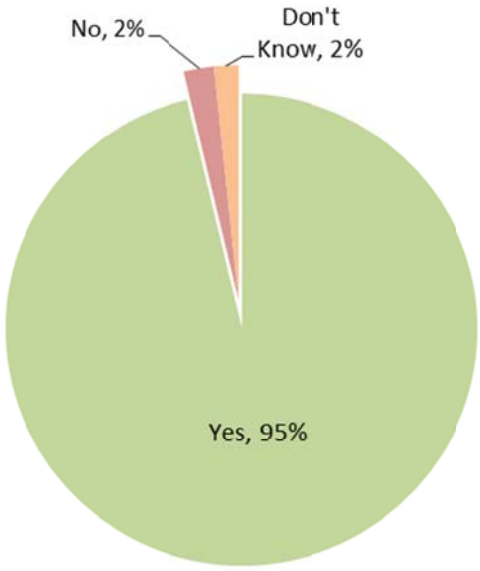


Figure 5cii.24.	If Yes, Is MECC part of your appraisal?
By Org	NS - there was no significant difference in response to this question by organisation type
By Level	NS - there was no significant difference in response to this question by competency level

Overall One third of staff (32%) said the MECC was not part of their annual appraisal but 41% didn't know. Nearly one third (27%) said that it had.

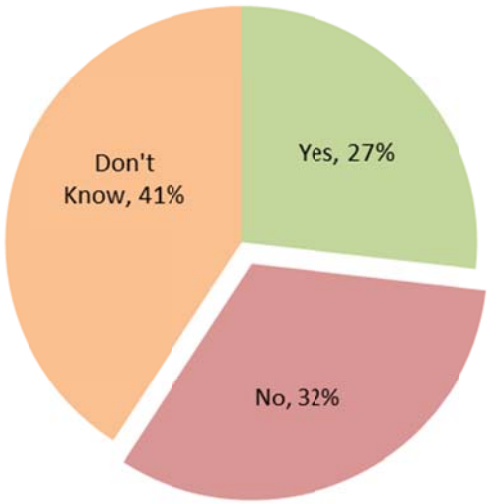


Figure 5cii.25.	Has MECC become part of your core (regular) practice?
By Org	NS - there was no significant difference in response to this question by organisation type
By Level	NS - there was no significant difference in response to this question by competency level

Overall The majority of staff (67%) said MECC had become part of their core practice. However, 16% (one in six) said that it had not and 17% (one in six) didn't know.

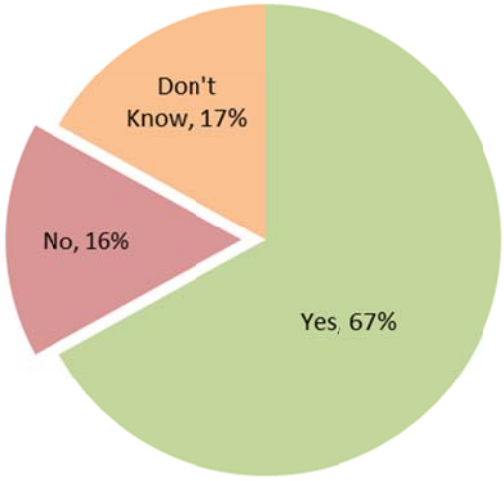


Figure 5cii.26.	To what extent has MECC changed how you work with people who use your service?
By Org	NS - there was no significant difference in response to this question by organisation type
By Level	NS - there was no significant difference in response to this question by competency level

Overall Over a third of staff (38%) said that MECC had little changed how they work with people who use their service. Around 40% said this had changed moderately and 22% (one in five) said it had changed a lot.

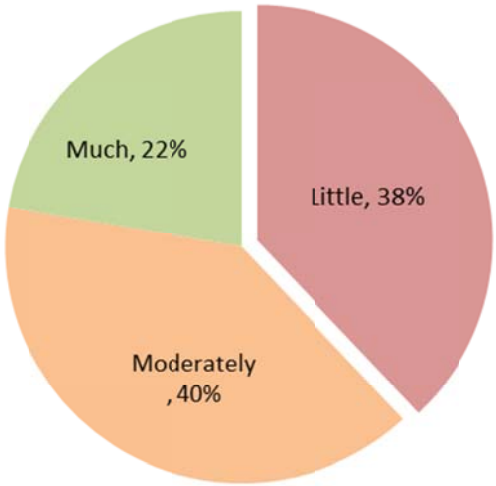


Figure 5cii.27.	Since MECC do you think referral pathways for health and wellbeing advice and services are much clearer now?
By Org	NS - there was no significant difference in response to this question by organisation type
By Level	NS - there was no significant difference in response to this question by competency level

Overall Nearly two thirds of staff (61%) said that referral pathways are about the same. One fifth (21%) said they were clearer now but 17% (one in 6) said they were not clearer.

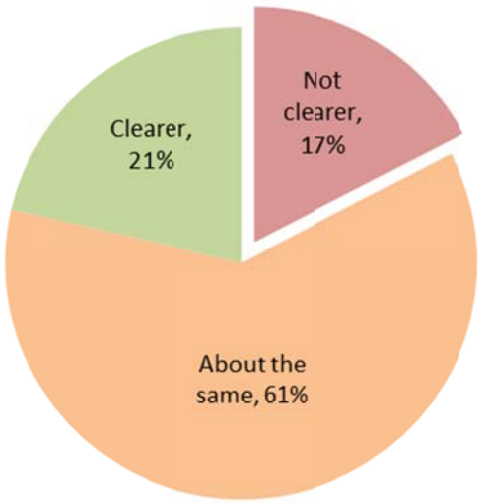
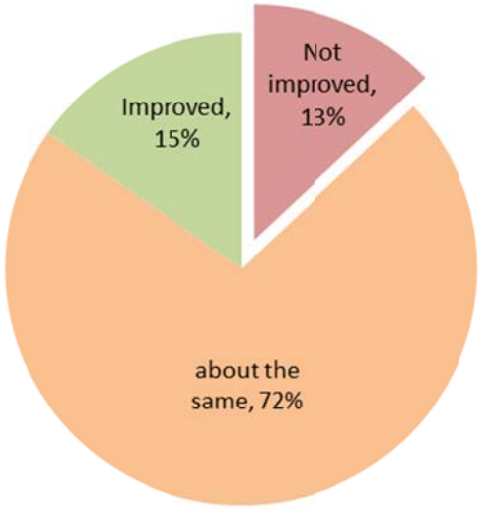


Figure 5cii.28.	Are you involved in referrals (to other services/receive referrals from)?
By Org	NS - there was no significant difference in response to this question by organisation type
By Level	NS - there was no significant difference in response to this question by competency level

Overall The majority of staff (69%) are involved in referrals to and from other services but nearly a third state that they are not (27%) or didn't know (4%).

Figure 5cii.29.	If yes, in your opinion have the numbers of 'appropriate' referrals into specialist health and wellbeing services improved since MECC?
By Org	NS - there was no significant difference in response to this question by organisation type
By Level	NS - there was no significant difference in response to this question by competency level

Overall The majority of staff (72%) said the number of appropriate referrals had stayed the same since MECC. Only 15% (one in seven) said this had improved and 13% (one in eight) said it had not improved.



Any final comments?

Overall of those participants who completed the open-ended sections to the Survey (n= 47), most felt MECC was a waste of time and very frustrating as it was something they were already doing. Participants suggested that the content of the training should be better targeted to the different audience (needs) and linked more closely to the SAT, including an opportunity to feedback and discuss their SAT results.

"Please try to target this training at services who need it, as there were more than myself working in many areas of the city who already spend all their time working this way. Also I have spoken to all my colleagues who also thought it was a waste of our time, just consider how much clinical time you have wasted on patient contacts / treatments having all health service staff doing these trainings."

"What's the point of knowing when to signpost if there hasn't been any information provided about WHERE to signpost. I believe this is the biggest barrier to providing advice, staff simply don't have easy access to information to be able to pass on, so they pass the buck and leave it other people to worry about. I also think that a lot of pressure has been put on staff to do the training without consideration of the person's job role. I consider it part of the holistic nature of my role to consider these types of issues. However I know that there are staff in other services who have actively passed the issues on to me rather than do the MECC intervention themselves. In general I feel that the whole approach has been quite condescending to staff how do this type of work on a regular basis."

5. di. Service Lead / Line Manager Interviews

Introduction to Interviews

The Evaluation Strategy was designed in line with The Outcomes Framework stipulated in the evaluation specification aims and objectives, clearly defined in the Making Every Contact Count (MECC) Programme (formerly Behaviour Change Programme) specification and in consultation with key stakeholders.

The commissioning agency specified the numbers of interviews to take place in its specification document - these were then revised to conform with the final outcome measures agreed. 28 Service Leads / Line Managers (SL/LM) and 48 Frontline Workers (FLW) were to be interviewed.

A semi structured interview schedule was developed, in consultation with the commissioners, to reflect the agreed system outcomes. The time taken to agree these outcomes was longer than initially expected resulting in an initial delay to the interview schedule being piloted with SL/LM and FLW. 6 volunteers from 4 different organisations – 4 SL/LM and 2 FLW took part in the pilot interviews and some minor amendments were consequently made to the schedules.

Once agreed to be interviewed, all interviewees were sent detailed information about the project and the interview process and a contract sent to them to sign and return agreeing for them to be interviewed and recorded.

Salford commissioners took on responsibility for contacting the original interviewees - inviting them to participate via email - sent out to all those who had registered for the Self Assessment Tool (SAT). The Evaluation Partnership (EP) was intending to do random sampling of the interviewees; however, as there was minimal response to this initial process and difficulties in attaining the intended number of interviewees, a different process took place. By the end of October 2012, only 2 FLW responses from 120 emailed requests had been received and none from SL/LM.

It was agreed jointly between EP and the commissioners that a new approach was needed. Different methods were initiated – direct action by the EP encouraging participation at a local Way 2 Wellbeing Workshop in December resulted in another 8 participants agreeing to be interviewed and the commissioners were also to ask Service Leads to approach individuals directly to encourage participation. The latter resulted in no further responses.

In January 2012, with just 16 interviews having been achieved, another approach was agreed and the total number of interviews required revised down. The EP would take full responsibility with a more proactive approach being adopted; directly contacting the SL/LM via email/telephone and asking for participation from both themselves and their FLW. This resulted in a much better response rate and by the end April 2013 a total of 40 interviews had taken place – 18 SL/LM and 22 FLW. There was understanding that this approach might result in the potential for the introduction of bias.

Methods

- 18 people were interviewed. 4 of the interviewees stated that they were in a service lead (SL) role with regards MECC. 10 of the interviewees stated that they were in a line management (LM) role with regards MECC. The remaining 4 did not specify.

- 16 of the interviews were conducted over the telephone and 2 were face to face interviews.

- All interviewees agreed to have the interview recorded. The interviews took from 20 minutes to 58 minutes to conduct. A semi structured interview schedule of questions was used. To allow interviewees to expand on particular points the schedule was used flexibly.

Interviewees

- The interviewees were working in a variety of different roles / capacities in various organisations:

  Salford City Council (SCC) – 8 interviewees from housing, public health, customer services, children's services, Health Improvement, Community Development

  NHS – 2 interviewees, both from Salford Royal NHS Foundation Trust

  Other – 8 interviewees from charities, social enterprises, voluntary organisations

- 2 of these interviewees were from organisations that provide services for children and young people.

- The majority of interviewees' roles were managerial, either in a commissioning or line management capacity (managing teams varying from 2 to 30 members of staff) with a minority having a combined managerial / service delivery role (having face-to-face contact with members of the public on a day-to-day or occasional basis).

Outcome of Interviews

The outcome of the interviews are summarised below under the main headings used in the interview framework.

NB: All quotes are as spoken, word for word unless in brackets. The code number of each interviewee is placed in front of each quote for ease of identification.

A. Implementation of MECC

1. To what extent, if any, have you been involved in the implementation of MECC in your organisation (in what way)?

- All of the interviewees had been involved in implementation in various capacities and to varying degrees.

- The majority thought it was relevant to their role and seemed quite happy to be involved. The Service Leads (SL) had all been involved in planning as well as implementation whilst the Line Manager's (LM's) involvement was directed more towards implementation and especially for making sure that staff had completed the SAT and training.

- There seemed uncertainty about when their organisations had become involved (i.e. the phase / wave) although the majority thought that it had been early on (i.e. November 2011 to June 2012).

- All of the SL could recall attending launch events or stakeholder meetings at the very beginning of their involvement.

- None of the SL or LM had been involved in the initial sign up to MECC.

13. Given to me because I have a lot of contacts with the tutors here at S, and I've worked for the org for over10 years. I'm considered to be "other projects" so I oversee a lot of the learning here…Support staff – don't manage any.

15. One of the first wave within the SCC…initially when it was first being launched….. we went to some of the earlier (stakeholder meetings)…our Asst Director we report to, he sits on the MECC Board. So we were onboard from day 1.

03. Not involved in the action planning. Colleague involved in the action planning and is taking SL lead in it. My involvement was to make sure my staff completed the … online training. If they passed that was ok but if identified further training they would……Have picked up on everybody who didn't complete it and they have done.

11. Right in at beginning…guinea pig / pilot. Incentive was CQUIN which was part of our contract so had to do it….Signed off overall contract initially….On the stakeholder group, IT group & in on the planning process…..Wanted to keep it simple.

15. Prompt re whether involved in action plan – not particularly. I went to the launch of it and I reported back to the other centre managers and staff about what the programme was. I was explaining about it in the first place and then it's been overseeing the training. So I have been involved but haven't sat down and written an action plan as such.

08. Took over from Chief Executive (CE) who was involved originally. CE signed it off. CE got involved in Action Plan.

- 1 interviewee stated that she was specifically employed to implement MECC. This large statutory organisation employs over 6,000 staff.

12. I was employed to implement MECC – specifically for 12 months. As such large employer – big deal to deliver it in a……..needed someone who has time for engagement & support.

- 1 interviewee stated that their organisation was involved initially but then did not go through with MECC as the timing seemed inappropriate. However, she is now linked in through commissioning services.

2. How has MECC's vision been communicated / cascaded within your organisation?

- The majority of the interviewees could recall how MECC had been communicated to them. Only 1 reported that communication had relied solely on an e-mail from the SL which was sent out to all staff.

- The majority of the interviewees were responsible for cascading the vision to staff within their organisation or team and were using existing mechanisms within their organisations.

03. My senior manger, who was involved in implementing it in Salford, she came down and gave a talk to the staff at one of our team meetings and explained what it was about.

- 1 LM reported that she was unaware of any communication about the MECC vision – simply about the need to complete the SAT. It was clear that she viewed MECC in a negative way, partly due to the way in which it had been communicated to her, and she was transmitting this negativity to her staff.

05. came through on an e-mail – said everyone has to do this (the SAT). I made sure they'd done it…..In all honesty you get a lot of these e-mails, saying you need to do this – you need to do this thing online…another loop….wouldn't know (how it was communicated / cascaded). Presume based on what it says it's (MECC's) about getting as much done as you can when you've got someone in front of you but I've got an agenda within my 20 min slot that I have to get through. that I'm evaluated on. I've not got time to cover loads of other things.

- 2 of the interviewees cited examples of difficulties that had been encountered in their organisations. Reasons given were practical difficulties associated with non-core staff e.g. volunteers do not have work based e-mails or attend staff meetings, staff working at multiple sites, sessional staff who work part time, information overly complicated.

13. Sessional tutors possibly aware of MECC but they don't attend (team meetings) because then it incurs a cost. So it's word of mouth…..Many of the volunteers will have moved through a pathway with us, possibly as beneficiaries, and have then moved to volunteering so some will possibly be more able to take it (MECC) onboard than others.

15. Initially it was relatively difficult. We could certainly tell we were in the first phase. We knew we were the guinea pigs really, so in that respect I know they've changed stuff based on everyone's feedback so I think the people going through it now or in the future will probably have a smoother ride in respect of it was…it was over complicated information in the first place,… at the start you were trying to describe something that wasn't actually there at the time, so it was quite a challenge to communicate the – the general ethos of it was quite straightforward – the signposting element – it was just trying to go a bit beyond that and what it would mean. From a staff perspective they say "what does that mean for me then? Am I going to be doing something different, am I already doing it?" and they were the kind of questions you couldn't answer at that point, until the training started.

3. How does MECC fit with your organisation's core business?

- All but one of the interviewees stated that MECC does fit with their organisation's core business but added that they were already doing it – it was not new. There were comments about the difficulties in seeing the difference that MECC makes i.e. difficulty recognising what constitutes MECC. In most cases it reinforced what organisations are already doing.

- Some interviewees could see a very clear fit with what some of their staff were already doing, but added that it might be of greater value to staff who have had less of a Health and Wellbeing (H&W) focus.

03. It fits very well. We're out there all the time. Sometimes we're the only people they see in a week.

04. It's very applicable. A lot is 'what we're doing anyway'. Offering advice / signposting / how they can make positive changes to their lives... So that side is second nature really. Recognising what we do already.

08. Perfectly. We have been doing motivational interview training & Action Learning sets – so we're very familiar with it.

12. Yes fully and staff believe so too.

16. All our advisers are trained to deal with every enquiry very holistically so their training will always lead them to look beyond the presenting issues anyway. That fits in very well with the MECC.

10. It's kind of stuff we do anyway (working with substance misuse but 9 out of 10 YP will have other complex issues). Housing, sexual health, signposting, brief interventions, - everyone does it as a matter of course on a day to day basis with their clients as and when it arrives…..Also if commissioners say we do it we do it! That's the reality – but luckily it's for the right reasons as well.

13. Very well because we're doing a lot of it already. It's kind of reinforcing the fact that we are doing it and this is what we're already doing. Prompt - Has it changed practice in any way do you think? I would say possibly yes. I think it's a raising of awareness more than anything around these health focuses and I think the staff are more aware now of the interventions they're making, and that these conversations that we're having are having benefit and we're actually recording them. (Where as) before we weren't recording them, and possibly not recording them around areas that we don't necessarily specialise in, rather like debt awareness, housing – the other aspects of it.

16. A big part of our service,….their service is around health and wellbeing issues which are core to MECC, and there's obviously a real synchronicity between that part of our service and H&W but also it fits in even more usefully with our core services because they were less H&W focused in the first place. So the additional training and awareness raising was perhaps more useful for those who deliver more traditional advice than those who give health orientated advice.

- One thought it was a tenuous link and that some of the staff were just not making the connection.

09. There are some sections where I think the link is quite tenuous (– eg X, but XX & XXX it fits quite well.) I don't think most of the staff see the link. They see it as something different, I'm sure a lot of them will be having these conversations with our customers and just perhaps just not making the connection. Several of the staff who did the initial pilot with the self assessment tool came away saying that wasn't their job, that wasn't what they were about – and ultimately the message has filtered through to their work team. Not resistance, but (they) didn't feel it as part of their role.

4a. How do you think clients using your service will respond to MECC?

- All of the interviewees doubted that clients would notice any difference as their services have already been delivering the principles associated with MECC.

- It was not felt that conversations with clients would alter as a consequence of MECC.

- Some stated that the public have not been made aware of MECC. Others referred to the lack of tools for gauging any changes in response from the public; however, some referred to the potential for increased referral, improved provision of information to clients – but these would be difficult to attribute to MECC.

03. Think it's something we're always done. We get a lot of compliments and thank you letters etc, so I don't really think, we haven't said anything to the customers about MECC, not cascaded it to them.

04. It's conversations that we have anyway as part of the support planning process. No real change there.

10. Not sure clients will know it's MECC – it's part of what we do anyway. We do MECC as part of our everyday work.

13. I don't think they're aware. It's so discrete as far as what we do and the conversations that we have, I'd say very little has changed.

15. Difficult one just to gauge because of the range of different enquiries and people. It's hopefully reinforced what they're already doing. So in that respect it's been difficult to say "yes, now they've got the training this is what they're doing" because they were doing that anyway. What it's done is formalise it a bit, made people think a bit more.

11. They wouldn't know it was MECC, they would never have heard of that. – (but) I would hope that it has perhaps raised the profile with staff a little bit of going the extra mile – being a bit more creative about the way they interact with people and if there is an opportunity there for suggesting something else they could be doing – having that little part of their brain –maybe we can tell them about …. Sounds like … we've got CAB, Job Club & skills & work advice as well – it's taking it the extra mile.

06. Mixed really – some will want to make improvements to their lifestyle / different lifestyle choices; however, a lot of them are at the start of a journey.

- A minority of interviewees felt that there might be some adverse reactions from clients.

15. From what I've heard a few members of staff, after they attended the training, went a bit too far and tried to shoehorn it into every conversation. A few of them have come unstuck on occasions. All with the best of intentions but you've obviously got to be careful what you say to people and how you say it. The buildings are very open plan and some people are just coming in to give a library book back and they don't want any other interaction apart form that. Some (staff) have had their fingers burned with what they've tried. Hopefully that's not put them off getting involved but I think it's a question of choosing your time.

- One respondent was very clear that clients would not notice but that the Service heads responded specifically to the MECC initiative.

08. (They) wouldn't realise what we are doing but in reception (we) have changed the layout of the Centre so it's much more face to face contact with our clients – so (we) can have the chat to them and we can interact with them more easily and talk to them re their issues.

4b. (SL/LM). Do you feel that MECC benefits the way your staff interacts with clients / users / patients?

- There was a very mixed response to this question, possibly due to the majority view that MECC is not new and therefore it is difficult to identify tangible / measurable benefits.

- There were some potential benefits that SL/LM referred to e.g. improved signposting and referral due to better information re other services; however, the downside to this was felt to be the lack of tools to support this. Some interviewees had anticipated that these tools would be developed as part of the MECC programme.

08. ***(See 4a 8. above re altering reception).*** **Prompt: Has MECC has made a difference? Has it been directly as a result of MECC that there's been a change in the reception area? – Yeh definitely /100%. Even the way we think of them has changed too, they are doing something bigger there – they can support & give advice to individuals that walk through the door. MECC has been the main driver.**

12. Yes, it made those staff that aren't normally in contact with patients think more about having these conversations with patients or patient's families…. also about managing their own staff – they are using the knowledge of MECC training to have conversations with (their) own staff about their own personal health & wellbeing.

04. Not in terms of how they interact – (but they are)) probably more aware of what they are saying and how they are saying it and making a note of it.

06. Not particularly, no – it's part of our core business to signpost people or to introduce people to things…. It (MECC) dovetails with it really as opposed to enhance.. it probably enhances it a little bit.

03. in respect of referring on, possibly - refreshed people or made them think they need to find out more e.g. if someone wants to give up smoking they'd maybe go and find out. Do fact-finding. Can't know about every service. Could set up a directory for people. Probably is one our intranet. Thinking more of something in our office.

10. I'm really committed to the principles of it, but has it made a difference to us? Not really, because part of case managing a young person with complex needs – means you do take on all of that.

14. Hasn't benefited our staff as we already use this approach and have been for many years. But it has formalised the assessment process – we've got a pre-assessment process through MECC which is really really useful and it's showing staff that even if they think they know something in fact it's a lot more complicated than that.

09 (Most of her staff haven't had training yet) Hoping it will make them feel more confident in signposting. It's about knowing what services are available across Salford.

- 1 interviewee suggested there were no particular benefits, with her feeling that clients expect staff to focus on one thing at a time and prefer 1:1 contact with staff, rather than self management / care; i.e. there is little time within the consultation to broaden the conversation beyond the main issue.

05. I think between smoking and wt, they say "I want to tackle one, I can't do both". They say "I can't think about that (smoking) at the moment." They can't cope with two big issues at the same time. So want to lose wt first and make some headway.

5a. (LM). How have you selected the staff to get involved with the MECC programme?

- The majority of interviewees had no difficulty in selecting relevant staff. Selected staff include managers, team leaders and frontline staff who have contact with members of the public.

- In a minority of cases a member of the Delivery Team helped the LM to select the staff according to the level.

- Half of those interviewed recalled that in their organisation, everyone was selected for Level 1.

03. We didn't select. Everybody, because they play a generic role. 3 teams cover the 24 hrs, 1 person dedicated control centre officer – comes into contact with people too on the phone so everyone's done it.

16. People selected were the Advice Service Managers who supervise the volunteers, and we also selected a number of case workers, debt workers – kind of people that had large caseload and spend quite a bit of time with clients. Thought it would be useful if they could convey this type of information e.g. to clients having serious financial problems which are no doubt impacting on their health. Those were selected to do the training.

- Two interviewees stated that commissioners dictated who was to be involved within her organisation and she had been told who they were by the SL.

05. Told to. ….They had to do the online assessment.

12. Commissioners told us – but have also had to replace / managed things around e.g. as one of the services have been disbanded.

- However, organisations that have volunteers have so far not selected them for training. There are a number of reasons for this e.g. access to SAT, unable to make this mandatory.

5b.(LM). How did staff respond to this?

- Again the response was mixed. SL/LM stated that some staff were very positive, others were uncertain about what it would entail. In some cases staff were disappointed to find that it did not deliver what they had expected, whilst others have been positive about their involvement and they felt it was what they did anyway. Some mentioned that it formalised the process which they appeared to like. **It is important to note that all of the interviewees responded to this question appearing to view "involvement" as doing the SAT and / or training.**

03. They're (the staff) very good, very flexible, adapt to anything, anything to help the customer, Nothing worse than going in and being asked something and saying, "oh I don't know". Many of them from a care background and gone through their NVQs so very receptive to things like this…..– anything to help them do their job better and keep people in their own homes.

13. there's one member of staff who possibly feels, hasn't necessarily resisted it but feels it doesn't fit with her post. I feel that it does. ….I tried my utmost but thought ok…(she didn't go on to do the SAT)…the rest of the staff passed with flying colours.

16. they were all generally positive. Not least because it fits in naturally with the way they work……I sold it to them that there's going to be this great new database of info. As advice workers, we all naturally

gravitate to that. So they were generally really keen. They thought they were just going to be able to click on something and be trained to be able to be aware that there's a so and so service in x that's going to help my client……until, they had to go on the training thing…. What they were saying to me was "ok I've done this training, I'm now ready to give all this info about H&W services in the city – where are they?". I'd say "someone's creating that database as we speak." And they'd say, "oh, oh ok" and at that point lost a bit of motivation. They're thinking that telling people other than in general terms to stop smoking they weren't really sure what they could refer to to give more information. That was identified as another central weakness in the arrangement.

06. Initially (it was) something else to do….when the concept was introduced they just took to it because it's what they do all the time. ….It fits in perfectly... It's what they do anyway – it's just formalising it now under the MECC initiative.

12. Actually we do this anyway. At first they were a bit reluctant because they don't like being assessed on something they know is their bread and butter and potentially failing their self assessment and then being told they have to go on training – when they have had a number of behavioural intervention trainings over the years.

- 1 interviewee made the link between the differing responses from staff in different roles i.e. clinical v non-clinical.

12. But those who weren't / didn't have a clinical background said it was really good – benefited from being in a room with health and social care people – forming a network of who to refer into.

- 1 SL/LM seemed to resent the imposition of training for her and her staff, viewing it as just another thing that she and her staff had to do.

05. It's just another hoop we have to do, another online assessment. (Put it in same bracket as H&S / fire online assessment / training) A little bit of resignation.

- One interviewee referred to MECC being viewed by his staff as another initiative - a passing fad, which despite the intention to embed, would not be.

15. A bit of a difference of opinion really. I think our staff are very varied – from various backgrounds – some are really upbeat and take things onboard. Others are a lot more cynical. So you've got people at different ends of the spectrum and a lot of them falling in the middle. So some of them have come back and said they've really enjoyed it. Most people said they felt the training was quite good. I think it's fair to say that whenever staff go to anything like this there's a fair amount of cynicism beforehand because there's been lots and lots of fads. When MECC was first announced they didn't want it to be something that goes on for a year and then everyone forgets about it and moves on to the next thing. They wanted to embed it into the orgs. That's not always what's happened historically with this kind of thing so I think it's fair to say that some staff went in (?majority) thinking "what's all this about?" and most the feedback's been positive. There are some people who've said they don't think they've benefited from it cos they're doing it already but they're certain members of our team even if you send them on training about something new they still wouldn't be positive so it's more about them than the project.

6. What are your thoughts around the SAT process / training?

SAT

- Most of the interviewees had a few comments relating to the SAT and training. All of the interviewees had firsthand experience of doing the SAT as well as supporting their staff to do the SAT. One seemed to think it was a useful process.

10. It was good at making you think. It gives everyone a broad basis and even if it gives people the idea that 'I need to get myself a list of numbers together so that should anyone ask me I know where to direct them to or to get some telephone support' - that in itself is empowering for clients.

Recurrent themes were:

- Logistical problems (logging on, no e-mail address for sessional staff and volunteers)

15. Was logistically difficult – have some staff who only work in an evening – 5-10pm. For them to find time to do the SAT….but then you've got to get them in in the day time to do the courses.

16. Most of the training we wanted delivered to the volunteers, as they would have the most contact. We were never able to resolve a training route for them that would work for them e.g. it all had to be done by them logging on and giving e-mail accounts and we said they can't do that and we can't expect them to give their home e-mail.

08. Problems with the original SAT process for whole team. Real technical issues / frustrating.

- Fear / embarrassment / devastation associated with "failing"

03. In the line of work they're in they'd be very disappointed if they didn't get the questions right It's unnerving when you do it. You don't want to get it wrong. You want to pass first time…."I've been identified for training – I must be rubbish at this. Everyone else passed and I didn't." Then you go on the training and there's the added pressure of doing the test again and if they don't pass it there's "I've got to go for more training" so confidence goes down.

06. Staff were embarrassed that hadn't 'passed' the test as think have the knowledge.

12. Some highly regarded members of staff have failed it and have been devastated but recognise that they are missing opportunities.

- Integrity - differences in how staff completed the MECC was linked to outcome ("pass / fail")

03. You could work out the answer yourself and guess. When you've got a large group of people, I suspect if someone didn't know an answer they'd ask in the office and someone would tell them the answer. That's the danger of these online things. If someone's done it next to you you ask "what did you put?" You then put that down but you wouldn't necessarily have got it right.

05. Read the questions out and did it between us. It was dead easy. I sailed through it. In all honesty you have to think about what answer they want, might not be your answer. It's like any exam. You're not there to be truly honest (16.55). Think what the answer is to get through it. It's irrelevant really.

15. We did it (the SAT) very honestly in terms of - fair to say that when you're doing your SAT if you wanted to fudge the books it's probably quite easy to do. We said there's no point (doing it as a team)

cos we're not going to get anything out of it. I'd rather if you're going to commit to something do it properly. As a consequence most of our staff went through the training.

04. Went well – assessment itself something you can get through if you want to – tick appropriate box. Not a real test.

- Concerns regarding whether the SAT is an appropriate tool to judge competence

03. When doing these tests you just want to get through them so you say yes. Doesn't mean you can do it (your job) well, or at all.

- Ambiguity of some of the questions

13. it was down to approach and I think a lot is down to confidence and I think we can feel confident but when we're being asked "how confident do you feel" you don't want to go "yes, I'm extremely confident". It isn't really in our nature is it? So I think that as far as people were confident but they say they're not extremely confident because it's something we are really doing already.

08. Questions not well written – struggled initially.

- 1 interviewee suggested that instead of the SAT there should have been a more traditional e-learning tool with a learning module followed by a test. She felt that Staff were more familiar with this type of tool.

03. Maybe if there was…sometimes we have e-learning modules where you read about things as you're going through and then you answer questions on what you've read / learnt from that. Maybe something like that rather than going straight into a test…you read a scenario or what MECC's all about so you're in that frame of mind when you're going in and know what people are looking for.

- 1 interviewee reflected on the changes that have been made to the SAT, viewing the changes as positive.

13. I'm glad they made the changes; I think they needed to make them. I think some people would have struggled pre July and the % was very high. Good that they've merged the introductory with the intermediate. I think just having a level one avoids any kind on confusion.

- 1 interviewee commented on the SAT being a more practical tool than all staff having to be released for training sessions.

03. For us training is a big issue because we need to keep the service going. We can only send 1 or 2 people at a time. Couldn't say come and train all our 30 and they'll go away and do it. This for us is a better thing, that someone can sit at computer for 15/20 minutes and then do an exercise about it.

- 1 interviewee commented on the difficulty she had experienced when trying to monitor which of her staff had accessed and completed the SAT.

03. The only thing I don't like is when you go looking for you staff they're all by first name and not surname – very frustrating that you can't look at your own people. Everyone's there. It's a bit of a nuisance – you only want to look at your own. If you've got 3 Anne's you've got to look at them all. For me you should be able to get just your group of people. Quite a long list on there and when you're trawling down.

Training

- Responses were varied depending on whether the interviewee had personally undergone training and / or had staff who had been on training courses. However, as with the SAT, there were a number of recurring themes, some positive, some negative.

Positive

- Useful and enjoyable
- Valued the multiagency / multidisciplinary approach
- Confirmed that already doing MECC
- Resulted in increased confidence
- Useful for staff who weren't expecting it to be.

13. It was quite refreshing. Hadn't realised that Welfare Rights have an advice line, and just looking at where it was being rolled out, completely across the board, to Hope Hosp with it's thousands of employees to really smalls orgs, charities and people like ourselves.

15. Training was multiagency - that made it quite good. People there from various different disciplines….There were a couple of Speech and Language Therapists who work in the centre and I know them but I didn't really know what they do and it was quite an eye opener e.g. Didn't realise they do all this stuff with young offenders and all sorts of things. I guess everyone's unaware of what everyone else does really.

13. Did you feel more confident after training? – yes I did. I felt that I had greater knowledge; greater insight into what was looking to be achieved and it really helped me as far as then speaking to the staff about it. In some respects it was a benefit that I needed it because then it really allowed me to explore it further and then say….yes, it was helpful.

04. Most useful part was being able to talk to people from different areas.

Negative

14. Not sure the training is that useful (for us as already have this type of training in place – it's nothing new to them). It's integral to what we do (and we will continue to do behaviour change training internally).

11. Unless incentives, then doesn't see how orgs would carry on doing the training / train the trainers.

04. The training itself – didn't gain anything from it.

12. Mixed response to training. Level One training had lots of positive feedback – was a day now a half which is much better. Feedback from Level 2 training – Varies - morning really useful afternoon petered off. Could have been more condensed. Depends on experience they've had / how qualified they are.

- 1 interviewee, whose organisation relies heavily on volunteers, commented that the training is not flexible enough / did not meet the needs of certain staff groups or the organisation.

16. Most of the training we wanted delivered to the volunteers, as they would have the most contact. We were never able to resolve a training route for them that would work for them…much lower impact on them, and that was something I discussed with Delivery Team member who acknowledged that the service design had never really accounted for using 100 volunteers in an organisation. I also explained that we…can't oblige our volunteers to do anything. They come to us and they're trained and they have to give advice within our framework and auditory processes. I can't then go to them and say you now

have to also deliver this service as a MECC trained person. I don't think that had been factored into the training in the first place. If you're going to use 3rd sector orgs and the bulk of their staff may say, "you know what? I'm not interested in this"…We never resolved that. MECC as an ethos and a style I think it's brilliant and I wanted to support it and I did support it as much as possible but without quite getting over that hurdle. Potentially it's 100 volunteers based in townships in Salford that we haven't' been able to get them all trained. There's nothing quick and smooth enough to be able to offer.

7. Some of your staff will not need to complete the MECC training because they passed the sat; are there any differences in how this staff group are delivering MECC?

- 10 interviewees were not able to say as all of their staff had passed the SAT.
- 5 interviewees thought it made no difference.
- 1 interviewee did not think there was any difference but could not say for sure.

15. It's really just raised awareness and it does give you something to think about – how you interact with people, and opportunities etc. It was helpful in that respect, but you can only do so much in a short training course and those that were better at it before the training are still better at it now.

- 1 interviewee reported that all his staff had been trained (including himself) and therefore he did not have a cohort of non-trained staff to make a comparison. However he suggested that it is perhaps more significant that some staff are naturally more helpful than others. He did not feel that the training provides people with the skills but heightens their awareness.
- 1 interviewee felt it definitely made a difference.

12. Absolutely Yes. Most staff who didn't need the training don't seem to have fully understood what a MECC intervention is compared to their normal day to day work.

B. Embedded Sustainability

8a. To what extent is MECC embedded in your organisation's strategic and business plans?

- Most of the interviewees were not sure whether MECC is mentioned specifically in their organisation's strategic or business plans. All of these made reference again to the fact that MECC is something their organisations do already. One said it was.
- Some of the interviewees did mention it as happening through appraisals and job descriptions, but others acknowledged that it was not yet 'embedded' directly into their plans but that it might be in the future.

15. It already fitted in with a lot of stuff the Council were doing. It dovetails perfectly because in terms of SCC and where they're at….Even before MECC came around the council's priority fitted into it perfectly…That's the challenge going forward – we've all been on the MECC training and we've not day to day seen anything radically change in terms of embedding it.

16. Our development plan might make reference to it but as one of many influences in the way we deliver our services.

13. It's definitely embedded in that we've taken it onboard and it's something that we're going to continue doing.

06. In staff appraisals every single person has as part of their objective "*to ensure that MECC is brought (that year) into any interaction possible"* & it's monitored through monthly supervision & case reviews with staff.

09. Strategically there's been a decision to take it on board but don't believe it's 'embedded'. Know that ultimately it should be integrated into job descriptions but think they are quite a long way off that at the moment. Maybe need to get a bit further down the line.

12. It's not at the moment – but have had agreement that the MECC "strap line" will be included in our future job descriptions; plans afoot for brief 5 minute introduction re MECC in inductions.

11. (We) will have something in business plan re case studies and recordings & it won't be allowed to go off our radar. It will be part of our volunteer system too – funding just been found for volunteer programme.

14. (It) Is at City Council level via Well Being Board. Is an expectation that it's in our Spec and MECC will be stipulated in that. And will be in our Business Plan.

- 1 interviewee commented about other ways in which MECC might be judged as being embedded.

08. As soon as you walk through the door (i.e. the change to reception) – that's why we changed it (MECC).

8b. Does the organisation's strategic workforce planning include or demonstrate commitment to MECC and in what way?

- None of the interviewees were able to answer this question.

9. How is the MECC role currently linked into:

9.1 Appraisal

- The majority of the interviewees reported that appraisals are done within their organisation.
- 6 indicated that MECC is currently linked to these.
- 3 stated that there is an intention to do so.

03. Due around now. Have an online system and then we discuss what targets we're going to set for following year. Then they're recorded on there. We'll have one (target) that may be that they (the staff) will engage in the MECC and they need to take responsibility for ensuring…what we need to decide is how they're going to record it.

13. I don't think it is; however, we have introduced a new appraisal form so there's nothing to say that it couldn't be put in, and there wouldn't be any resistance. That's valuable. I'll mention that.

9.2 Mandatory training for managers

- The majority of the interviewees were unaware of MECC being linked into this although 2 suggested it was in certain sections of management.

- 1 from a large statutory agency referred to the organisation's electronic mandatory training record which records all mandatory training – this does not currently include MECC.

05. It's not on Snowdrop (which is x's way of electronically recording all staffs' mandatory training. Generates email if training not done).

9.3 Mandatory training for staff

- 9 interviewees reported that MECC training is mandatory for core staff (i.e. not for volunteers or sessional staff).

13. Most certainly, yes.

9.4 Induction of your new staff

- 11 interviewees stated that MECC is linked into induction.

- 1 did not know, referring to there having been no new staff employed within the organisation.
- 1 interviewee reported that it is not linked but he would like it to be. However, he felt that the first priority was to move forward on the issue of delivery of training to volunteers.

16. All these were things that I was involved with, in thinking about how we might do this, eg volunteers – idea was when starting we could integrate it into their induction but because we never got past that point around the training delivery I never moved that forward. I would be more than happy, as a straightforward way of training our volunteers, for them to have that in their induction, They would probably find that an interesting diversion from their training as XXX workers. Include a 1/2day session on MECC – I think that would work really, really well. Easy to implement. Someone from MECC would come to one of our XXX every 3 months – to speak to our new volunteers.

9.5 Job descriptions (JDs)

- 3 interviewees have them linked into JDs.

- 4 others stated that the aim is to link MECC into job descriptions in the future.

- However, the majority did not have them linked in and one of these stated they would if the commissioners asked them to.

08. Written into job descriptions – part of training and induction – will do SAT and go onto do training.

10. Types of support you've had for implementing MECC

Internal (i.e. from within own organisation)

The majority of interviewees could describe some types of support they had received (some following prompts from the interviewer) from within their own organisation. Types of support included:

- From Chief Executive
- From Assistant Director
- From SL via team meetings, e-mails
- From Project Manager employed within the City Council
- Peer support
- Line manager / service lead

13. CEO has been very supportive, and within team meetings we've obviously emphasised the need for it and the all round benefits.

15. Certainly from on-high, they bought into it and we've all been told.. asked to get involved in it. In that respect we've had the time to do it. Time to organise it and for staff going and doing the training. They were told from day 1 that this was something that the Council were involved in and they were to go for it.

Project Manager appointed mid point – so initially managers had to get on and make it happen amongst ourselves. There is a bit more support (since PM appointed) if there's anything we need or need to feedback.

- 2 interviewees reported that although they do receive ongoing support, they knew that they could ask for more help and support if required. They felt that managers have autonomy to implement.

03. Following prompt acknowledged that receives support from within own organisation but…. I think in some terms when we're asked to do something we're asked to get on with it and if we need help to go back.

- 1 interviewee from a large statutory agency reported that she had received no support – had been told to get on and do it via e-mail from the SL.

External (i.e. from outside own organisation)

- The majority of interviewees could describe types of support they had received (most following prompts from the interviewer) from outside their own organisation; however, comments were generally quite vague. Types of support included Delivery Team member, MECC newsletter, emails and events.

- 2 did suggest that they had no support now, though they did at the very beginning.

10a. What's the best level of support you've received? Why's it worked etc?

- 1 interviewee could not identify any support that she had found helpful.

- 2 interviewees felt that the best support had come from within their own organisation.

15. Assistant Director – involvement at the outset and him buying into it was quite significant for our service because it marked out to us as managers, that's been cascaded down, that this is something that we are involved with. It's not just a half-hearted thing. JT sits on the Board so as a consequence you're going to be expected to see results and he's not going to be very happy if we come along and say none of our staff have been on the training etc.

- 4 interviewees stated that the best level of support came from the Delivery Team, but both commented that this was better during the early stages.

13. (Referring to Delivery Team support, which had been there initially, but had tailed off) Yes but I don't think we've really needed it. I think because we are small, because it's been taken on board and I don't feel that personally I've needed any support. Prompt - Would you know where to go for support if you did need it? – I suspect it would be public health…can't think of the name of the gentleman..? RG and MH. We haven't encountered any difficulties.

16. Really good support from ** (member of Delivery Team) (until late summer 2012). Met her a few times and she helped with the action plan. I know I fed back to her the issues re training and how we can make it more useful for our volunteers. Had lots of really good conversations with ** (another member of Delivery Team) early on in the development of the project.
Since they've gone? – Looked back through e-mail trail (during the interview as not really able to identify any support) – it's largely MECC newsletters. The odd invitation to some workshops, things like that.

11. Are you using the communications MECC toolkit? If yes, how are you using it?

- There was a mixed response to this question. The majority were not quite sure what the interviewer was referring to but following clarification the majority of the responders stated that they had not used it, were unsure or had used it initially but were no longer using it. The others reported that they did use the toolkit and circulated anything relevant to their staff; however, how useful it was seemed variable.

13. Get regular updates. There's a good service lead one came out which was presented very clearly and was easy to read and to follow. Could see what work is being done across the city. It was helpful for me and for the staff to know it's not only us…..and to read the case histories as well. It's really helpful because it gives staff ideas and makes them realise that these are coming from other orgs and this is how other orgs are doing it and reporting on it.

- 1 interviewee would have liked to have it sooner but recognised that as a first wave it was still in development.

15. Yes. All circulated to staff when they've came around. Probably landed a bit(late) – and it's one of the downsides of being one of the first service – it was possibly a bit later than we'd have needed it cos we were starting a programme as all of this stuff was being developed and it really came to fruition after we'd started the training. Already knew about it to a large extent but we knew that from the start – that's not a problem. People on 2nd or 3rd wave have a smoother experience.

- 1 interviewee referred to additional information he receives from a former Delivery Team member which he finds very helpful. This does not come to him under the banner of MECC.

16. I tend to share any kind of communication stuff that comes to me to all our xx Officers and they put posters out. Receive lots of info from ** (former DT member), even now, about health and well-being services in the local community. Those are all put out in the xxxx. She does that separately from the formal MECC. Put it out in all our waiting rooms that says "in your locality there's just been a new cycling

day put on for people who are obese." That gets promoted in all the xxxxs. I see that when I go round the bureaus.
Does the information carry the MECC logo? No, it was really from me talking to and saying I would be very useful if we could have that and she sent it out even though she's not involved in MECC anymore…I don't think.**

12a. Are there any particular barriers / challenges to implementing MECC?

- Almost half of the interviewees (6) stated that there had been no problems in implementing MECC, but 1 did qualify this by referring to the small size of her organisation. She reported that she was aware of other SL/LM facing challenges.

13. Not as far as ourselves but for other organisations – I've picked that up by attending the stakeholder reference group really. E.g. freeing up staff, which appears to be a key element…for the training. I think with such large volumes and what they're having to deal with it's logistically a huge challenge….. Difficultly getting people to take it on rather than seeing it as another piece of work.

- Within this group, 2 voiced the opinion that staff might cite reasons for not being able to implement MECC but there were excuses rather than real barriers / challenge and or it is not a priority for them. This perhaps links to staff's perception of MECC.

15. Don't think so. Once people have been on the training it's one of those things you can't force anybody to do (suppose you can do) but it's more a thing of encouraging and it's that kind of environment anyway – not punitive. In terms of barriers I don't think there is…..they've (staff) got the perfect forum. Staff have been given the training and skills – can't say "we've not been given this that or the other". They're encouraged to go the extra mile to help people and refer people.

- The majority of interviewees identified at least 1 barrier / challenge:
    - Time / frenetic pace of work with high volume of clients

05. It's time….don't delve. The only time I do anything is if they're sat there in front of me going on about something…..I'm not looking for problems.

15. When it's really frenetic and you've got stacks of people waiting then it could be challenging to justify spending an extra couple of minutes with somebody when you've got to get through the queues – get somebody to their appointment. If they're late you get criticism from the PCT.

    - Questionable relevance to service / "not our job" as narrow criteria for access to specialist service

05. I'm not looking for problems. It's only if it comes up that I do it. That's where I see the Way to wellbeing portal – that's their job not mine. I'm one of the services they would refer to when they do more of a holistic assessment. I know it's a two way thing but I see it's more people coming down to me.

    - Definition of MECC

12. Trying to explain the difference between MECC intervention and the work that people already do – it's very difficult.

    - Monitoring

07. Speaking As Commissioner
They won't have the capacity in future to be accurately monitoring the contracts. They'd be able to put it in the contract re ensuring people go on the training but beyond that no. Not sure that beyond training there would be any other stipulation in the contracts.

03. Referring to need for simple way of monitoring to demonstrate to commissioners that the organisation is doing MECC.
Don't want to put something in place that people (staff) think "this is a flipping nightmare". It's the then easier for them to say "I haven't done any". I don't want that. I want to encourage people to record what they've done….I know for a fact…very confident to say we do this (MECC) every day. It's just getting it down and knowing when a MECC's a MECC.

- Lack of a service directory / database as an aid to referral

11. An easily searchable database of everything that's on in Salford that might be of use to anybody… that you can get the information quickly. That would back up MECC and so many other things as well. Must be current, good quality information.

05. People don't know what other services are out there.

- Dwindling support from Delivery Team and loss of momentum

15. There were a few operational – lulls, quite a few system problems at the outset and as a consequence there was a bit of frustration when IT wasn't working. As a consequence it's fair to say we had to give it a push at various points to get back into it.

12b. What things do you feel could overcome these // would help you and your staff to implement MECC?

- A small minority of the interviewees had practical suggestions about how to overcome the barriers / challenges.

  - Development of Service Directory – containing information re service descriptions, referral criteria, referral forms

  - Development of alternative approaches to training – utilise existing methods that work well and making it as easy as possible

16. Suggestion – they could have gone to an org such as xxx. They know that we've already got a well respected, nationally provided training programme for volunteers. We can assume if they've all gone through that process they've been assessed by the xxx as being able to see clients, then we can put them up at a certain stage of the training because someone's already assessed their appropriateness in that regard - to communicate with people and deliver information – now maybe we just need to present them with some broader information about the kind of stuff that's out there and available because effectively we were asking people to be retested on something they've often, they've already been tested on as being at a certain level of competence. So I think it would still be useful to deliver a different training for different people and may be say let's just do a big awareness raising session and invite them all to an event for 2 hours at a venue. We'd say "you're all trained volunteer advice workers, we want you to be information providers on H&W services and we're now going to talk to you about that for the next couple of hrs, and then we're going to give you some packs to go away with. Go ahead and be those people." Rather than going through a rather futuristic online test that then just churns out a score, which says, you're now ready to go and deliver information. It seemed a little too rationalist. It's

not the way we assess people. We assess by observing, not by giving them a computerised assessment and then saying you can now go and see clients. It would go disastrously wrong if we did that.

- Avoid a one size fits all approach to implementation

- Provide definition of what a MECC intervention is / problem of trying to explain the MECC intervention)

12. I don't see a way of overcoming that barrier – once they are in hospital they're in hospital. I can only see overcoming it if you can put other public services through the programme – schools, colleges, universities and other community based services – for them to be signposting people away from hospitals and into community services. The nurses will not change their practice - the patient is paramount ultimately. They are not going to stop asking the million and one questions that they have got to ask just so it fits in around with MECC.

- Development of simple monitoring systems which incorporate feedback to staff.

13. How will you monitor your organisations' success in implementing MECC? / Is there formal monitoring of it?
What specific performance indicators / targets have been set for your organisation?

- Some of the interviewees reported that they were not aware of any ongoing specific or new monitoring requirements with respect to MECC; whereas others were incorporating MECC into their existing monitoring, developing their own monitoring or doing it in an informal or slightly different way. 3 of the organisations were subject to a CQUIN with the PCT and therefore reporting it back officially.

- 2 respondents did make reference to their CQUIN and another who was subject to a CQUIN admitted they couldn't monitor the outcomes but were monitoring the delivery and suggested that they needed things triangulated.

11. We're collecting data on reception - Have a CQUIN – 'To implement MECC and collect data' – paid a couple of grand -– and it's part of our contract…. We should be doing it anyway, but it's allowed us to concentrate on recording bits of advice that are not merely signposting somebody

13. Think the CQUIN is no more because we've embedded MECC within (our organisation). We now report to Public Health…it's still a requirement - quarterly reporting.
Was there was a chunk of money attached to it? That money is no longer there…it's in core budget.

12. (Have a CQUIN). We're just monitoring the delivery – we can't monitor the outcomes because the whole point of it is to signpost into community services which is historically in primary care which is outside the hospital. So we don't have those figures – we need things triangulated. We need something at the community end to see if the numbers of people are on the incline / increase in self referrals.

- 2 interviewees have incorporated MECC monitoring into their existing monitoring.

08. Think it will go well as it feeds into our quarterly reports for our contract that we do anyway. Has a really good fit & the team has got used to collecting case studies – ones that stand out – so it should go well. (They have a 3 year Public Health formal contract).

- 1 interviewee was very clear that her service has specific targets but these are nothing to do with MECC.

05. My service is judged on is how much weight someone's lost. Not interested in any other improvements.

- 1 interviewee reported that she had developed her own monitoring system – one that is simple to use and provides feedback to her staff; however, she also expressed the view that it was perhaps made more easy to do due to the small size of the organisation.

13. I introduced a monthly MECC sheet with all the focuses on, broken it down in to weeks. Circulated to all staff and I ask them to log when they've had an intervention on alcohol, physical activity or something like that. I can keep an eye on that and then I collate them all every quarter. Then look at the stats and send it out again to staff so they know what we're achieving. With it being a small organisation that's something I can do…..It's very portable. It's just an A4 sheet that has the weeks, the month and the total.

- 2 interviewees reported that their organisation has adopted a very informal approach to monitoring / isn't doing it formally; although one of them did acknowledge they wanted to go back to the Delivery Team to look at doing it more effectively.

10. We're not doing it formally… have filled some in but not sent back – but need to go back to Delivery Team and get agreement re how to do it more effectively – don't want to duplicate what already doing in case notes. Want to find a way to evidence the number of outputs and then support that once a quarter with a case study from each person but will need to go back to whoever (in DT).

15. It's all very general sort of feedback about "I spoke to this person the other day…."… informal. Not done massive amount of formal recording.

- One interviewee stipulated how there had been a change in their contract which was now much better; previously there was too much being asked for.

08. Problem was there was a difference between what we had been asked to do in our contract – it didn't fit with what the Delivery Team were suggesting. This has now been changed – it was all about numbers and outputs whereas the Deliver Team were wanting Outcomes…..definitely better now – more power in the stories rather than in the numbers. In the contract – it's almost ridiculous really what they have asked for around MECC.

14. How do you see the MECC programme developing in your organisation over the next 5-years?

- There were a variety of different answers here. One was very clear that it will be embedded into core business.

12. Think it will become an intrinsic part of core business. It will be included in job descriptions, inductions, ongoing PDRs/PDPs etc. Further embedded into the system.

- Only one interviewee could not see a future for MECC, three were unsure and a small number of interviewees stated that MECC is very much what they do anyway.

09. Not sure. If can get staff through initial training and get them to start having the conversation – that will be a big achievement and ultimately that can feed into the whole approach of trying to improve health of the people that live in Salford….. Doesn't sound like there is much backing support from the organisation as a whole – due to financial climate and efficiencies – need to see how can bring it in without impacting too much on the way people deliver the services…… In theory people think it's a really good idea, in practice sometimes there's a bit of reluctance cos managers can't quite see how it's going to happen without it impacting on core services.

04. It's got a lot of potential for making a difference. It's simple. It's very much what we're about anyway.

11. Think it will still be there – even if the rest of it isn't – the ethos of doing it will still be with us and we're doing it anyway.

16. So in some ways we're already doing a kind of MECC service. I think that's another reason possibly why I haven't been pushing it as much as I was previously…..I think that maybe subconsciously seen that as we're doing it. If we look how it might develop we need to think about duplication – is that already happening through other services?

- The majority could see a future for MECC and identified actions that would be required over the next few years. Some of these have already been covered in the above; however, some cited actions that could be considered process / inputs:
    - Priority to formalise and embed MECC
    - Maintenance of staff morale via the development of effective monitoring systems so that staff can see the impact of MECC
    - Extending MECC to non-core staff
    - Introduction of train-the-trainer but some practical concerns
    - Introduction of effective monitoring
    - More signposting
    - More level 2 interventions.

03. Put in business plans and then we're all doing it – lots of services front facing. Lots of people doing it – it's formalising it and putting a structure to it where you can actually see that people are doing it.

13. Did attend a train-the-trainer workshop. I think a lot has to do with time – we're quite pushed already. I don't really think that we have the capacity to actually do that. We did explore it. I thought "Oh my goodness" – there's a lot more to it than I initially thought.

15. We've got through the training and it's now how we as an organisation and a service keep the momentum up. I don't think we've done massive amounts of anything since the training and that's a concern. You can easily lose momentum. That's the next challenge. In some respects that's easier because you're not having to send people on training so operationally it's not as difficult but it is difficult to get a mindset change which is what MECC's all about. That's going to be more difficult than where we've been at. You can get through training and see it's progressing, tick people off one at a time. What happens now is a lot more difficult to measure and manage.
Prompt: what keeps it live – monitoring? – Yes. So if you don't you're going to just talk about something that happened in the past.

13. You may be more inclined to start signposting more, may be more level 2 intervention. I'm finding that I'm doing a lot more about money and benefits, and such. I think because of the changing climate there may be more level 2. All the staff were only trained up to level 1.
Prompt re whether this might result in higher-level training for staff to support level 2 – it will come through experience, knowledge being cascaded. We're currently working towards the matrix standard which is all about information and advice so we may well find that some staff will take on additional training through that. So consequently that may have a knock on effect in respect of the nature of the intervention and the level of the intervention. So it will be interesting to plot….to find out if we are doing more "weightier" support.

06. We do what we have to do and then it fades into the background. (We) need to reintroduce it to staff again and jog people's memories about it.

15. What do you feel are the factors for a successful roll out of MECC?

- All of the interviewees contributed to this question. The main themes are shown below:

    - Communication – continued and clear

03. Need good communication about what it's about – it's intention, why we're doing it. If people don't engage in it and think it's worthwhile they won't do it.

13. To be open and honest with staff to appease any concerns and any worries very early on. I think that's key, and just to make them aware that they're doing it already and that all these wonderful conversations that porters have people is all so relevant because they're all conversations and it doesn't have to be a major piece of work. It is that opportunist moment, that conversation, that nudge as they say. So I think for me that would be it. It's a great opportunity for staff to reflect on themselves and I think that has huge benefit for the workforce because it's raising awareness not only with what we're doing but with who we are.

    - Effective monitoring of MECC contacts and interventions

12. Needs to be measured at the frontline of the community based services that the people are being referred to rather than just monitoring delivery – need to see success in the people that are turning up at the community services. Need to have some kind of measurement at the frontline – not at the hospitals.

    - Changes to the MECC training e.g. e-learning to replace SAT and training; roll-out of properly resourced and supported train-the trainer programme

03. Maybe if there was…sometimes we have e-learning modules where you read about things as you're going through and then you answer questions on what you've read / learnt from that. Maybe something like that rather than going straight into a test…you read a scenario or what MECC's all about so you're in that frame of mind when you're going in and know what people are looking for.

09. If can get all frontline staff trained & get case studies to show we've helped people – that will be a success story.

    - Reassurance to staff that MECC does not mean more work – rather it is an enhancement; Make it less complicated than people think – Make it easy and accessible. Make it fun

10. Making it easy to incorporate it into their work – so it doesn't feel it's something else – send the message it's part of your everyday job. …..This isn't something big & complex we're talking 5 or 10 minutes as part of your everyday work.

11. It'll have to be done very simply. It should be a fun thing with lots of rewards and – MECC Champion of the month – anything that will raise its profile and make it a bit fun. Was all a bit head pecky to start with - has a complicated management structure behind it. It has to impress councillors and senior staff. Think it would have helped from early on to make it a positive thing – was a bit of 'you will do this – why haven't you done that?' Can see why they are doing it because they are risk averse and want to prove results.

    - Continuation of support from the top (including political backing where appropriate) – within and across organisations – to create "buy-in" and commitment

11. It'll have to have some back up from officers – otherwise it will wither.

12. Core team needs to remain in place – otherwise it will be doomed to fail as there won't be anyone chasing already busy organisations for targets etc.

03. Senior managers need to be engage with it – not just us at the frontline – the Directors, managers and their managers – all involved and committed. If they're not then…It just gets put on the backburner. Even the CEO needs to be committed to it so she's supporting the managers below. Councillors get involved too.

- Problem re economic climate / timing

14. Biggest issue has been the timing of it – come about when economic decline, people are loosing their jobs – people are doing more for less – so to add MECC on top of that for orgs that are not driven by health improvement – it's going to be very very difficult.. eg Fire Service have reduced core staff – to ask them to think re brief interventions it is a particular challenge. The targets for MECC should be revised.

- Not to impose a one size fits all approach, thus empowering managers to use their autonomy to make it happen

14. Acute vs Community setting approach is so very different – diversity of approaches for different settings needs to be thought about – a different SAT for different settings. MECC to be tweaked more depending on the type of setting you are in.

- Resource MECC properly, including time

08. Maybe we don't have sufficient resources to deliver the Train The Trainers programme – particularly if it's a small organisation; not sure how committed organisations will be to sustain it without funding to support it. A great idea but maybe not realistic.

11. It needs some money behind it – smaller vol orgs will probably do it but can't see bigger organisations.. it'll be forgotten about unless there's a senior officer part of whose job it is to make things happen and it's a target for them – how's it going to continue really? There's no capital in it for them.

15. We've done a top-down sort of dissemination of information and I think that's been useful. A blanket approach was useful. Everyone's got buy-in to it and doing it. Initial commitment at the very outset. The ability for us to - we were told, make it happen, go and do it - there weren't any caveats to it. No hidden agendas. Just case of get it done. The resources were there and we were allowed to just get on with it. If we'd had one arm tied behind our back and they'd said "you can send people of this day or this day" that would have been very frustrating and I think everyone would have just got fed up before they'd even gone on the training. Got to commit to it, not just in word but in resources and actions as well. We were lucky we were given that.

- Other things mentioned included:
  - Clarity about what constitutes a MECC intervention (see comments in 16 below)
  - Sharing of good practice and peer review.

16. Additional Comments from Interviewees

At the end of each interview the SL / LM was invited to make any final comments. Many of them chose to do so and these are set out below.

General

13. I'm relieved that it's gone the way it has. We're only a small org but at the time it seemed to be such a big ask, in fact it's worked well, and is working well, I believe.

06. It's embedded in our practice anyway & it's a reminder for staff to look for a different way / different approach to sign post people to programmes that will benefit the service users.

05. It's just another government initiative rolled out to say, "we've done this", but it doesn't have any impact whatsoever. It's another of those white elephants. That's all I see it as - a bit of a whim.

10. It's good for everyone to have the same knowledge and same basic benchmark level of standard of knowing how to interact with service users.

Targeting

12. It's not been met with opposition – it's a fantastic programme – it really, really is, but it's about directing it towards the departments and organisations where these skills are required and not in the areas where we already have skilled clinicians e.g. at porters / health assistants who have more potential time and more likely to have opportunistic… contact….
Commissioners of MECC / Delivery team were responsible for developing the CQUIN and deciding who to target the programme at – (Our Organisation) would probably have targeted different groups – as those targeted in the original contract were 'already doing MECC' & we believe it would have been more appropriate to target those more casual face to face workers – eg porters / health assistants who have more potential time and are more likely to have opportunistic… contact.

Defining and understanding a MECC intervention and difficulties associated with it

11. It was difficult to define early on what's the difference between what we're doing now & this MECC thing. We're doing it already – that's a common thing you'll find.

11. If somebody asks where the French class is – that's not a MECC, but a classic example – a fellow came in to use the lav and somehow got talking to the receptionist and revealed he'd got problems with coming off drugs – he'd also come out of an institution and got his own bedsit... Anyway 10 mins later we'd got him signed up for narcotics anonymous, we'd got him booked in for a healthy cookery class, and he was going to come along and try some Reiki healing. That was at 20 to 5 on a Friday when most people are thinking about going home and that was 100% a MECC – a brilliant example of a MECC intervention.

12. For those who wouldn't normally have interventional behavioural change conversations with people, they can tell the difference because MECC is something completely different for them – they don't do that as part of their day to day.
However, explaining to a district nurse for example, that the conversation you're having with people around housing, benefits, tax credits, sexual health, smoking - all the hot topics listed & identified in MECC, …..don't count as MECC interventions – so how do you know the difference? – when is it a MECC

conversation and when is it not a MECC conversation if the conversations they are having are around the same topics?

I don't know the difference myself - we just have to record the interventions we are having.
So for those staff groups it's been really difficult to pin point what is a MECC and what isn't so we've just been recording everything because they do cover pretty much everything – it's part of their job.

Responsiveness of Commissioners to feedback from Organisations

12. In response they (Commissioners) have altered the monitoring form – because before there were some very rigid questions. It didn't fit with how the Services were working – and the fact that the (organisation) can't measure it realistically.

Certainly since last August – the commissioners have been more responsive to our feedback / our problems…..They have been responsive and given us the space and opportunity to develop it ourselves internally.

14. Main feedback (to commissioners) is that (the training) needs a more concrete case study approach. Some feel they could have ticked all of the answers. This has been fed back (to commissioners) and they have been making changes and tried to get rid of the ambiguous questions.

08. Problem was there was a difference between what we had been asked to do in our contract – it didn't fit with what the Delivery Team were suggesting. This has now been changed – it was all about numbers and outputs whereas the Deliver Team were wanting Outcomes. Definitely better now – more power in the stories rather than in the numbers……In the contract – it's almost ridiculous really what they have asked for around MECC.

Directorate changes / Uncertainties – (working, but in silos)

04. Currently a lot of directorate changes taking place within the Council – moved directorate. Were Sustainable / Regeneration directorate now Health & Social Care. MECC is happening within an 'inner circle' as opposed to a joined up effort – people aren't settled / it's all new. Not making a difference re how it's working – things are carrying on like MECC but people still doing it within own circles until they appreciate that their neighbours are doing it and it kind of becomes more of a joined up approach.

5. dii. Front Line Worker Interviews

Methods

- 22 Frontline workers (FLW) were interviewed altogether. 2 of these were interviewed for the pilot which took place in July 2012 and the rest were interviewed between January and March 2013. 3 of whom (9, 12 & 16) did not contribute to all the questions fully, one thought she was going to be asked purely about the training, another did not finish completing the Self Assessment Tool (SAT) as she had computer troubles; the third did not feel he had contact with the public but he had attended the training. 3 individuals from organisations invited to be interviewed, declined.

- All of the interviews were conducted over the telephone and all interviewees agreed to have the interview recorded. The interviews took from between 12 to 50 minutes to conduct. A semi structured interview schedule of questions was used. To allow interviewees to expand on particular points, the schedule was used flexibly.

- The interviewees were working in a variety of different roles / capacities in various organisations:

  Salford City Council (SCC): 9 interviewees from Sheltered & Supported Housing, Council Tax & Benefits, Welfare Rights, Gateway Centres, Neighbourhood Team, Integrated Youth Support, Health Improvement, Community Development

  NHS: 2 interviewees, both from Salford Royal NHS Foundation Trust

  Other: 11 interviewees from charities, social enterprises, voluntary organisations, College.

Outcome of Interviews

The outcome of the interviews are summarised below under the main headings used in the interview framework.

NB: All quotes are as spoken, word for word unless in brackets. The code number of each interviewee is placed in front of each quote for ease of identification.

A. General and contextual

1b. Types of people FLW normally work with and interact with on a daily/regular basis

- **8 x General** – no specific age group or vulnerability 8, 11, 12, 17, 20, 22, 23, PA01

- **7 x Adult targeted / vulnerable** 2, 4, 6, 7, 9, 14, 18

- **5 x Young People (0-25**) – age specific (2x vulnerable – 3, 15) (3x General – 1, 10, 13)

- **1 x Didn't have contact with public** – 16

- **1 x Limited contact with public** (1-2% per day) but did respond to all questions as felt were relevant to him – (PC01)

- 19 of the interviewees had face-to-face contact with members of the public. The actual amount of contact with the public on a day-to-day basis was variable, with some seeing people on an appointment only basis and others on a drop in basis. Depending on their role and the organisation they worked for, people using their service were referred to as patients, clients, customers, tenants or people. People were seen individually or in groups in a variety of settings:

    - Clinics
    - Community / Youth Services
    - Their own homes, including tenancies
    - Nurseries
    - Outreach and walkabouts
    - Gateway Centres
    - Schools
    - Colleges
    - Hospitals

- Some of the interviewees had dual roles, whilst others spent part of their time on overall co-ordination of a particular project (including, for example, appointing session staff, facilitating partnerships).

- 40% of the interviewees reported that people must be referred to them in order to receive a service. Referrers included General Practitioners (GPs), primary care mental health professionals, Job Centres.

- 60% of the interviewees saw people without the need for referral.

1c. Is talking to people about H&W (H&W) what you'd be doing normally? // As a 'frontline' member of staff, describe how you talk to people about H&W?

- There was a clear indication that the majority of those interviewed (18) felt they were already doing this before the MECC project was implemented. Many of the interviewees also gave examples of how they talk to people about H&W.

06. (It) Forms part and parcel of what we do / It's like 2nd nature. It's got to be linked into H&W.

12. It's what we do normally – it comes into (our) general conversation. It's general chit chat – a normal process.

17. generally starts with everyday conversations "how're things" – can be to do with their children, the home, their health…anything can start the conversation.

14. I ask them about their work history, their health incl alcohol and smoking, about their diet…and then I look at interested and leisure, and any MH history. I try to look at the individual in a rounded way so that when we are planning their next step on I can look back and think they've worked in this area or got skills in that…it helps me to help them.

20. if someone comes in and they're struggling to pay something, you look at their income and expenditure and if they look like they're spending an awful lot on cigarettes you can refer people to the stop smoking service in Salford. If struggling financially on food you can refer them to the food bank so it doesn't' become an issue…..comes up in conversation.

- One expressed that they wanted to talk to the public re H&W but was unable to because they were too busy and because of practical issues.

22. The problem that we have here is that unfortunately it's so busy you can't always find that time to spend with customers…can spend a bit more time with them in the evenings.
The way the reception is set up…This is the problem - all our desks are open…but I lower my voice. Some people are on benefits and they don't want people knowing.

- One interviewee had limited contact with the public.

1d. So, do you see yourself as an advocate for H&W? In what way?

- The majority of those interviewed saw themselves as advocates for H&W. Some of the interviewees described the way in which they do this e.g. via holistic assessment, signposting.

04. (It's an…) Integral part of what we do.

06. It's about re-empowering them / It's about making changes for themselves - You're there to guide them along that path.

- Some also believed that most of their staff think so too.

10. Definitely – and most people working in this service would say the same.

12. Oh yeh!! I think every single one of us in the building does regardless of what we do.

2. How did you feel getting involved in MECC?

- Most were generally happy to get involved. Some were uncertain what it was about initially, but when they realised what it was, and they believed they were doing it already, they were quite happy. A light bulb moment when they realised that it was what they were doing already.

- Some reacted positively, that it was 'official' / gave what they were doing a 'label' and appreciated being recorded; they felt it was giving their work recognition and gave them something to base their work on.

- One interviewee felt that her colleagues, who were not from a health background, might feel differently compared to her.

02. I'm all for it, where there's communication and liaison and services all interlinked I'm all for it. It's how we can do our job better.

13. I think we did it initially but without an official title. We've always done it. He (Health support worker)) reassured us it was what we were doing already, so to carry on as normal.

08. At (the) beginning – for me & the rest of the staff it was "oh here we go again"…. When we found out more detail about it – it's something we do and did every single day. This wasn't anything new to us because we did it anyway as part of our general day to day. Yeh, people are very positive about the whole thing – it being official. Before we helped people but we didn't report to anybody.

11. It (doing the SAT) made you realise that you're actually doing something that has actually got a name.

06. It's what you do isn't it? & how you engage. It's part and parcel of what you do on a daily basis. In my opinion it gives it a label. . Rather than looking at it as a programme in itself, I just think it's kind of like for standards on working.

01. It made you formalise what you've learnt.

14. In terms of doing it, it's not a problem. For me it's not that different to what I was doing anyway, but it's about recording it so that we've got the statistics to feed back..
14. I wasn't too bad cos I'm from a health background, so not too daunting for me. My artist colleagues who aren't trained in any health profession, they might have felt a bit more anxious about it…but I think everyone was fine at the end.. just the thought of it, would they be able to do it.

15. Initially, (I) didn't know what it was all about until we'd done the training… and realised that, to be honest, we're doing most of what it represents already which was good to know. The advantage is that it just reminds us to keep making those contacts and keep asking the young people about the those different areas that aren't just about my role.

20. It's important because it's promoting partnership working. It's basically a one-stop solution to being placed in the right spectrum of what they're looking for. In my every day role, I probably do it without even knowing. As a team, on the whole I'd say we've done it from the day we started – we've been referring people. H&W are paramount. If people are ill they're obviously claiming more benefits.

- Some were concerned it was going to be time consuming but then they could see it was confirming what they were doing already.

23. I thought "oh no". But I have to say it has been a positive experience. Didn't know what it was. I was thinking it was going to be lots more paperwork.

There was some nervousness but still a feeling of positive energy towards it.

10. (I was) nervous initially but keen. Thought it was positive. Looking forward to it.

- There was concern / resentment raised by 3 interviewees, that they were being told to do it by managers and that it was mandatory.

03. (It was) mandatory so didn't have much say in it. It was something that we had to do…cascaded down by e-mails. Told that this is some training that we all have to do…as soon as possible and gave a deadline for it. Prompt re how that felt – just another added thing to what we have to do anyway…we've got a lot of mandatory training we have to do online so it's just another thing we have to do.

- 2 of the respondents, suggesting they had been asked by management to get involved, felt that the SAT was not appropriate and one of those was very concerned that it was 'pitched' at health professionals rather than Educationalists.

16. Initially pretty good – more due to my personal interest in it. Also recognised that the neighbourhood and Salford as a whole have significant health inequalities. However, I've become cynical and question its appropriateness to my role.

01. We were kind of asked by management if we would do it and it was something we thought, 'yeh ok something else we can do', but on reflection after doing it, I'm not sure it was pitched at us really – we felt, well I felt really it was mainly for health care professionals, people within the health profession as opposed to in a college / in an educational environment.' ..we literally had to Google it whilst we had the questions up.. that was really difficult for us..

- Some of the respondents thought that that 'MECC' was the SAT / Training only rather than the wider concept; but that it did reinforce what they were doing.

01. It (The SAT Toolkit) made you aware that what you were doing, you were doing right. It reinforced what you did.
Prompt: Is that because you think of the SAT tool when you talk about MECC?
Yes I do. I mean, actually we do a lot of that – MECC, I think we do that - it's part of what we have to do anyway. You know it's part of the job. (I've) done it now and so can move on. Yes, I ticked I've done it. I can prove I can do it and I know what I'm talking about, so I can now move on and can do what I was doing.

3. Explaining MECC to a new colleague or a member of your family, how would you describe it // What would you say?

- The vast majority appeared to understand the MECC concept in some way, but still believed it was something they did anyway. Many seemed to have a very narrow interpretation of it - some thinking of it as signposting and referral, some looking at it just from a health perspective.

14. It's about taking every opportunity to highlight health issues really. Every encounter that you might have with somebody you raise the issue, put it in the person's awareness. They can then choose whether they follow that up at all…raising awareness, how it impacts on their general wellbeing.

07. Signposting them to the right service if they need it.

15. Referral – that's part of our agency anyway – we're a ref service. I'd basically explain to a new member of staff that this is the way of basically saying to another person, to signpost you to something so that you've got all of your baselines covered. …..referrals are part of our service.

20. It's about referring people to the correct areas to be able develop a good standard of living and H&W. Referring someone on to the correct department so that person can gain help, knowledge or support.

18. Being opportunist.. doing brief interventions with people. If someone wants to make changes in their life it's about having the confidence to signpost them on to something or help them if you've got any services in the centre or in any way you can.

10. Taking the chance and the time to speak to people about their health & their wellbeing and also being able for them to identify what H&W is because a lot of people don't know that. It's the promotion of heath & wellbeing.

- Others saw it in a broader context – getting more out of the conversations – being more proactive.

11. As it's said. Making Every Contact Count. Don't let anybody walk away. Make the contact count and refer them onto somebody. It's what it says it is. It's not just about the reduction in the smoking, you can't ignore them if they don't smoke, it's about the person themselves – it's about making that contact count and referring them on to someone who knows about their problem.
I was seeing someone that was referred to me re smoking – she wanted to give up because she couldn't afford them… She had lots of issues, she had trouble with benefits / nuisance neighbours / debts – I referred them onto the health trainers and they took her on and got everything sorted out now totally, she's on a free debt management programme. She's been sorted out – she doesn't feel as isolated now – she's had the Council on board about the kids smashing her windows. Things have been done; she's not been left out in the cold. She reduced by about 30% but she's going to phone us back.

Prompt: asked Re understanding it when first told about MECC.
11. I struggled with it at first but then I got the gist of it.

Prompt: When you were doing it, were you thinking of it in terms of MECC?
11. Um, no, I don't think so really, I was just doing my job.

08. Everybody would describe it differently – I would explain the thing behind it - The Making Every Contact Count….You can pick up different things just from talking to somebody – they might casually throw away a remark: *'My niece is in America & I don't know how to use Skype'* – straight away we signed her up for a computer – It's general talking and learning to recognise the signals… recognising when someone is asking you for help without asking you.

- As suggested previously, many of them did feel they were doing it anyway.

13. Doing MECC is doing our job and it's as simple as that to be honest. It concentrates you more – so you're more aware – makes you concentrate more around the H&W issues. It does sometimes make you stop and think but it's part of our job too.

- One believed it was about ensuring people have the correct information for choices / decisions and others said it was about making the most of a conversation and referring on.

04. It's about Making Every Contact Count – ensuring people have the correct information to make their own choices. You can lead a horse to water but you can't make it drink it – so it's giving everybody the information and support they need to then make their own decisions and choices – or to get further help off other professionals – that are specifically trained in that area.

17: Expanding a conversation and getting more out …not allowing it to get closed down. When I'm talking to someone about any issue, health related or not, I'm not an expert in any field…know a little about a lot of things. What I do know is there's a lot of support services out there for different things and it's about giving people that knowledge.

06. It's about not missing opportunities when you're engaging with people – actually about listening, taking on board what's being said, not missing opportunities – not missing key messages from clientele – being able to put it in place and deliver what's needed for that client.

4. How do you see MECC fitting in with your organisation's core business?

- The majority felt that it fits into their core business very well and or fits perfectly and some referred to it as strengthening their business. As before, the majority suggested that MECC is part of what they have already been doing.

06. It kind of fits at the core of what you do. There's no point missing the opportunity to deliver an intervention when you have the opportunity to deliver it. You've got the captive audience. You're there, they're listening to you – you make it count. It's something that you do without realising that you're doing it.

10. Because health is such a core part of what we do, then I think it fits in really well – we do so many brief interventions and so much work around health, that it fits in perfectly about what we do. It strengthens us. It gives clarity to what we do.

- Some disagreed, but these were those that didn't have a good understanding of the overall concept.

01. Not really, not in its format as it stands. Like I say, it's more for medical and health care professionals, as opposed to educationalists. (Referring to the SAT toolkit).

07: Don't think it does really. I think it's something we've always done anyway, so can't say anything's changed since it's come along.

B. Experience of SAT and MECC Training

5. Tell me about your experience in completing the SAT Tool?

- Most of the interviewees were somewhat concerned with the SAT – though the majority had taken it before the major changes had taken place in September 2012.

- Some had logistical problems re accessing the SAT / logging on and were very scathing about it initially – i.e. there were some practical issues, but they did acknowledge that most of these have now been resolved. One didn't complete the SAT through problems with access and then wasn't followed up to retake it.

Pre July: 08: The setting up of it was appalling. I was getting up to 27 emails a day for each person initially – ridiculous. It was horrendous from start to finish.

03. Difficulty accessing it online…couldn't get onto it. Took me ages to get on and do it…… difficulties with the password and getting on to it…they sorted it eventually. Don't think they had my name down.

23. Did pre July 2012. Took ages to log on. Can't remember what the problem was. Got lots and lots of e-mails and they didn't seem to lead to anything.

- Some found it straightforward / common sense.

20. Basically a lot of it was commonsense, about how you'd deal with certain people in certain scenarios. With 10 years experience I was alright with the online assessment.

22. It was pretty straightforward….the first section was alright.

14. Not particularly hard. Quite easy to understand the questions.

- Others found it easy, but had clearly cheated in the process. They admitted that if they had answered honestly, they would probably have failed but if they played the game they could anticipate what the answers should be / were expected.

06. (You) can cheat on line – People try and do it in groups.

16. Referring to second time he did the SAT. The process was bobbins to be honest. I said "I'll play the game" and as a consequence I breezed through it. If I had done that the first time I wouldn't have had to waste ½ day training…. Too many "ifs, buts, maybes" in the questions….know colleagues who've played the game.

07. We did it as a team – 6 of us at a time. It was a bit of a laugh, bit of a joke doing it because a lot was very obvious so all you had to put was "exceeds expectation" or "totally comfortable" for every question. That was the running joke of the office - that we were totally comfortable doing anything…..playing the game – anticipating what they needed. A hoop to jump through. Knew that if you didn't want to go on the course you made sure you didn't.

11. I wondered what half the questions were about - I didn't understand the purpose of the questions initially. But when I got into it and read up about it on the internet I knew what it was about.

- There was concern that the questions were not measuring a good level of competence and there were some suggestions that people were thinking of the SAT as an e-learning package and were unhappy about the way their learning was being assessed.

17. Pot luck some of the answers…a bit of guesswork …couldn't really judge them (the person answering them). Don't think it found a competency level.

06. MECC competent. (I) didn't find (the) e-learning package very helpful as can't sit & discuss…..The learning doesn't prove that you've learn anything. (There's) no way of being able to check the person's learning.. It should form part of the induction process.

06. The learning doesn't prove that you've learn anything. (There is) no way of being able to check the person's learning.

- Quite a few expressed concern of their initial feeling that they would fail / feel stupid but that otherwise it was quite useful / not a problem and were pleased to have 'passed' it.

13. MECC competent At first a bit panicked as (I) could see the clock ticking in the corner but I was fine and just did it and it was fine. Got through it and so didn't go on the training.

04. MECC Competent What will I do if I fail? It's our job – I'll feel stupid if I fail. Apprehensive. Otherwise not a problem.

10. MECC Competent. Didn't think I'd pass it – nervous but pleased I did as I believed I had a good understanding of a lot of things. I found it quite useful – it's important for me to know I know these things. It's also good there is training so people can go and refresh themselves.

- One of the interviewees, who expressed concern about failing, felt that she was constrained by the way in which the questions were asked.

17. Thought of failing…it can potentially make people feel incompetent even if you're doing a good job. It very much depends on your answers…and the answers were, well, you know…wanted to answer "sometimes" (when asked re confidence in dealing with certain scenarios).

- One individual clearly felt that the toolkit, and particularly the training, was a waste of time and resources and was very unhappy about completing the interview – she had thought that she was going to be asked purely about the training despite being sent all the pre information and signing a consent form.

09. It was a full day and I've got a massive case load of clients and it took me a day out from seeing people. To be trained on something that I do regularly / daily anyway. (It) was a waste of resources and Council money… because it wasn't just me on the course – most people were saying the same thing. We're professionals who refer on on a regular basis – we don't need to be taught to do it again. . I can't believe that it's still going on. Prompt: Are other people in a similar position as you? I think so – in my organisation.

- One individual did not finish the SAT – she had taken level 1 but should have done level 2 – she then pressed the wrong button and got muddled, was then off sick and so did not complete it. She forgot her pass word and in the end no-one followed her up internally, so she has never finished it.

6a. At what level did you complete the training?

- Generally there was quite a lot of confusion about the level that the interviewees were taking the SAT or training. Although there were definitely 10 that stated they were MECC competent – i.e. didn't need to go onto the training.

6b. What were the most useful things that you got from the training?

- 10 of the interviews were MECC competent and so didn't access the training. One didn't finish the SAT.

- Some of those that accessed the training clearly got some benefit from it, about learning different approaches, networking, clarifying MECC and the trainer's belief in the ethos of MECC.

11. It was interesting listening to different people's approaches. I did try different approaches after that. Using different approaches with different people / groups.

03. … Being aware of the services in Salford and how to make referrals. How to make contact with someone who might not be compliant or might not be willing to engage; things that might be quite sensitive and your initial approach to that. However, (I've) not really changed my practice…it's our bread and butter of what we do.

02. The fact that you can see that the tutors giving the training want to improve the lives of the people in Salford. The government is in the situation where they need to save money in the future, the NHS is at bursting point…it's all down to finance, and if you can look after a tenant in the home and prevent them from needing that service, in the long run they're going to live a better life and it's going to save an awful lot of expense that may no be necessary. The way the trainers were showing us advertising about Weetabix and beauty products and saying these subliminal messages is the way advertisement go about things. Asked group what they thought about that. Analysed it and realised that customers get bombarded by things and think "I need this and need that" and actually they don't.

22. When I did the training it made more sense…..it seemed really obvious….I'm better with that (training) you see. If someone shows me (I understand0. That's how I learn. (I feel pressurised doing things like that on the computer. I don't do it well, don't cope with it well. I got more out of the training (than the SAT))…it highlighted things really. Things that you think you're doing and you're perhaps not.
Prompt: re whether working differently since been on training
Yes. Think I'm doing more. And interacting more with the team itself. We share more stuff as well.

23. It was reiterating the stuff that we do on a daily basis. We didn't know we were doing something right but we were doing it anyway. It was a bit surprising that we were doing it, not spot on but…

- One stated that she did not find it particularly beneficial, though it might be useful for new individuals.

08. I didn't find it particularly beneficial. To be honest no – I didn't get anything out of it. Somebody who's brand new and not been doing it before might have done but this is our daily routine, what we do, so it was quite repetitive.

- One stated that he did not find it particularly beneficial other than making him aware of the MECC as a "brand".

16. Nothing, though (the training) did flag it (MECC) up….make me aware of the "brand".

C. Implementation of MECC

7. At what level of MECC are you operating and how was this decided?

- Most of the people interviewed were very unclear about what level they were working at or how it was decided – a few (4) suggested it was managers / departmental level that chose what level they were operating at.

- **5** x Level 2 // **2** x Level 2 & Intermediate // **12** x Doesn't remember / Unsure / Unclear // 1 x N/A.

8. How confident do you feel in delivering MECC?

- There were degrees of confidence expressed – most of them felt that they were confident in delivering their work but some suggested that it wasn't to do with MECC or it was what they did everyday. The way they answered this question appears to be related to their experience re brief interventions and it seems that they feel they are doing MECC anyway as part of their role.

08. Absolutely no problem what-so-ever and the same for other staff – 100% as well. And very positive about it. It's what we do everyday – helping people, sign posting people. Chatting to people helping people get what they want without actually saying what they wanted. Dealing with the people we deal with it makes perfect sense.

10. Pretty confident. It's the core of what we do – don't find it difficult. People are doing it – starting to see the link but it's not happening across the service universally. It is what we're doing and it should be part of the work we're delivering.

07. Completely confident in trying to refer people onto different things and talking to people but from a MECC point of view I'd say it's not made any difference to our workload or what we do at all. We're continuing to do what we've always done

17. Very confident in managing a conversation and being able to bring it to …expand a conversation. But when I do that I just see it as part of my role, not like "doing a MECC". I kind of think " What is a MECC?" It's what I do in my job.

- Some did express a small degree of improved confidence.

Prompt re impact of passing SAT on confidence level
20. Because I didn't have to go on the training I suppose it did…I felt a bit more confident that I knew what I was doing.

22. Depending on who the person is and how they come to the desk and approach me I feel fine and comfortable doing it. But if they come and they've had a few beers (which does happen quite often, or they're on drugs and bouncing all over the place) I don't always feel too confident. Depends on what they want to discuss really….there are certain people I'll say things to and certain people I won't. I'm a pretty good judge of character. I'd pick and choose who to give information to…depending on what they're like at the desk.
Prompt re whether more confident having gone through the training
– Probably more confident.

23. Fairly I think. Prompt re whether increased since MECC – possibly.

- Others questioned the question itself as they felt that it was what they did anyway.

09. It's a procedure that is external – very similar to what I do – it just isn't called MECC.

01. I wouldn't say I would be delivering MECC, I would be doing what I did.

9a. Tell me about your experience of initiating a conversation with a person about their H&W?

- Most of the interviewees definitely found it difficult to find an example which was specifically linked to the MECC initiative; they often expressed that they were doing it anyway. **08** sums it up well:

08. A lady came in just to have a cup of tea in our café and we got chatting – she felt very vulnerable and on her own and wanted to meet new friends. Within half an hour, we'd signed her up for a card making class, signed her up to do a dance class and we'd signed her up to do an arts class and she's gone from strength to strength – the change in that lady is unbelievable. Prompt: Is that to do with MECC?
08. Well this is difficult – I think we're more aware of it now because we know we're recording – but it's exactly what we would have done – with or without MECC, because that's what we're here to do. It's something we do on a daily basis and we always have done.

- 13 of the interviewees suggested they could not put their experience of initiating a conversation with a person about their H&W down to MECC or do not even consider MECC; some of these suggested that they use an official assessment pro forma any way and would be doing it as part of their daily work without labelling it as MECC.

06. I don't even consider MECC – It isn't something we've ever discussed – only time was when whole team had to sit down & do the online training (SAT).

18. Having the MECC there is a constant reminder – something we need to be doing but it's not something that's changed since the MECC.

- 1 of the interviewees felt that she was tuning in more for cues from clients following her involvement in MECC.

03. Something that they'd (parents) initiate.. and then (I) pick up on and tune into that really. Discussing that a bit more to get more detail. E.g. parents smoking who wanted to give up, had 3 or 4 children in the house and I gave her some advice on who to make contact with in order to get some help with that. As far as I'm aware they did take that info onboard and did seek some help. Prompt re whether she felt more able to do this as a result of MECC. Yes, maybe able to tune in a bit more effectively and know exactly what services – we came away with leaflets about lots of services – and it was a case of knowing what services were most suitable. I could actually hand something physical over.

9b. Explore difficulties / successes? What did you do when you were faced with this situation?

- The vast majority of interviewees (18 out of 22) found this a difficult question to work through as they didn't feel that they were seeing successes / difficulties as a result of / anything to do with MECC as such. It's not over and above what they are doing anyway. One individual could link her actions to MECC and 3 did not answer the question.

14. In my capacity I have to ask them some quite difficult questions e.g. self harm, so I don't find any of the questions too daunting to ask. Clients know they don't have to tell me things but most people like to talk and get things out.

22. People can be as nice as pie…and turn like vicious. The aggression can be unbelievable in one split second…(especially issues re money). You get a feel for people. Most people are nice. If things not nice I steer away from it really.

- There was one individual who could link her actions back to MECC and gave an example of a woman who mentioned gambling.

17. Mentioned she'd been to bookies. She said she was fed up at home…so within a few passing conversations…I picked on this and the third time I saw her I did make room for that conversation to be opened up and what happened she did open up to me…told me a lot about her gambling problem. Had never said that to anybody. From there referred her to Gamcare and she's now in counselling. …it's about listening to key things and picking out she needs to open up. Just having that open space. It's an example of using MECC skills and recognising when there's potentially more that you can work with…rather than just saying "did you win at the bookies?!"

9a. What if any particular knowledge or skills did you need?

- The answers given here by the interviewees were skills that they felt they needed to interact with people and they were not attributed from 'doing MECC'. 100% of interviewees said that the skills had nothing to do with MECC – because they were referring to skills they have / already use.

• **Age experience**	• **Good influencing skills**
• **Self awareness**	• **Ability to accept that clients don't always take on board messages**
• **Level of confidence re competency & experience**	

17. The key to delivering any kind of frontline work, including MECC, is confidence…..being confident in your own ability. Haven't got a lot of knowledge about a lot of things. I've got a little bit of knowledge about a lot of things and if I don't know, I'm quite honest about that. If I don't know the answer, I say I'll find out and let them know and following up on that as well. Being honest if it's something you can't deal with.

• **Having insight & not tunnelled vision**	• **Be detached & see the bigger picture**
• **To be a people person**	• **Recognising when to talk and when not to talk**
• **Listening**	• **Trust**
• **Clarity**	• **Building relationships with clients / tenants**
• **Good relationships**	• **Good knowledge & understanding of the brief intervention**
• **Measuring success / effectiveness**	• **Referral process and ability to check with colleague if don't know**
• **Think outside box**	• **Openness & honesty**
• **Understanding and tolerance**	

20. You don't speak down to a customer. You inform them in a way that's not patronising to them. You're not telling them that the way they choose to live their lives is wrong.

• **Ability to liaise with other orgs**	• **Ability to be sympathetic**
• **Specialist knowledge**	• **Mentoring**
• **Ability to engage**	• **Knowledge of locality & services within it**
• **Empathy / compassion**	

20. Empathy and a sense of the real world are paramount…cos in Salford we're working in one of the most deprived areas in the UK and you have to take that onboard.

• **Time & space**	• **Insight into priorities**
• **Know your limitations**	• **Accepting that not everyone will accept help**
• **Respect**	• **Knowing when to back off / Recognising primary issues and leaving other ones to later on**

17. (Re woman with gambling issues) The gambling is her primary issue – the one she's got to deal with and look at first of all. We've had conversations about giving up smoking but she's nowhere near ready to give up so it's not something I'm going to hone in on; however, we drop it into conversation and she knows there's support there and when she's ready there is a lot of help there.

9d. Has Salford MECC influenced how you approach these situations?

- The majority of interviewees felt that MECC had not influenced how they approached their interaction with individuals and that it was something they had always done; however, there was some indication that MECC reinforced / strengthened what they were doing, even though it didn't influence them.

08. No – I'll be very honest - it's something that we've always done – we're more aware. We do log it, whereas before it was just a common place thing. Signposting we've always done. I can't honestly say that MECC has influenced me – perhaps made me more aware of what we do, rather than just taking it for granted that this is what we did..

06. Truthfully, No.

23. The actual talking to people, that's what I've probably done in each job I've done, so it's probably accumulated. You get a sense.. when to talk, when to let them talk and when to say something and when not to say something. Think it comes with age…cos I'm a great age!

11. It's a bit extra – it does give me information. But it's my job. At the beginning it did, but now it's just part of my job. It gave me a lot to think about, but it's just part of my job….. It works alongside it – it strengthens what we do and gives more clarity.

01. No for me it reinforced things really (NB. She was Referring to the SAT).

13. Maybe I'm a bit more aware. But I felt I did it anyway. It was reconfirming that what we were doing was right.

D. Impact of MECC on Service Delivery/Sustainability of MECC

10. How have your conversations with the public changed since the introduction of MECC?

- All interviewees who answered the question (18) stated that their conversations have not changed since the introduction of MECC; however, 3 made references to monitoring / targets that did not exist before, one made reference to the portal and one thought it may be happening sub-consciously.

04. No… cos we were doing it anyway.

06. MECC hasn't influenced it. It's more target driven now.

08. It's not made any difference to our daily work – the only difference is we're now recording it whereas before we just did it.

18. But MECC is always at the back of your mind, to get so many MECC's a month. The recording…..!

15. They haven't…although actually I have made a few people aware of the fact that there's a website (Portal) they can have a look at. Useful for people who won't engage with the service if they want to do things themselves. ….. No, because it's inherently something we're all trained to do.

10. **Maybe done it subconsciously.**

11. What types of ongoing support for MECC have you accessed?

- There was a mixed response to this - 5 had no ongoing support, whereas the rest had support in some form or other; a specified person within their organisation, websites – incl Way to Wellbeing Portal, newsletters, emails, going to local events or referring back to training course material, being some of the responses.

12. Is your organisation supporting you in implementing MECC and if so, how?

- The majority felt that their organisation was supporting them – particularly through management, newsletters or emails, though one suggested that she thought their organisation thought it was a tick box exercise and another that they were 'told' to do it. 2 suggested not.

01. I think they were keen for us to do it, but once we'd kind of done the things that we did on it we've not heard anything… it is my personal opinion ..it was a tick the box exercise to say we were offered it.

06. It's something that we've been told to do, if I'm being honest.

- 2 linked the support that they receive from their manager with the requirement to record MECC activity.

17. (Manager) very supportive….. Always reminding staff to record their MECCs. Generally brings it in at every opportunity. We're supported to do our jobs.

18. My manager's always going on about it! "How many have you done this month?" It is put into our targets – so many to do – personal targets for MECC. Mine for next year is 100. Got to get 400 over the centres.

13. What other types of support would you like to help you with your MECC role?

- Most felt that they had enough support and so would not want any more, but some did specify. 5 referred to the need for better information e.g. A Service Directory, referral criteria, examples and sharing of good practice from elsewhere.

07. Website with list of different services and link to each one so you can access the referral criteria and forms.

14. Referring to website – info or examples to read re how it's being implemented elsewhere: Would reassure people that they're doing it in the right way.

15. Information re any new agencies and ones that fold due to lack of resources. Relies on staff finding out. for themselves.

- 1 interviewee qualified why she did not feel the need for more support.

20. I think that the way Salford did implement it i.e. doing the online assessment, people who weren't confident or competent in moving forward got additional support. Don't think there's anything else they can do.

14. Do you think that working in partnership with other organisations has improved since your involvement with MECC?

- The majority felt that it stayed the same as they already had good relationships with partners, some were unsure.

13. (It's) stayed the same as had very good relationships anyway.

04. Whether it's changed through MECC, I don't know, I'm not too sure, I wouldn't like to say for definite.

- 1 felt that recent organisational change and funding difficulties might be having a negative impact despite MECC.

17. (Organisations are) getting "precious"…don't refer to the best service for them (the clients). It's a number crunching thing. There's a whole host of things in the way.

- 6 felt there had been a change, with one of these seeing a benefit to her own organisation by virtue of having provided a stall at a MECC road show.

15. Attended road show / event at Walkden Gateway (Dec) where there was an update. Took service information and had a stall. It was a very useful day to be honest . We found that we had lots of questions from people that were attending. Good day for our service – we got our name out there.

08. Yes, we're working with different people – not sure why it's improved. Can't say it's definitely because of MECC. More agencies are on board and can share experiences.

- 1 felt that MECC has made no difference BUT voiced concerns that things are getting worse generally (not necessarily as a consequence of MECC).

18. People are coming to us with a lot of high needs and maybe we need to refer them on…we are good at referring on and signposting people but I think we are taking a lot on ourselves that could be referred. The problem we have here is trusting other services and how they're going to deal with….these people are using our services. We want to give them the best. We're trying to refer them on to other services but from past experience we've not always got the best from that service. It puts you off a bit….we take these things on ourselves. Maybe we should keep on at these services because at the end of the day it is their responsibility really to progress this person.
14a. If so how?

10. People understand it more and there's a stronger link with what we're all trying to do…& for me.. when I am doing stuff around health, now I really need to check that out, I really need to check if anyone else is doing this and making sure there's no duplication – that we're all working to the same targets.

03. Greater awareness of the different services and support networks that are available.

22. Makes us more aware of pointing people and knowing where to send people.

14b. If not, what factors get in the way?

- Less than half of the interviewees identified factors that get in the way. Factors included lack of trust in other organisations, inappropriate referrals, poor referral information and poor range of services to refer to.

18. Trust. Been let down in the past. How many times can you keep referring people and letting them down?

22. Referring to a sense that people are directed to the xxx Centre inappropriately, by for example, GPs. Fob people off…..lots of people coming to the Centre have been given the wrong information.
Customers can then get annoyed because they have wasted their time. – they'll moan to us but they won't put a complaint in (against the person whose sent them there incorrectly). People don't question it – they do as they're told.

22. Some people won't go to some places (they're referred to) because they've had bad experiences.

02. Referring to somewhere and the person referred to says they don't deal with that issue anymore. You feel like you're banging your head against the wall and not getting anywhere. If we had MECC procedures fully in place you wouldn't be pushed from pillar to post.

07. Relies on staff having their own info re what other services offer and how to refer to them. Would be better to have centralised database.

18. Better information about what other services offer – perhaps expectations would be more realistic.

15. Do you think the information for referrals has changed since the introduction of MECC – expand?

- Most felt that it had not changed (15) and that it was happening already, some were not sure but one felt that as a result of MECC she was now more aware of how to access information to assist referrals and this had been incorporated into her organisation's computer system.

03. We're carrying on with what we were doing but maybe a greater awareness about what's out there.

08. No because we just go about it the way we've always gone about it.

23. I think you do know where to access stuff now whereas you had to really search it out before. It's a port of call for information. Prompt - tool or database? – keep our own of course under the heading of MECC. It's on our (computer) system here, on our desks. Something we can all access. It's quite useful…..it's more a case of reference.

04. Not sure if it's to do with the introduction of MECC, or if it's because there are more people to refer into as well – I couldn't say 100%.

- One felt that though there was no difference there was a reason for this and also a solution.

02. think we're in a transitional period and need to get all the "big wigs" together to change procedures. Unless it's agreed at the very top…certain departments say "I can't give you that information" – not linked together…Need info to move forward. The whole idea of MECC is that we're all singing from the same hymnbook and we're not.

16. What if any, might be the key barriers to implementing Salford MECC?

- **There was a very mixed response to this question with no specific answer being repeated apart from 'Time & Money' (x3). 5 suggested there were no barriers.**
    - Time / Money (x3)

22. I think I'm aware of people around me. I want to tell them more information. I can't spend as much time as I'd like with them. I think I'm always aware of that. There are queues and people tutting, moaning and calling us. I don't feel I can always give them the full attention. We just don't seem to have enough time to spend with people.

14. People might say time although it doesn't have to be a lengthy intervention.

Other issues that were raised included:

- Lack of information re services / inaccurate out of date info

15. Not being aware of services that are out there.

18. Even the City Council website is sometimes not up to date and you're referring people onto these services which are no longer running.

- MECC not embedded within all organisations

16. come at a bad time.. when there's been quite a lot of change in organisations on the back of budget restraints / cuts. Would be interesting to see how many people who were trained initially are still around.

- Initial problems in the way the initiative was dictated to them with no feeling of real involvement

08. No not now – ridiculous way they did it initially it turned everybody off – right at beginning – no thought about it – it was *"this is what we have, this is what you do".* Bad start but now don't have a problem.

- Clients themselves – resistance to change; feeling bombarded with advice from multiple professionals; public having other priorities e.g. benefit changes

17. Too many services, too many agencies, too many questionnaires…people do get a bit fed up of it. There's the potential there for MECC for it to run like that as well. But people wouldn't know that they're being "MECC'd". We don't say we're going to do a MECC on you but everyone starts to get trained and implement it…tries to do it, it might be all a bit too much, especially if you're not experienced and if you don't know when to leave it alone. People are given targets and if they've got to do 100 MECCs they're just going to potentially jump in there and not get it right.

03. The individuals themselves (clients / families) maybe not wanting change.

20. Customer participation. You can prompt people and tell them about services but unless the customer wants to move onto the next level…with everything else that's going on at the moment with benefit reform people are not interested in what you're telling them because you're telling them their housing benefit's being slashed…and at the moment whilst all this is being implemented they've got more important things…you feel like you're preaching and it's not being taken onboard. Even if you've got just one person that's taken a step forward then you've made a difference.

- Many different and duplication of services

07. We've got the Health Improvement Team, the Big Life Company, the NHS – lots of different people offering similar types of services and the line between them gets very blurred…you're not sure who's offering what. And they're changing without anyone finding out why or what.

- Recording MECC contacts – taking up too much time

18. Created extra work. It's remembering to do it because we do do it (MECC) so often…it's just part of our work…sometimes you don't get the time to do it so losing a lot of that I think….the numbers probably aren't true to what we are actually doing…we're doing a lot more.

- Being bombarded by too much irrelevant information re MECC

23. Maybe constant communication on it (MECC). I got lots of personal communication (cos they had my personal address) and I wasn't sure what that was about or why I was getting them because I don't think it was really necessary because the ones through here were enough. …Bombarded at first. You'd start off reading them. They'd be quite lengthy as well and you'd get half way through it and realise it didn't really apply to us particularly.

17. What factors are important for a successful roll out of MECC across your organisation?

- A very mixed response to this question, though 5 did feel that it was very important to have a relevant and up to date Directory of Services / Service Information *(NB: See SL/LM interviews which had a similar response)* and another 5 felt that simple and timely monitoring was important.

  - Directory of services / Service information – filtered & relevant **(x5)**

15. I think MECC is about – knowing who everybody is and who to refer to and who you can signpost on to.

  - Measuring success – make monitoring/recording easy – simple / timely / demonstrating/linking performance with feedback to show purpose **(x5)**

10. Being able to measure the success. …Making sure it's being used universally across our service & everyone is using it in the same way and understanding it.

14. People (staff) collect data…. it's meaningless unless you get a report back. If you can see a report that says this is what your service managed to do over the last quarter they attach understanding and meaning to it otherwise it's just yet another exercise to do…if they see something coming back they have ownership…feel more inclined to do it.

- Push & Direction from manager / leadership **(x3)**

16. … someone to bang the drum or it gets lost in with the other priorities that people are facing.

- Training **(x3)** // Training for all / get rid of SAT **(x2)** // Training should be part of induction

13. **Continue what they are doing - keep the training up.**

02. And irrespective of level in organisation - for something like MECC training should be given across the board. (From his previous experience in the Civil Service) If you put everyone in the same class training goes smoother. People open up more if they don't know each other's grades / levels.

22. Though recognised that this suits her particular learning style rather than SAT - you could see it (MECC) and they could explain it…it's instant information and I thought the group training was much better than doing it online.

06. MECC should be part and parcel of induction training - it would be useful to do the training package rather than the online SAT.

11. It would be good to have refreshers. A couple of hrs to get updated. You do forget when you've used it a few times (referring to training she'd been given) – I slip back into my ways of doing things.

- Refresher training

20. The only time I get refreshed about it is when I get a newsletter….everyone's so busy we forget about it (MECC). We're just ploughing through the workload and forgetting about referrals. MECC is taking a bit of a backseat.

- Clarity of purpose & role – Everyone working to same end **(x 2)**

16. Be clear about why you're doing it.. and communicate that.

23. Getting everyone onboard to the same way of thinking. Gets loads more done cos you're working compatibly. Now work much more as a forceful team now. We all know now what we're doing. It's got it's name and we know we're doing it and we can work towards it.

- Broaden out MECC to other services **(x 2)**

04. To broaden out MECC to services such as the Soup Kitchen / Night Shelter.

14. In the past only certain professionals were working in this rounded way, so as a scheme it is very good.

- Enthusiasm

15. If you're not interested you won't be bothered

Others included:

- 1 x Building personal confidence
- 1 x Streamline services & iron out overlaps
- 1 x Better IT
- 1x Network events
- 1 x Peer support
- 2 x Support from managers
- 1 x Using Teamwork / having a cohesive team

14. Regular slot at team meetings to discuss and feedback how they're getting on. Discuss if encountering problems and share ideas.

- Review / Reflect / Modify

08. **Sit back, take stock of everything that's been fed back to them before they go gung ho… I think if it's done properly and they take on board everything that has gone wrong – and things do go wrong, then I think it will be a huge success because this is our opportunity for everybody to be singing from the same hymn sheet and that is so important so people aren't going to the 17 places to get the one thing they want.**

18. Anything to Add? Expand upon. Ask?

- There were a number of mixed responses to this and they are shown below.

Positive

14. Feels it's a positive thing – a good thing for Salford to have implemented. It brings everyone up to a certain level in whatever capacity you work in…if you've never done anything like this before then at least you're bringing everyone up to a certain level and for those who might have been doing it it reinforces the fact that they were doing the right thing all along. It's about prevention, rather than waiting until people develop a chronic problem and then trying to deal with it then.

22. Yes – there are a lot of staff that do it anyway – it's the nature of the job. But I think it's highlighted things that you thought you were doing or how you should be doing that you're not doing. I think it's made us aware that we're not doing as much as we should…because I think we don't have enough time to do it. I'm more aware that I should be doing more where as before I thought I was always doing it.

23. As part of the MECC thing we rang round (we keep lots of stats) and get information off our enrolment forms. It was amazing. It was a really nice experience – we were greeted on the phone as friends, they remembered us. The feedback was fantastic. We didn't get any negative at all. It was lovely – a real positive thing to do. We're doing something right…… wouldn't have done this without MECC

10. Found it really positive and really helped me in terms of what I'm doing and have been able to read the website and read up on it – been positive for me.

02. I'm enthralled by it (MECC), can't be any more enthusiastic about it because I believe it's the right way forward. I'm 100% committed to MECC idea……everything we do on a daily basis is to help our service users, not to become ill in the first place…not just about health, money too. Very varied everyday.

- We were doing it anyway

04. **I felt I was doing it before – then we got the MECC and then you think, oh yeh, we were doing it anyway, it's just now got a fancy name.**

- Standards of Good Practice

06. It's kinda standards of good practice. It's about basic competences and standards of good practice and this is what you should be doing and this is how you should be delivering. .. I've never heard anybody talk about it.

- MECC has had no impact

07. MECC doesn't exist for us really…it's not really taken off for us. We're continuing doing what we've always done….and I don't think there's really been any support or help in implementing it. I couldn't tell you who was in charge.

- Some staff not using computers – a real barrier

Some of our staff don't use computers everyday – so that was a huge barrier for them. It's just thinking a little bit – and not everybody's the same.

- Saturation of services and information – not re MECC

18. It's ridiculous the amount of services and agencies we've got in the area. I do think people do get fed up. Our community is quite hard to engage with especially when you're doing walkabouts because they've been so saturated – they don't see the value in things because they've had so much thrown at them. It's stopping them coming to services. Not due to MECC – it's always been that way. We offer free services and we're wondering why we're getting such low numbers. But you look back and see they don't want to come out of their houses anymore because they're getting things in their own homes – different services, so why should they?

- Unfortunate Beginning

18. I just think it was unfortunate – the beginning. It was the *'Do as I say, not do as I do'* and I think that was the wrong approach – there was no meetings beforehand – it was there you go, get on board, do an assessment. .. They must believe in the people – initially patronising as they were doing it already, but now it's gone positive and working very well.

- Questioning the recording and wanting to know she is being valuable

17. Make sure it's (the recording system) tight and see what it's doing. Can't quite get the value of me coming back every time I've had a (MECC) conversation and ticking a box. I'm not seeing the bigger picture, what difference am I making by ticking that box? I'm doing the work and I'm not disputing that that has impact but I don't quite getting why I'm ticking the boxes.

- Better communication of MECC – Branding

16. MECC as a "brand" is a success…most people aware of what roughly MECC is and what it's about.

20. If we got e-mails and refresher training more, on a quarterly basis, or a designated page on our intranet site when you first log on, when it comes on, people might think about it more. Market it a bit better.

5. diii. Delivery Team Interviews

Introduction

In the original MECC evaluation specification the focus was on obtaining qualitative data from service leads (SL), line managers (LM) and beneficiaries (frontline workers (FLW)). However in May 2012 it was decided that there would be merit in interviewing the members of the Delivery Team (DT) and for the outcomes of this data collection to be incorporated into the final MECC evaluation report. The DT was seen as a rich source of information about how delivery of a behaviour change programme on the scale of MECC in Salford had been supported and facilitated, and to learn from the experiences of the various members. The timing was important given that many of the DT members were soon to leave to take up new posts.

Purpose of the Qualitative Data Collection

To capture from the different members of the DT their individual interpretation and perspective on the origins, development, rationale and operationalization of Making Every Contact Count in Salford. Also to capture individual's views on the critical factors for success in developing and implementing MECC or a similar large scale behaviour change programme elsewhere.

Method

The Evaluation Partnership developed a short semi-structured interview schedule, which was agreed with the Commissioners. The Commissioners identified 10 DT members, all of whom were contacted by a member of the Evaluation Partnership. Each of the DT members was interviewed over the telephone, with the interviews lasting 25 minutes to 1 hour. The interviews took place between June and November 2012, with priority given to the members who were due to leave. With the agreement of the interviewees the interviews were recorded using a digital recorder. Feedback for each question was transcribed. Data was then organised under themes and sub-themes linked to the questions with some illustrative responses included.

The informal semi-structured interview schedule was based on 6 main themes that did have a degree of overlap:

1. **Origins** – how did it (MECC) all start / whose idea was it?
2. **Rationale** – what was the reasoning / justification for MECC in Salford?
3. **Development** – how has MECC developed over time, from the original idea to where it is today? What, if any, are the differences in MECC compared to the original idea? Why do you think these have occurred? What do you think the role of the DT has been in developing MECC? What has your role been?
4. **Implementation** of MECC across Salford – how was it taken from an idea / concept to implementation? How was it "sold" to other stakeholders? What do you think the DT's role has been in this? How about your role?
5. **Operationalization** of MECC in Salford – how has MECC been made operational "on the ground" and what do you think the role of the DT has been in this? How about your role? What challenges have you encountered in this role?
6. **Sustainability** of MECC in Salford – how do you think MECC will be maintained / continued and how do you see the DT's role in this? How will you be involved with this?

Summary of Main Findings

Overview of Interviewees

- The 10 interviewees came from a range of different backgrounds, with none of them being engaged in MECC full time, although a small minority spent the majority of their time on the project. 1 interviewee had been involved with MECC from the outset. The others became involved at various times between October 2011 and February 2012. The DT members were drawn from a variety of different organisations:

  Independent Consultants x2

  NHS x4 (included staff whose employing organisation changed to Salford City Council (Public Health) during the time they were involved)

  Salford City Council (SCC) x4

- All of the interviewees stated that they had specific roles in relation to MECC. Some had more than one role:
  - Strategic lead
  - Project management
  - Communications
  - IT
  - NHS SL responsible for MECC implementation within an NHS provider organisation
  - Service support leads – focus on engagement and implementation support
  - Training

Origins of MECC in Salford

- The majority of the interviewees were able to describe the origins but in varying degrees of detail. The majority referred to the trigger being a visit to Salford of the National Support Team (NST) for Health and Inequalities although some were vague about the actual name of the NST.

- The period of evolution was thought to be 3 or 4 years ago.

- Some made reference to Salford being one of a number of pilots of an initiative that will eventually be rolled out nationally.

01. Began with early discussions in the Public Health (PH) Department. The role of PH was changing at that time – restructuring into providing and commissioning roles, and also a shift in how PH was being delivered…..trying to do earlier to reduce some of the inappropriate pressures on the more specialist PH services. ……tied in with discussions regarding health gain in Salford and the visit of the National Support Team (NST) for Health and Equalities. The NST report "kick started" it ….included a series of recommendations that were fed back to the PCT and the City Council. The NST message was to "industrialise" behaviour change interventions and do them on scale…The thinking evolved and then crystallised from the recommendations of the NST.

06. Recognition that there's been a lot of hard work to tackle that (health inequalities) but something new needed to be tried and something on a large scale. The story I tell is that the start came from the DoH HI Team that did an audit of how Salford were doing and suggested harnessing the staff of the public and private sector to raise the issue of individual's health and wellbeing (H&W) with them in their everyday work. Ambitious programme to get people's H&W on their agenda and get people to make little changes that could make their lives better now and in the future.

- 2 of the interviewee were unsure about the origins of MECC. One of these had only been a member of the DT since April 2012. Neither had been involved in the development / design of MECC.

02. David Cameron's initiative. Understand eventually it'll be rolled out nationwide….understand Salford's one of a couple of areas in the country to take this on in pilot form and learn so that it can be rolled out seamlessly….But don't know who invented it

08. Being honest, haven't got a clue.given a brief and gone from there…Seen various White Papers but nobody's said to me this is why we're doing it

- The majority of the interviewees stated that the overall lead for MECC had come from PH although both the PCT and SCC were fully supportive, SCC becoming involved shortly after the PCT. The PCT was identified as the organisation that allocated a large amount of money for MECC for 2011/12 and 2013.

01. *XX*, PH Consultant, was leading it. XX was pushing against an open door…..The Chief Executive and Chair of Salford PCT were very supportive of PH – understand its importance and its role. The City Council then embraced the concept of industrialised behaviour change programme.

Rationale for MECC in Salford

- **There was consensus that MECC was introduced in response to the poor health indicators in Salford compared to the rest of the country. Reference was made to worse than average life expectancy for both men and women.**

- **Many of the interviewees referred to past attempts to address health inequalities and a history of partnership working and multiagency initiatives; however, some referred to the need for agencies to work "smarter" and across the wider determinants of health i.e. broaden out to include wellbeing.**

03. To tackle health inequalities. Ever since I've worked in Salford …know the figures we get presented in so many different meetings…I know rationale is to try to make an impact on those numbers….they're slowly decreasing but not quickly enough…as services get more squeezed (cash and manpower) there's a drive to get people into self management, low level interventions, to reduce demand on services and impact on H&W.

05. Someone came and did a visit to Salford and it all linked into the Joint Strategic Needs Assessment where they do all the profiling. One of the health inequalities bodies came to see us…said need to do better jointly…have significant health problems..need to work "smarter" …(MECC) sold as a response…and an ideal time with all the restructuring – very little choice but to find different way of working.

05. Salford's always been known as quite innovative in its approach. There's been a lot more coming out about the effectiveness of brief interventions and because of such high levels of deprivation in Salford…….always been quite strong partnership working across the City.

07. Wide disparities in health across Salford…..this just isn't right. What can we try and do….rather than coming from a more traditional clinical based approach to try and fix it, let's try and tackle the wider aspects and try and do it early.

08. People expected to deliver value for money…so makes sense if staff can address issues beyond the one issue they've been trained to deliver…refer the right people to the right services….improve customer service and customer relationships…save money for everybody…make it easier to deliver services…more holistic approach to health and well-being. (Gave example of person needing financial support whose

spending money on cigarettes and alcohol finding it difficult to change until the reasons behind the smoking and drinking are tackled.)

- 2 interviewee linked this question to frontline staff and the many opportunities that already exist for them to broaden out conversations to cover health and wellbeing.

02. It makes sense really…….to upskill members of staff to be able to have the confidence, if they don't have it already, to have conversations with people and deflect people out of hospital settings into primary care settings……personally I see this as a mirror reflecting exercise for people already providing interventions. However I see the greatest benefit of MECC happening in departments where they don't have staff who are doing this on a day-to-day basis – porters and domestic staff who spend quite a lot of time speaking to patients – upskilling those people. This is where the programme has its greatest strength really….it should be part of people's core values really. If you work in a healthcare setting you should be delivering these kinds of outcomes for patients and have their best interest at heart.

07. From PH side I've picked up that there are other initiatives around the country like MECC but principally focused around health. The idea behind this (MECC) was to try and widen this to social wellbeing type issues, hence the Council's involvement.
Health factors are affected by social economic factors. It's impossible to disentangle them – they're absolutely linked. There's an understanding and recognition that this is the case. Within Salford we've got all of these frontline organisations dealing with all kinds of issues, around all of the MECC competencies, not necessarily not just public bodies – we've got 3rd sector, vol orgs – a whole raft of people dealing with the public at the frontline so let's get these people involved and cover all the topics – health and wellbeing type issues.

- A minority mentioned the evidence base for brief interventions. 1 interviewee stated that the time seemed right from an organisational perspective, with PH moving into SCC, and that the resources had been put in place to implement a city-wide behaviour change programme.

09. There was research coming through that said if you do brief interventions, brief advice across the board and industrialise it then you do have an impact but it does need to be done at that level. If you're thinking of long-term impact on health inequalities and SMR there has to be a step change in the way things are done. So Salford was prime for MECC type work.

Development and Operationalisation of MECC

- **The responses reflected the time that respondents had been involved with MECC. Some clear and distinct stages were identified – identification of need for MECC; examination of evidence from elsewhere (focusing on large behaviour change programmes in other areas and particularly the implementation rather than the outcome); programme design (tailoring the approach to Salford); implementation (including dedicated project management); review and refinement.**

01. Prompt re reason for starting big - Wanted to maximise people's enthusiasm and not disappoint them…… Very surprised that so many wanted to get on board.
Picked and mixed from what was already out there and "tailored" an approach to best meet the needs of Salford….Made it clear that it was not going to be an easy ride and there would be learning as we went along, that it wasn't an off the shelf package……People got involved in different ways…at different levels and at different speeds.

- There was consensus that the principles and ethos of MECC were well received, viewed as sound and applicable to organisations across Salford, which resulted in them being receptive to become involved.

06. Never been any problem with staff or orgs getting what it's (MECC's) about and in the main it's been viewed as a very sensible thing to do. Around the fringes some staff that are a bit grumpy about it because they think they're doing a lot of this already and particularly gripes with the SAT……. But in the main it does look like organisations have bought into the idea.

- There was consensus that the programme was ambitious and at the beginning was perhaps overly complicated and prescriptive. Most of the interviewees referred to changes made to the original plan and that it had been appropriate to make these.

01. It went quite big and now we've realised it needs to be a bit more streamlined and manageable. This thinking has happened quite recently. The mid term review has been every helpful and made me wonder why did we make it so complicated. It was trying to please everybody and perhaps we let it get a little bit too wide and complicated. Need now to make a few decisions and say well no that's not what's feasible and perhaps do it a different way. Went too overboard in trying to include everybody's requirements

03. When visited organisations feedback was that process stuff done but not enough about engagement of staff within organisations…..almost an acceptance that organisations would do that themselves…think that was expecting too much. Made some changes due to the realisation that organisations can't get the message out e.g. introduction of Service Support Leads. In terms of original programme structure not changed that much – just looking at different ways of getting it implemented

07. As it's moved from theory into something real that's definitely helped us to get organisations onboard

01. Quite happy about it (the changes made to MECC). It needed to happen. We've been clear that this is learning and we've been listening to what the service leads are saying and responding to that which I think is really important…Overcomplicated to begin with….has become more streamlined and manageable over time – slowed it down….Recognised that it's not possible to please everybody all of the time….and that one size does not fit all.

- However 1 interviewee was critical of the time taken to make the changes.

03. The length of the halt is a concern. Organisations have been engaging their staff but SAT and training now delayed for them… I think enthusiasm has waned, seem to be losing momentum. Partly caused by the halt but also becoming apparent before that. The appetite is easing off.

- Some of the interviewees were critical of the approach adopted in Salford. These were people who had not been involved in the initial design and implementation phases.

02. Referring to contrast between Salford MECC and other areas - Principles are the same. Process just different. Why that's so in Salford I'm not sure other than to say it can only be because obviously commissioners want to see a particular type of outcome to justify this payment (CQUINN)….not necessarily the most natural "fit" for….(specific organisation)…. . I spoke to other areas when I first joined (the DT) (West Midlands; York and Humberside)…and I've kept in touch…for feedback and advice about how they've done it (MECC) and they've done it in a more sensible way. They've subsumed this programme within their core values from inside out…and it went viral in both places. Had really good take up because they weren't monitoring outcomes in the way we're being asked to – it was just a case of "these are your core principles. Do you feel this is part of your duty as health care provider employee?" Everyone said "yes"….and they were allowed to do it in their own time and not monitored on their outcomes. Measured at service point – where people being referred to…people referring themselves to…just monitoring outcomes from that end. Really great take up.

03. Surprised that certain things had not been completed at that point (when SAT launched) – seemed to have got some of the practicalities worked out but not so much re engagement of staff…..Some of the work needed to be done at earlier stage – before roll out.

05. Underestimated the breadth of the agencies involved (e.g. organisation with over 6000staff and smaller voluntary organisations)……Not enough planning at the start but not sure if there's another way it could have been done with the timescales…..it's felt a lot like catch-up along the way…. Underestimated complexity of the process. Only when seeing it in practice that we were able to really understand where we were going to hit some difficulties. In some ways I think it was needed.

07. I got involved too late…should have had more structure earlier – that would have helped. Got the impression that it had been run around the City (by PH), quite sporadic, health focused. Half the people involved knew what they wanted but the message wasn't getting through. There wasn't a clear pathway – didn't even have a semblance of a clear route forward. ….Can't make them do it if they don't want to) expectation that orgs would do MECC but they won't – some have got contracts (SRFT) but most haven't. It's not a good idea because we're telling you, it's a good idea…there's a definite need to understand how all these orgs work and that this is a hearts and minds. Won't get anywhere with performance indicators.

- The majority of the interviewees gave examples of specific changes that have occurred, some of which came about as a result of the decision to revise and refresh the programme. None of the interviewees felt that the changes compromise the rationale and principles behind MECC. The changes have been grouped as follows:
  - Developed Service Support Lead role for some of the DT members to provide tailored support in designated organisations. More able to be responsive and provide tailored support based on an understanding of the organisation i.e. not a one-size-fits-all approach
  - Appointment of DT members with specific lead areas or specialist knowledge / skills e.g. training, IT (technical support and advice, website development), communication, HR, service provision, marketing
  - Changes to SAT tool and competencies
  - Changes to training – fewer levels i.e. more streamlined, combining training for staff working with children and young people with those working with adults
  - DVD and guidelines for staff re delivering interventions
  - More systematic and structured approach to engagement with and within organisations as realisation that it was too great an expectation that organisations would be able to do this entirely on their own.

Role of the Delivery Team

- As reported earlier the 10 interviewees had been members of the DT for varying lengths of time and in varying capacities. The DT did not exist at the outset of MECC but very few were aware of how and when it was established. The impression was that it had evolved from the groups set up at the start e.g. 2 Task and Finish (T&F) groups (1 adults; 1 children and young people), competencies group. From this emerged not just the DT but also the Stakeholder Reference Group (replaced T&F groups, combining the organisations working across all ages. The DT was thought to have come into being in October 2011, around the time of an Early Implementers' event.

01. MECC is so big that it's not appropriate for one person to be holding all the reins so I wanted to have a group of people coming together to lead on different work streams. These formed up into the DT"

- A majority of interviewees were not aware of the DT having defined targets or objectives although most stated that its primary function is to ensure delivery of MECC. It is seen by most as a decision-making and problem-solving group, able to respond to feedback and make changes to the programme.

Its relationship with the Project Board was unclear to most although most reported that it reports and is accountable to the MECC Project Board. There was awareness of high level reports being submitted to the Board but a consensus that communication was one-way i.e. the DT does not receive feedback from the Project Board.

03. Produce high level reports for PB but get nothing back from them. Never seen their minutes. Never met with PB.

04. I don't get a firm sense of strategic direction coming from the PB if I'm honest. DT marshals itself in a way, sets it's agenda, taking a nod at the direction from the PB. We've worked pretty well collectively as a group. DT provides the direction (for MECC).

06. The balance in terms of governance seems to be practical to me. It's not burdensome and where we've needed to take decisions to PB they've been supportive of what we want to do.

- There was a consensus that the DT has been and continues to be an important factor in ensuring MECC implementation and sustainability. It is clear that new roles have emerged for the DT over time, resulting in some existing members taking on the role of Service Support Lead, and new staff with specific skills / knowledge being drafted in to address specific issues. Most of the interviewees stated that they had an important role in getting organisations signed up to MECC regardless of any specialist role they had.

01. One of DT's strengths is it is "organic" – not fixed but flexible and responsive as MECC evolves. DT has spread the load. DT has been critical.

02. Prompt re clarity of roles in DT. Yes…quite clear to see who does what and who's responsible for what in terms of guidelines for levels, who leads on the programme, IT, training elements.

04. Articulated what the framework is, how it should operate, developed the RAG system to monitor if on track. A lot of it is about engaging with the different services to explain what we're trying to achieve with MECC, trying to get people to sign up and at same time being respectful of day-to-day operational demands. It is a fine balancing act for services…..Done pretty well e.g. SCC – got around 500 staff through SAT and started to progress through the training – a good news story.

05. Initially feeding into the competencies….involved in the development of the SAT. Supported these questions – didn't write them…Reviewed them after the pilot…mapping out the processes if you like – the journey somebody would take.

- A few DT members gave examples of specific tools or approaches that they use to encourage organisations to sign up and implement MECC in their organisations.

03. Prompt re clarity of role as Service Support Lead – for all the orgs I had responsibility for, I went out and met with them all to find out where they were up to – any challenges etc – and introduced the concept of an action plan. Used the action plan template as a basis for my discussion with an organisation – goes through a process – where up to, what needs to be done. Took notes at the meeting on the action plan and then typed it up. Aware that asking them to complete one of those it was another ask on top of all the other things they're being asked for at that time. That was pragmatic approach I took. Established relationships with them.

03. Involved in selling the concept – running through the background – why important to Salford. Who is involved. How will enhance what they do. Consistent messages. Being part of city-wide project is a good selling point. (3rd sector orgs have to be more "out there" to secure funding so focuses their minds). Can see links and potential for better outcomes. Some orgs have said no, usually around timing. Keen to be

involved despite this. One or two orgs have played cat and mouse….if I've managed to get in and present they've joined in.

04. Once bought in, what next depends on the org. Next step might be pilot group of staff to do SAT. Discuss time commitment, which staff will benefit most, what levels are appropriate……Provide focal point for queries - sometimes just walking people through the process. Simple pragmatic things like explaining the registration process, need for unique identifying number, what competencies are. Provide information, guidance, problem solving.

04. Going to team meetings to explain what MECC trying to achieve – frontline staff interested in how it's going to help them to develop as an individual. Stress that MECC isn't a one-off training initiative. It's about changing how orgs operate - about being proactive and not fire fighting and trying to relieve the pressure off services and helping people to make changes themselves

- The importance of the period of review / reflection was identified as key to the future of MECC.

05. We were getting a lot of feedback. It became more obvious. As we went through and people were working through we could see where we were getting blocks in the system, how people weren't coming through…the training…failing the post assessment. People were getting stuck….stakeholders saying these people going on 3 training sessions which was far too much. Think when we set up the SAT there was a question about that but it was left as let's run it and see what happens. So we ran it and it became pretty clear to everyone involved that it was a major barrier. We lost …1 organisation although I think they'll come back on board (though personally it wasn't the system it was the organisation that was the main issue there!)

- The majority of respondents voiced concerns about the future of the DT. Though felt critical to the future of MECC the DT's future existence appears to be in doubt, with the majority of DT members taking up new posts and no replacements identified. Some interviewees stated that attendance at DT meetings had dwindled over time, reflecting other work pressures and priority afforded to MECC. All on the interviewees seemed to view this as a real risk.

01. DT is experiencing staff changes due to structural changes within and across organisations – Project Board keeping an eye on these.

03. Initial couple of meetings was a very full group but it has dwindled a bit. This is one of the challenges going forward. Everyone's being stretched so much. Think the resources on the project are an issue – people. Other DT members part time on MECC. Commitment to DT and the programme is being challenged.

04. Ambitious, city wide programme, so have to have number of people who are fairly well connected to start that engagement process and help people along that process, extol the benefits, explain what some of the pitfalls have been and coax and cajole them along the way. The DT has been absolutely essential. Got to have some kind of succession planning…need people who are capable of making these connections, making sure that the engagement continues to move forward and make progress with sustainability. That's key. There's still a lot of work to do.

05. Entails quite a lot of work and amount of support that organisations would require was underestimated. That's been the difficulty. A lot of people(on the DT) have been borrowed to make it happen…proving a risk now…people leaving.

06. I'm really impressed with how the DT have been able to work through it. People on the DT have had to reapply for their jobs and they just keep working through it. It's to their credit….things haven't come to a grinding halt unlike in other areas. ..impressive that they've not found excuses not to do things. They

definitely believe in it. (Without the DT) MECC would have been a shambles. If hadn't been there we could have ended up with not getting decisions made, got into some disputes / disagreements. Having that working relationship has made all the difference and because we know each other and we do work as a team we've been able to be honest with each other. Prompt re whether feels that DT needs to continue in medium to long term – there are some big decisions to make. We've got a change / revamp in the way we run things so there's that to take care of and when we're through that it really will be getting serious in terms of what happens as the programme comes towards the end.

07. Without the DT MECC would grind to a halt…a massive risk.

Sustainability of MECC in Salford

- All of the respondents voiced concern about how MECC will be sustained in Salford. Various reasons were given:
  - Perception that MECC is seen first and foremost as a workforce training programme and that when the training provider withdraws from Salford this will cease
  - DT seen as fundamental to sustainability
  - Uncertainty about who will coordinate future training and deal with logistics
  - Maintaining high level / senior buy-in at time of competing demands, financial pressures and significant organisational change
  - Salford people not sufficiently aware of MECC – not "public facing" and no formal acknowledgement that certain organisations have embraced MECC
  - Lack of uptake and interest in train-the-trainer approach to future MECC training
  - Perception of prescriptive approach to sustainability which some organisations are resisting or finding too difficult / impractical to achieve e.g. job descriptions
  - Over reliance on Service Leads (SL) to cascade / roll out MECC within their organisations
  - Uncertainty about future communication e.g. resourcing of and technical support issues for IT.

- **Some practical solutions were offered:**

01. Develop something akin to a Charter Mark like Investors in People but more "public facing". Stakeholders would receive this if actively involved in MECC and it would build on the Service Offer. Public would know which of the organisations they are in contact with are actively involved in MECC. It would also be more visible for the staff.

02. Publicity. If the legacy could be a quite prolific high profile public campaign then will be difficult to push out of people's minds.

03. Put resources into the DT and Service Support Lead role. Don't see enough action being taken to address that. People being pulled off the project left right and centre…unless we can sustain the team we can't sustain orgs into the project.

03. Need for definition document – should have been in place before delivery. Define what an intervention is at level 1 and 2. So staff know what's expected.

03. Monitoring and feedback - need to agree how going to capture and collate information – risk of losing interest because staff won't get any.

06. Develop modules for induction and mandatory training – more awareness than training.
06. Identify who will organise the training - book venues, book trainers, iron out problems with booking system….. A big job! ? Health Improvement Service.

07. It's become evident that we need a different tack here (from original plan). Wasting time, energy and effort. If we push too hard the doors will shut, so back to the hearts and minds thing. We need things built into the businesses of the organisations. For me sustainability is getting the organisations involved in MECC, getting them doing the pathway, monitoring the behaviour changes. All the organisations are different. Start getting some kind of performance things around the interventions and the outcomes, not the inputs. Build into businesses.

- There was a general consensus that there are real challenges and it seems uncertain whether MECC will survive in the next 3 to 5 years.

05. Prompt re confidence that MECC will survive in next 1,3,5,years – I don't know. Definitely the next one. It depends a lot on what happens with the Way to Well-being portal,…how committed…needs someone in charge of leading it. It won't happen on it's own. I'm concerned by constant change in the DT….needs to be something in place. Hope it'll be here in 3 to 5 years. I think it's really worthwhile but whether it'll be in the same format or something else? Don't know. Don't think the ethos will go away in Salford.

- Only 2 interviewees stated that their involvement with the DT and MECC was likely to continue beyond March 2013. As previously reported respondents were concerned about the loss of continuity and all felt that this would have a negative impact on sustainability.

Critical Factors / Key Ingredients for Success in Implementing and Sustaining MECC in Salford.

- All of the interviewees were invited to reflect on their experiences of being members of the DT and to identify the critical factors / key ingredients for success. These have been grouped into the following:

    - Communication – being clear about what MECC is and why doing it. However keep the number of people involved to a minimum to avoid delays and mixed / confused messages

01. Absolutely critical ingredients is communication" – a plan across all stakeholder organisations, from Chief Executive / Officer level to ground level. Present arrangement too ad hoc…needs much more weight.

03. More work to promote it with frontline staff - need to understand the importance of it and why they're being asked to do it.

06. Communication and winning hearts and minds – so they'll do it properly and not just tick boxes.

    - MECC is nothing to fear and it helps people do their jobs and to make people's lives better

02. Recognising when it's appropriate to be delivering these kinds of interventions, having these opportunistic conversations in this kind of setting. Also I'm quite keen to tell (staff) that actually they're already doing a lot of this and it's an extension of this…we're expanding on their current knowledge by adding in other topics..Things they'd not normally talk about e.g. benefits / debt management. They're quite impressed actually. Quite a few of them have fed back to me about conversations they've had with people..quite keen to gain these extra skills.

04. Sell it in the right kind of way – that it'll help people to do their jobs and to make people's lives better.

04. The key (to MECC) is helping people to do their jobs and helping Salford residents to enjoy healthier, better lives.

- Senior level buy-in and a commitment to resource adequately – not just rhetoric; be firmer with organisations – place expectation on them to do it properly

01. Market the vision to the senior team so that they understand it and they will support it being embedded in their organisation and why, and then they will support their senior and middle managers to actually do what needs doing…..through not only communication but also production of relevant board papers and presentations. There is a lead-in time to this.

- Don't assume that each organisation can / will cascade information

03. I suspect if you talked to the people on the frontline there'd be a mixed response re what they'd know about, how the message in the organisation is being told. Larger organisations there's a risk that messages not passed around….depends on how their communication is managed. Organisations expected initially to do all of that. Expecting someone to get a handle on what the programme is about by attending 1 event is unrealistic, especially if then expected to cascade it. The success of MECC is dependent on how the message is spread.

05. Do not rely on Service Leads, albeit trained / briefed, to go back within their organisations to roll out MECC.

05. One of the biggest challenges has been communication down to different lines. Hasn't happened as we'd anticipated. When I go out and meet people on the frontline they're saying, "MECC – it's just an assessment, a test of what we already do". If you sit down and explain it to them they say, "It makes sense." But because it's come down their management structure ("we've got to do this") they do it and it's not always been well received.

- Maintenance of momentum with clear structure and route forward for roll out

01. Re-energise as the project goes along – reminding organisations why they agreed to get involved in the first place and how and what they need to do to remain on-board.

- Properly resourced, designated support staff – preferably staff who already have established relationships with the organisations to be engaged

05. Programmes such as MECC require dedicated time and people to drive it forward.. Need to have support available for each organisation, particularly at the outset. This support should not be transient and reliant on borrowed people. Know there's a lot more areas…big question over the capacity at the moment to go and get new people on (MECC).

05. It helps if the people recruiting, promoting and supporting organisations have already got established relationships with those organisations.

05. Bringing the support staff together is important. It's been very supportive and given the opportunity for everyone to bounce ideas off one another. For a cross agency project of this scale there is benefit in having support staff drawn from more than one sector.

06. The right person with the right credibility to work with each organisation – someone to link MECC with the organisation's purpose – make it real / apply to real life situations.

- Receptiveness to the need for change (flexible / adaptable) – in programme design and implementation BUT only when consistent with the principles

01. Not a fixed approach; not a one-size fits all, especially for sustainability and performance monitoring But being clear where changes cannot be made if they go against the principles of the approach, and explaining why the changes cannot be made……keep the principles of large scale change in mind throughout.

05. Important to stop and listen to the people implementing the programme, to be responsive. You're so committed to it you almost expect that level of commitment in people you work with and it's not quite there…it's quite frustrating and makes you go back and think "well actually, what've we missed?" That's one of the strengths – the stop and pause thing at the minute – we are being responsive.

08. Generally be firmer with organisations – only let them do it if they're going to do it properly… we (DT) are bending over backwards to accommodate them…being too nice to them.

- Keep things simple – though does not necessarily mean you have to start small

05. MECC is not simple to implement and needs to have clear steps. It's quite complex. Initially seen as being quite simple but unless you put together all the steps involved for the Service Leads it's a considerable amount of work really…one of the big underestimates – how complicated the process would become.

- Organisations need to be able to recognise the added value of being involved
- Recognise that MECC is NOT a workforce training programme but a large scale behaviour change programme. MECC should be an intrinsic part of core values, but recognition that this requires a big shift / change in working practice for many and this takes time

09. If services are continually having to deal with people at the bottom end where they need high levels of care or high levels of input, the cost that comes with that is unmanageable and unreal to some extent and the future is about we can't afford to do things that way anymore. So the starting point for organisations is to understand that MECC is very much higher upstream and if it's done in the right way and becomes part of how you work it will make a difference in terms of people doing different things. They'll listen to what you're saying and they'll respond to things and they'll take a bit more responsibility for the decisions they make, or they'll know more, understand more or be aware more. So my first thing would be that orgs see it that way and it's not just a training programme to help people to have conversations. It's a programme to help make a difference to the way that people work and the responses that people make to those contacts. So sign up to that and then you know what it's about. And then everything follows through from that.

- Monitor and feedback – inputs and outcomes, but must be simple / manageable

02. Change how outcomes are measured – definitely, without question. Only the people with access to people's records are able to record these conversations. For people like ** there's nowhere to record this information. Can't walk around with a clicker or clipboard. ….monitoring should see the value of the programme at the point of self referral. We might deliver a MECC intervention here, nothing will happen, then they (the client) go home, set fire to the chip pan, the fire brigade come round and give another intervention. Still no change in behaviour but then get into trouble with the police, spend a night in the cells and same intervention again. Lots of consistent messages and only then will they actually realise need to self refer to go to appropriate service. So not appropriate for us to measure the intervention, or the fire service, or the police service. It's at the service end. The benefit will be realised because of the consistent messages. (Person will think) "I'm now here..I was told and told and told…". That's what will happen ultimately.**

04. Performance metrics – a lot of resistance detected about having to collect information. Seen as additional burden. Needs to be simple, meaningful – what is done with the information and use to improve services. How do you marry MECC metrics with what organisations have to collect.

05. The services are surprisingly interested. Want something to show that they're doing it. "We're going to invest in this so what, at the end of it? What are we going to record?"

06. Monitoring – must not put orgs off by being too onerous. Be clear about why collecting and do something with it…. Focus on outcomes….organisations want to see an end product.

- Simplify the pathways and assist staff by producing service directory
- Build training around the needs of organisations – flexible approach

05. Make sure the training requirements can be accommodated within each organisation and each discipline / staff group – if too many steps and too many courses, organisations are less likely to participate.

- Take into account that many organisations rely on volunteers. Reflect this in how training and support is provided

04. Create a virtuous circle where we put something back to the volunteers – provide training for volunteers who have previously been beneficiaries of services and now working in voluntary capacity within services. Would make great case studies – received a service and then put something back in to them and maybe gone on to build new careers.

- Accreditation for those who have been trained – adds value

04. Some sort of accreditation for the training – certificate that's transferable, can appear on CV…links in to staff question re what's in it for me – professional development, learning new skills… it's commutable.

06. Give staff certificates (but these should come from the organisations themselves) to go in CPD folders. A well done! (from service leads preferably).

- Provide opportunities for sharing good practice and learning from difficulties encountered
- Develop network with other areas implementing MECC / large scale behaviour change programmes – to learn with and from others

03. There are other MECC programmes elsewhere – maybe more cross-working to see how they're doing, learning from others or sharing our learning. Everyone doing it in their own way. Could have developed training programme that all could have shared.

04. Take stock of developments elsewhere and see if there are opportunities to learn from these.

- Be aware of the wider environment and anticipate and react to changes
- Publicity so that members of the public understand what MECC is

02. Publicity to keep it in people's minds as we move forward. Why aren't we making a bigger deal of the fact that everyone across Salford's doing this?…if the public knew about it would it be such a bad thing? Would they then not seek to find more information about the project? Could put the information on-line and people could feedback to their own families…get over the consistent messages.

- The areas where there were the greatest differences of opinion are as follows:

- Whether financial incentives improve performance

02. Prompt re whether QUINN and whether its existence has "concentrated the mind". From our point of view it has steered the focus somewhat….focused on certain departments, but not necessarily the right ones.

04. Financial incentivisation v altruism – not had to offer financial incentives within XXX. I've played it down.

05. Financial incentive e.g. through CQUINN, does not seem to be the motivating factor for organisations to get involved with MECC. Not everyone's got CQUINN so no financial incentive so the fact that so many organisations have agreed to do it(MECC) is really good…good that they're trying to make it work. It's one of the strengths of the programme.

- If the SAT should be maintained or replaced by e-learning or face-to-face training for all staff

05. Everyone should go through the training….in an ideal world….I think the SAT has been a huge psychological barrier. It's hasn't been "oh, we're all going to get trained". It's "oh, there's a test"….very hard for workers and especially teams. Between teams and within teams you get natural competition.

08. You do the MECC on-line assessment and that's it – you pass it; you never hear anything ever again.

10. Would not have had the SAT – would have used e-learning with module and test. SAT – it's very obvious which questions send you on the course and which don't. Surely you need to mix things up more so that it's a test and to really know who needs to go on the training. We got fed up of saying it really!! Almost like, staff would see it(MECC) as "I'm ticking the MECC box by going on the training (doing the SAT etc) but I don't have to change what I do." That's not what it's about.

- Where to direct the most effort to achieve the greatest impact – some suggested that focus should be on upskilling staff who do already spend a lot of time speaking to people but do not normally provide brief interventions. Others seemed to suggested strengthening the "business as usual" (doing it already) message.
- Target effort on larger organisations to maximise impact

08. Target effort on larger organisations to maximise impact– I don't feel it's best use of time to persuade, for example, small GP practice to participate before other larger organisations.

- The value of the MECC website

08. If having a website ensure it is kept up-to-date, relevant and costed in. Don't assume existing staff or departments can absorb the work…Have shorter URL for website – it's the longest URL I've ever seen! Review website content – doesn't sell it (MECC) too well. First page says MECC is a behaviour change programme and that's where I switch off…people (staff) don't know what a behaviour change programme is. All it talks about is behaviour change, not what's in it for the person doing it…think it should do…for the organisation, staff and customers. Instead it's just blurb that you'd read in a council strategy. Not going to get involved….sounds too complicated. Got to remember these are frontline staff who want to go to work, to their job and go home.

Key Learning Identified From Delivery Team Interviews

- Ensure strong and continuous leadership – for overall programme and within each organisation – to maintain momentum and enthusiasm
- Involve representative organisations in programme design – large, small, statutory and 3rd sector – so that a flexible, pragmatic approach can be developed for implementation
- Be responsive to feedback from stakeholders BUT not to the extent that it compromises the principles and ethos of the programme
- Need for DT or team of people operating at a senior management level who are able to engage with managers and also mentor frontline staff. Preferably those who have already developed strong relationships within organisations and know how they operate
- Tease out the unique selling points so that MECC stands out from other initiatives – be clear about what MECC is and the benefits for staff and the people of Salford. The aim should be to assimilate MECC into everyday practice so that it becomes part of core values
- Resource adequately, though does not necessarily mean incentivisation
- Communication is key – requires different mechanisms, not solely reliant on IT or assumption that managers can cascade information
- Do not be overcomplicated in approach – should be simple and manageable, with regular review built in. This does not have to mean that it must start small, but take time to pilot first to iron out obvious problems
- Try to anticipate other things that might be needed to support the programme and have a clear plan regarding how these will be addressed e.g. service directory to aid referral, Way-to-Wellbeing Portal
- Beware being prescriptive about the approach to sustainability – emphasise the need to embed but provide guidance, support and examples of tools
- Review approach to assessing staff competencies
- Be flexible in how training is delivered, taking into account the varying structures and processes in the organisations and how training is delivered
- Monitoring requirements should be considered as early as possible. These should be as simple / practical as possible. Mechanisms for providing feedback re monitoring should be put in place.

5. div. Chief Executives / Heads of Service Refresh Interviews

Introduction
In June 2012, the Salford MECC Project Board requested a stock take to identify what is working well and what may need to be adjusted to better meet the needs of organisations invited to participate in the programme. They wanted to gain a better understanding of how Chief Executives and Heads of Services view the MECC programme, and their thoughts on what could be improved for its roll out across the city.

The MECC Delivery Team requested feedback from a number of Service Leads from the main participating organisations. The Evaluation Partnership were given the contact details of six Service Leads - representing the range of services /organisations across Salford involved in MECC, such as: NHS, Non-NHS, Large and Small and Voluntary sector organisations. The sample included Public Sector Services, A large Voluntary Organisation, A Foundation Trust, A Social Enterprise and A Community Benefit Society. The interviewees included:

Director of Operations
Chief Executive - Executive Director
Service Lead / Senior Manager
Executive Nurse Director
Head of Service *and a*
Strategic Director of Service

It is important to note that one of the organisations interviewed has a remit for the whole of Greater Manchester and Salford represents only 10% of the service; they felt this hindered some of their responses.

The MECC Delivery Team provided the Questions for the Refresh Interviews based on specific information needs at this point in the project's development. These were:

1. How important is MECC to your organisation / service?
2. To what extent do you see MECC as an opportunity for shifting the approach of frontline staff?
3. What's the significance for your organisation/service of the fact that MECC is a large scale change, city wide programme
4. What are the opportunities and benefits of MECC to your organisation/service?
5. Are your senior managers committed to the programme?
   (If there are reservations what are these?)
6. How does the MECC vision fit with your organisation's vision & how is this fit communicated across the workforce?
7. What are the challenges your organisation /service is experiencing in taking MECC forward?

Semi- structured interviews, conducted over the telephone (n=5) or face-to-face (n=1) were used for data collection. All interviews were recorded using a digital recorder and detailed field notes from the two Interviewers; feedback for each question was transcribed and data organised under the same headings; themes and sub-themes within the responses were identified; data and themes were cross-referenced and shared amongst the Evaluation Team for verification.

FINDINGS

1. The importance of MECC to the organisations / services concerned.

Of the 6 organisational managers interviewed there was a strong consensus amongst most that MECC fits well into the type of work their staff are doing already or it compliments the work they do as a service. Overall, comments about the importance of MECC to their organisation or service were positive:

- That it *improves communication and has assured that staff are having conversations (with the public) around health improvement interventions that can improve their health.*
- There were expressions of medium to long term benefits including improvements in long term outcomes, reduction in reliance of secondary care and an opportunity to *use intelligence gathered to understand & design service delivery accordingly*.

Although the importance of MECC was acknowledged, they also recognised that some staff within organisations did not always see the relevance of MECC to their work

- *"Some of the teams are finding it much easier to implement than others and so have mixed reactions re the concept. Easier if in a team that's already doing sport / health issues but those teams that are in other areas … finding it much harder to implement and make sense of it"*

In this respect, there was a consensus throughout that MECC was potentially a challenge, particularly for some of the smaller or 'non-health' related teams, within their organisations: *The concept is fine but practically it's been a challenge.* Thus, despite the importance of MECC to the organisations interviewed, some reservations about the implementation were apparent.

2. MECC as an opportunity for shifting the approach of frontline staff

To what extent do you see MECC as an opportunity for shifting the approach of frontline staff?

Most of the managers interviewed felt that MECC was a positive step, particularly in the current social and economic climate:

> *Potential marvellous opportunity to use those contacts with service users to design better services more intelligently to meet the real need out there... if can use intelligence we gather in a better way we'll be able to improve outcomes for people – Particularly important we do this efficiently & effectively at time of shrinking public purse*
>
> *From leadership perspective it's absolutely significant because the strategic direction of health & social care means we have to develop greater partnerships for commissioning & delivering services*

Most interviewed felt that it was a *'nudge'* rather than a shift; particularly if they felt that they were already *doing it anyway*. Although MECC was acknowledged by all as an opportunity to *shift the approach adopted by their staff* this would not be immediate - *more a medium term outcome when staff start to change their mindset.*

A common theme running through their responses was the expectation of MECC as a training programme to standardise the approach adopted by services across the City:

> *It's making sure that everyone is working to the same standard… " It's an opportunity to standardise everyone's approach" and that "everyone has the same level of understanding and skills"*

In contrast, others were concerned that such standardisation and 'one size fits all approach' may affect the ability of organisations and services to reflect and respond to local needs:

Would benefit from having a city wide approach, but guess it still needs something underneath to allow for local perspective

Some of the smaller organisations highlighted that a one size fits all approach to implementation was not always helpful and some flexibility is needed:

"One of the challenges re the city wide approach is to have a product that can meet all organisations needs and implement it accordingly." They don't feel this is happening with MECC.

Similarly, several interviewees commented that those working in the health setting were using MECC and embedding it into their work far more readily than other non-health sectors. Not surprisingly, those organisations with a specific remit for promoting health are more receptive to MECC.

- Some staff are finding that adding on another conversation about health is difficult – particularly if it's *an alien concept* to them.
- Another manager commented *some staff are realising that having a conversation makes a difference*.

Others were concerned that MECC could increase their workload if the expectations of the organisation were not clarified: *Principle behind MECC is fine – but need to be clear re what we're prepared to do and what we're not in terms of a range of services – some of this should be more about some self help but MECC will be able to do that.*

Although the majority of the six managers interviewed were in favour of MECC, at least one acknowledged that this view was not yet shared by all managers in the organisation and saw this as his responsibility

- *I see it as a marvellous opportunity for us to join in that city wide area approach & think it'll make a real difference to people's lives…some middle managers not connected with it enough & don't understand it – a problem for me rather than for MECC.*

The emphasis on MECC as a Training programme was evident in all responses.

3. Significance of MECC being a large scale change, city wide programme

Although few specifically discussed MECC in terms of Large Scale Change, there was some evidence in their discussions that the concept was at least being adopted and that the value of this approach was recognised at the level of the Service Leads.

The majority believed in its significance as a concept – the ability to strengthen partnerships and the opportunities to have a more uniform approach across the city.

- One felt that from a leadership perspective it was absolutely significant *because the strategic direction of health & social care means we have to develop greater partnerships for commissioning & delivering services.*

- As one Service Lead however commented '*One of the challenges re the city wide approach is to have a product that can meet all organisations needs and implement it accordingly.* The organisation concerned didn't feel this is happening with MECC at the moment.

Despite this, a 'one-size fits all approach' was regarded by most as unrealistic particularly for certain types of organisations. There was also a comment of the importance of keeping a local perspective as well as keeping it city wide.

4. Opportunities and benefits of MECC to the organisations / services concerned

A mixed reaction was given by interviewees:

- Some believing that MECC was providing a real opportunity for their staff with the provision of training, development of more effective systems and procedures, *another tool* that staff can use and the potential of better engagement of staff to patients / clients 'Lots of training on offer'

Some had high expectations of the benefits of MECC:

Organisations benefiting – medium to long term should see a reduction on reliance of secondary care interventions – patients taking responsibilities for their own health

A view shared by other managers:

- *Better effective systems & procedures & better efficiency… redirecting people at the point of contact leading to more self help…*

- *For public Re-education / re-engagement around self help & different avenues where can get information rather than relying on the professionals – re community responsibility.*

Others felt it was too early to see any results and further work was needed to embed the approach: *We're not there yet; it's* not *entrenched enough yet to make a difference.*

Although Partnership working was frequently mentioned as a benefit from MECC, another manager commented '*We already have partnership agreements with organisations across Salford'.* Suggesting duplication of effort.

4. Commitment of senior managers to project

Initial sign up and commitment to MECC was described as strong and although there may have been some initial reservations, as staff started to engage and understand the process there has been support, with some staff *actually enjoying this*.

For some, this high commitment had declined. Although most claimed that their senior managers were committed to MECC*, some senior managers were starting to question and doubt its implementation.*

Staff '*are less enthusiastic now than they were as they feel they are not getting proper responses from the MECC team* re implementation and that *MECC aren't listening.*

Some had clearly invested resources into supporting MECCand were worried about the return on investment in the future:

- *Significant training on top of a lot of other training have to undertake* leading to *practicalities of delivery of training not the outcomes – we've trained over 400 staff so far.*
- *Managers have been committed as far as they've been involved in it up to now – has been bigger picture stuff re where we go with it.*

Service Leads attributed this to several factors, mainly internal communication and commitment and 'organisational fit':

- *…some middle managers are not connected with it enough & don't understand it*.
- Clear reservations were expressed about *fitting it into everything else we're doing,* and that some are *having frustrations as they have struggled working through it.*

5. How does the MECC vision fit with your organisation's vision & how is this fit communicated across the workforce?

The overwhelming majority agreed that the MECC vision fits well into their organisation's vision:

> *Yes, we have a quite comfortable synergy with MECC's vision & ours and what we are trying to do* or *Yes it compliments our approach and gives it a robust health fit.*

Most of the organisations have ways of cascading the information down to staff, although one did suggest that a large section of their staff were still not on board with it yet but that they did have plans to integrate it onto their business plan for this cohort during 2013 / 2014:

> *There are gaps in communication across the workforce – haven't hit manual blue collar workers at all with MECC but as part of business plan 2013/14 in particular* → will ask specific question re MECC – *how we can use it / what are the advantages / SWOT analysis – will be looking at opportunities. Want to take some of the duplication out – whether MECC can do something for us.*

Another manager explained how his organisation was investing in MECC for the long term:

> *MECC is going to be built into the values of the organisation this year & subsequent years via behavioural anchors & goals and objectives - sending a message to staff that this an important component of your role.*

6. Challenges in taking MECC forward

Many challenges were raised re MECC's implementation and how it will / can be taken forward. The main challenges expressed related to internal capacity, internal capability, access to the internet, training, data issues, recording & monitoring, changes and uncertainties.

Internal capacity –*releasing staff from frontline duties – time & costs and concerns that for small organisations it's very difficult re capacity & how to get it started on own*

Internal capability - the fact that some of the services can't see the significance of MECC when it's so very different from what they are currently doing. *It felt overwhelming*. Recognising the big differences between employees and volunteers and what can be expected of both – we *can't force volunteers to do things.*

Access to the internet – concern expressed from 1/3rd of those interviewed – that it's no good having web based training for staff that have no access to the web.

Training – A mixture of feelings about the training element – some were very happy with it, whilst others felt that MECC *felt front loaded with the training and* that the SAT was controversial particularly in terms of passing / failing. Suggestions that – to avoid replication, those organisations that were already doing training could incorporate the MECC training into existing training was raised on more than one occasion.

Data issues / Recording & Monitoring – data discrepancies in terms of reporting and monitoring issues – yet to be clarified - were also raised.

Changes and uncertainties – waiting for what?
That there have been many major changes along the way and it feels *messy.* That initial communication from MECC was weak, that *we are waiting for the next stage*, that we are not sure

what we are meant to be doing after the training,. *What's next? – we need something real to give to our workers* (after the training).

7. General views towards MECC

Mixed reactions were received but the majority were generally positive about MECC, though they recognised the potential difficulties in its implementation, the need for greater flexibility and the recognition that there is still a long way to go:

- *It adds to what we're doing / It's another tool in the toolbox / It's a significant catalyst in our staff appreciation that the acute service is part of the health & social care service and not separate from /* It has been a training opportunity */ Our staff are enjoying this & our staff are telling me that this is ok./ It fits with how the service is going at the moment /* It's an opportunity to take further & integrate into internal systems / *It's not something revolutionary but …*
- *There is a need to recognise that smaller organisations should be able to set their own pace; is frustrating having to implement it in such a specific way.*
- Would like MECC to have a more flexible & understandable approach re how to implement it – rather than *"do it like this"* attitude. *Found it difficult to implement based on the tools that we've been given*.

One organisation expressed concern that initially they were very excited and felt it was an opportunity for change and were pleased that they were an early adopter – but with all the changes and expectations from MECC of organisations *"the momentum is being lost" and now feel "it's just another thing we've got to do"*

- In implementing MECC, it's important to recognise that one size doesn't fit all – particularly in relation to the sizes of the organisations / different approaches needed - *a bit pointless learning from big organisations / some of them are so very different - it felt alien.*

Most of those interviewed admitted that there was still much to be done re getting the message across – *We're finding that many people we come into contact with working in voluntary organisations haven't heard of MECC / I don't believe all staff understand it – senior staff do and staff at a local level who participated in the training do / There's more to be done re getting the message right through my bit of the organisation – a failing on our behalf.*

There was a positive feel about the support leads in providing an overview of what MECC is and giving organisations general support.

Ideas for future of MECC

- *We are a large organisation that has a major training element to our work … "maybe it would be good if MECC could give more ownership to organisations to undertake training in their own way and then be given materials and support to back it up."*

Conclusion from Chief Executive / Heads of Service interviews

The interviews resulted in considerable feedback from organisational leads (Chief Executives) on the experiences to date of the implementation of MECC. Overall, views towards the principle of MECC and the fit between the goals and vision of MECC and the goals of the six organisations represented were very positive. Despite this there was *still much to be done* and the momentum needed to be maintained to ensure continued buy in and longer term success and sustainability. There needs to be additional activity following the training for example 'after-care' service to help maintain implementation of concepts in to everyday practice. Additional work is needed to improve communication within organisations to cascade MECC to a larger proportion of staff and fully embed into organisations. A more flexible approach to MECC training and implementation is critical for some of the smaller and voluntary sector organisations, especially those without sophisticated infrastructure or electronic communication systems (email etc.).

5.e. Case Studies

Part of the Impact/Outcome evaluation originally intended to utilise case studies for the purpose of providing additional and rich data. The Evaluation Partnership (EP) proposed asking a selection of MECC beneficiaries (staff) to write short case studies:

(i) illustrating examples of typical staff-client MECC - focused interaction and
(ii) illustrate examples of the 'client journey' through systems (organisations) using MECC

Staff who volunteered would be given a template to guide completion. Initially it was proposed that staff would provide a minimum of 6 case studies, 3 of both (i) and (ii) over a 9-month period to illustrate how MECC actually might work in practice. However, this longitudinal design was thought to be too burdensome upon individual participants and, through agreement with the MECC Evaluation Commissioning Group (MECG), was altered to a proposed sample of volunteers at 3 points during the evaluation period. A total sample of 6 case studies was planned from service leads / line managers and 9 from front line staff. A simplified template was designed for case study data collection.

Volunteers were requested via email invitation to all staff registered with Salford MECC. Participants were, however, not forthcoming despite a number of reminders, including one copied to line managers. In agreement with the MECG, a new approach was taken, talking directly to service leads and ringing line managers for support. 3 Services took up this opportunity which then resulted in direct telephone conversations with willing participants and templates being sent out to them. Four case studies were returned, but unfortunately they were found to be lacking in suitable monitoring data for evaluation requirements as the content was not directly linked to specific MECC interactions – but rather interactions that were happening already. They also appeared to be returning the same information that was submitted for internal monitoring purposes.[1] Discussions with staff at the time, suggested that frontline workers (staff) involved in MECC were being saturated by MECC requests from line managers and the MECC Delivery Team, which may explain resistance to volunteer and engage on additional work/activity for the evaluation.

It was agreed with the MECG that the internal monitoring data would be shared with the EP; this was received during June 2013, along with a summary report.[2] Upon review of these reports, it was considered that the monitoring data was 1) less comprehensive than that required for evaluation and 2) not delivering the depth of information suitable for illustrative case studies.

The evaluation presented here does not, therefore, incorporate case studies.

[1] At around the same time as these EP evaluation requests were being sent out, the internal monitoring of MECC was requesting a large number of case studies from organisations with CQUINs
[2] MECC Delivery Team (June 2013). MECC Summary Monitoring Report.

5.f. Evaluation for End Users

The evaluation of Salford MECC initially sought to develop indicators from end users to determine some of the specific outcomes of the programme. The outcomes for end users were:

- End user's concerns/issues are discussed and raised sensitively, in a timely and solution focused way
- Increased confidence [by end user] in one to one consultations to discuss multiple issues
- Increased opportunities in receiving behaviour change interventions at a time and location that are more suitable and convenient.
- Increased proactive action planning, advice, information and support received by a range of services
- Improved motivation to change health and wellbeing behaviours due to on-going quality client /professional interactions/ relationships

The process of developing the tools to measure these outcomes went through several iterations with the EP and the MECC Evaluation Commissioning Group (MECG):

1. Initially four options for accessing end users were proposed, with a view that to evaluate MECC accurately, then end users that had experienced an interaction with MECC-compliant staff would need to be distinguished from those that had not
2. It was concluded that none of the options were viable within the evaluation budget and timescales – thus, the end user outcomes were removed from the evaluation requirements
3. Instead, the EP team were asked to demonstrate the value of MECC to end users from the planned case studies by identifying those which show-cased end user benefit
4. Also, a review of questions within the Salford Health and Wellbeing Survey 2012 was planned to identify those which are relevant to MECC; the evaluation would then recommend these and any additional questions which could be used in future surveys to evaluate MECC.

Following subsequent discussions on measuring social return on investment (see Section 6), it was concluded (on 14th Dec 2012) that some attempt should be made by the evaluation to assess what social value health and wellbeing interactions with staff might have on members of the public.

Rationale:
The evaluation of MECC will attempt to identify the **value*** that service users place on having a positive interaction with staff. The volunteers do not need to be known to have experienced MECC compliant staff but will be asked to provide qualitative feedback on the outcome from an interaction with key frontline staff….in which they were encouraged to (i) raise the issue and/or (ii) this led to / were engaged in a conversation (then or at a later date) about their current lifestyle in relation to health and wellbeing and potential for change.

* results from this will also contribute to the EP proposals for the future measurement on Social Return on Investment (SROI)

The process undertaken was:

1. A focus group was arranged via the Clinical Commissioning Group patient and public involvement database of over 2000 contacts to recruit volunteers.
2. An invitation letter, information sheet and consent from were developed and a venue arranged for 20th Feb 2013

3. Only 5 volunteers could be recruited and on the day only 3 of these turned up – This was an unreliable sample; it was felt that the representation was poor and that it was not a reliable group to report back on
4. A second focus group was then arranged for 27th March 2013 and invites sent to targeted user involvement groups
5. Only 2 volunteers were recruited in this way and so the event was cancelled

Following the failure to recruit to the focus groups, a subsequent proposal to use a convenience sample in a public location to undertake an opinion survey was developed. After discussion at the Evaluation Project meeting with the MECG (10th April 2012), it was again concluded that outcome measures from end users were not viable within the evaluation budget and timescales.

5g. Social Return on Investment (SROI)

The original brief for identifying a social return on investment within the evaluation of Salford MECC sought to scope what data might be available and what measures could be applied and then to analyses this data, thus:

Cost Benefit Realisation (CBR) and Social Return
AIM: to evaluate value for money and scope for efficiency savings
Phase 2 scoping - agree outcome measures with stakeholders / client, eg:

- impact on referrals to specialist services
- reduced number of GP consultations
- number of people in work increased
- some measures to demonstrate that MECC is reaching most vulnerable members of the community

Phase 3 analysis

- Analyse data from questions from Salford wide surveys
- Design tools to assess CBR and social return over next 3-5 years, 5-10years - to be incorporated into future Salford wide surveys

Early on during the development phase, it became apparent that data from the Salford Health and Wellbeing Survey would not be available for measuring social return. During the development of the evaluation measures, proposed indicators were developed as:

- Ratio of costs (MECC inputs) to benefits (at workforce and population level)
- Comparison between cost of this intervention and comparable interventions

A SROI workshop was held between the Evaluation Partnership and with the MECC Evaluation Commissioning Group members on 14th Dec 2012 to try to identify datasets and tools that could be used for this evaluation outcome. Several principles were considered at this workshop:

1. SROI is a framework to structure thinking and understanding.[3] **It's a story not a number**. The story should show how you understand the value created, manage it and can prove it.
2. Value the things that matter and use financial proxies for indicators in order to include the values of those excluded from markets in same terms as used in markets
3. An assessment of how much the outcome in question can be attributed to the intervention being evaluated must be considered[4]
4. There are challenges to conducting economic evaluations[5] - particularly for integrated programmes because the interventions can generate very broad costs and benefits that are difficult to measure.
5. Be pragmatic, find a ½ way house!

[3] The SROI Network (2012). www.thesroinetwork.org/what-is-sroi-uk
[4] Nef (2011). Small slices. www.neweconomics.org/publications/small-slices-of-a-bigger-pie
[5] Turning Point (2010). Benefits Realisation: Assessing the evidence for the cost benefit and cost effectiveness of integrated health and social care. www.turning-point.co.uk/media/23642/benefitsrealisation2010.pdf

The discussions concluded that to evaluate social return on investment was not viable within the evaluation budget and timescales because:

1. Financial data could not be obtained from all organisations involved in MECC and using one organisation and a particular tool to assess cost benefit as an exemplar could not be extrapolated to all of MECC due to the wide range in size and activity across different organisations. Whilst there are cost benefits analyses available for specific programmes (eg. Salford health trainers) to collate such detail for MECC as a whole would be too huge an undertaking.
2. It had already been agreed that measuring any end user benefits which can be **attributed** to MECC is not possible – therefore hindering any direct measurement of social return. However, a qualitative understanding of what value end users place on a **positive interaction** with staff was considered to be important to provide a justification for MECC principles.
3. Salford Health and Wellbeing survey data are not available for the evaluation
4. The evaluation in its entirety already represents a benefits-realisation model (see below) and to attempt to create any basic (and potentially inaccurate) costs estimates would not enhance the evaluation.

Therefore, it was concluded with the MECC Evaluation Commissioning Group that the evaluation would:

1. Focus on the original brief and recommend tools to assess CBR and social return in the future, including questions to be included in the health and wellbeing survey
2. Undertake end user focus groups to elicit some views on the value people place on positive interactions with staff
3. Develop the benefits-realisation model as the framework for the evaluation report

5.g.i. Social Return on Investment (SROI) Tools

1. Benefits-realisation Tool[6]

This tool helps to make sure that the actual intended benefits originally planned for your project are achieved. Having a sound benefits realisation plan will increase the delivery of intended benefits and ensure that any resources allocated are being fully utilised. The MECC in Salford project had begun the development of a benefits realisation plan (though hadn't named it as such) in the form of the project Outcomes Framework. The evaluation has built upon this plan by the development of specific indicators to measure the achievement of the programme against all of the identified outcomes. Ideally, this would have been done more iteratively at the outset and the outcomes would have been modified based on the ability to actually measure/monitor success. In reality, the retrospective application of benefits-realisation principles might have produced a more independent evaluation of the achievements of MECC in Salford. The benefits identified against each outcome could, in the future, be developed as a cost benefit to aid measurement of social return on investment.

[6] A benefits-realisation model assesses whether a project actually achieves the intended benefits originally planned www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/benefits_realisation.html

2. Social Return on Investment (SROI) Tool[7]

Conventional cost-benefit analysis does not capture what really matters to people. There are many things which we value, as societies and individuals, which cannot be easily captured in economic terms. Social Return on Investment (SROI) is an analytic tool for measuring and accounting for a much broader concept of value. It incorporates social, environmental and economic costs and benefits into decision making, providing a fuller picture of how value is created or destroyed.

However, in line with the findings of the Demos report of the third sector's ability to measure and communicate the social value[8], there is a gap between the aspirations of the MECC Delivery Team for quantifiable measures of social value, and the ability of participating organisations to measure and capture basic social outcomes. More work is required on identifying social outcomes/value.

3. Values for Money Tools[9]

The national social marketing centre have developed a range of tools for assessing value for money (vfm) for a range of different lifestyle interventions: tobacco control, breastfeeding, obesity, bowel cancer and alcohol. These were specifically developed to calculate vfm for social marketing and behaviour change programmes and require input of costs, outcome data and values concerning the intervention. However, the MECC in Salford programme would need to select the appropriate tool for each participating service and/or adapt the tools to provide a more holistic evaluation across all behaviours.

4. National Accounts of Wellbeing

Social value must take into account a variety of measures which influence individuals' '**personal wellbeing**', for example: experiences of positive and negative emotions, satisfaction, vitality, resilience, self-esteem and sense of positive functioning in the world. The National Accounts of Wellbeing[10] also try to measure '**social wellbeing**' in the form of people's experiences of supportive relationships and sense of trust and belonging with others. However, to obtain data that is comparable to National Accounts would require a large complex dataset.[11] Salford MECC might consider including the measures of subjective wellbeing into future Salford Health and Wellbeing Surveys (see below) to determine social outcomes in terms of wellbeing.

[7] Nef (2009). www.neweconomics.org/projects/social-return-investment
[8] Leighton D, Wood C (2010). Measuring Social Value. ISBN 978 1 906693 48 0. www.demos.co.uk/publications/measuring-social-value
[9] National Social Marketing centre (????). Value for Money Tool. www.thensmc.com/resources/vfm
[10] www.nationalaccountsofwellbeing.org
[11] Office for National Statistics (2013). Measuring what matters. www.ons.gov.uk/well-being

5.h. Monitoring Outcomes for End Users: Lifestyle Survey Questions

The aim of the Health and Wellbeing Survey is to provide information on lifestyle choices for Salford residents in order to determine partnership actions to improve health and wellbeing. The Health and Wellbeing Survey carried out in 2011 used a questionnaire tool developed in Salford in 2006/7 but adapted with the addition of questions regarding preferences for changes to lifestyle.[12] The Evaluation Partnership had originally hoped that these data would be available for incorporation into this evaluation to support the measurement of End User Outcomes (see Section 5.f). In order for the MECC programme to monitor the following 'Outcomes for End Users' in the future, we recommend the continued inclusion of these questions within future Salford Health & Wellbeing surveys:

Outcome: Improved motivation to change health and wellbeing behaviours

Q35 b) Would you like to make changes to your lifestyle around any of these areas?
- Eating
- Being Active
- Drinking alcohol
- Smoking
- Other …specify

Q36 Have you had a go at changing your lifestyle for any of the above in the last 6 months?

Q37 a) Which ones have you had a go at changing?
- Eating
- Being Active
- Drinking alcohol
- Smoking
- Other …specify

b) Have you managed to keep up the change?

Outcome: Increased opportunities in receiving behaviour change interventions

Q39 Has anyone talked to you about any of the lifestyle areas mentioned in Q35-Q37 in the last year?

Q40 Who did you talk to?
- Friends & Family
- Council Worker
- Health Care professional
- Volunteer
- Community worker
- Other …specify

Q42 How would you **prefer** to make lifestyle changes?
- By myself
- With support

[12] Salford Council (Sept 2012). Salford Health and Wellbeing Survey 2011: Supplementary Report with recommendations. www.salford.gov.uk/needsassessments.htm

Outcome: Increased proactive action planning, advice, information and support received by a range of services

Q41 If you want to make lifestyle changes which, if any, of the following places would you go to for support?

GP
F&F
Internet, books, magazine
Leisure centre / gym
Health improvement service
Other …specify

In order for the MECC programme to compare social outcomes to national accounts, we recommend the inclusion of subjective wellbeing questions within future Salford Health & Wellbeing surveys:

SUBJECTIVE WELLBEING[13]

Next I would like to ask you four questions about your feelings on aspects of your life. There are no right or wrong answers. For each of these questions I'd like you to give an answer on a scale of nought to 10, where nought is 'not at all' and 10 is 'completely'.

Overall, how satisfied are you with your life nowadays?
Instruction: where nought is 'not at all satisfied' and 10 is 'completely satisfied'

Overall, to what extent do you feel that the things you do in your life are worthwhile?
Instruction: where nought is 'not at all worthwhile' and 10 is 'completely worthwhile'

Overall, how happy did you feel yesterday?
Instruction: where nought is 'not at all happy' and 10 is 'completely happy'

On a scale where nought is 'not at all anxious' and 10 is 'completely anxious', overall, how anxious did you feel yesterday?

[13] Office for National Statistics (2012). Integrated Household Survey User Guide – Volume 2: 2012 Questionnaire. www.statistics.gov.uk

6. Conclusions & Recommendations

Overall Conclusions

1. Work in progress

- As a systems-wide approach, MECC is only partially embedded at present
- Large numbers of staff have been assessed and/or trained via the programme; around 1,500 staff in 26 organisations in Salford have the knowledge and skills to deliver MECC
- However, the initial 'push' during 2012 has not been sustained during 2013
- There is variable engagement and uptake by different organisations, with some organisations more involved in design and implementation than others
- There has been slow inclusion of MECC into appraisal, induction and core training
- Training does not take account of non-core staff e.g. volunteers
- There is not a clear enough distinction between different staff groups (Level 1, Level 2, volunteers) in the added value of MECC or usefulness of specific training:
    - Some frontline staff (e.g. Level 2) are already equipped to confidently deliver effective behaviour change interventions to the Salford population (but they do not attribute this to MECC – see 2. below)
    - On the other hand, Level 1 staff are more likely to benefit from MECC training resulting in increased knowledge and confidence to deliver signposting interventions
- The complexity of Version 1 of the assessment (SAT) and subsequent modifications to Version 2 made it very difficult to determine the actual numbers going through the system
- The SAT may not be a reliable tool for assessing competencies
- The delivery of MECC training does not take into account the varying structures and processes in organisations and how existing training is delivered.

2. Value

- MECC does not stand out from other initiatives, or have a clearly defined 'unique selling point', so that the value for staff and benefits to the Salford population cannot be understood
- The aim should be to assimilate MECC into everyday practice so that it becomes part of core values
- Accreditation for those who have successfully completed SAT or training might help to add value
- Front line workers (FLW) appreciate how health and wellbeing are part of their organisations' core business and central to their individual role and appeared more willing to be involved in MECC than managers
- MECC has a strong resonance with what staff are already doing: they recognise the skills and knowledge necessary to undertake this kind of work and already feel confident in raising issues with the public
- Managers and Service Leads seemed more cynical about MECC, were less engaged and less optimistic about the challenges of roll-out or how long MECC would be operating in the future
- However, the value of MECC also varied widely between staff groups:
    - Those already using the principles of MECC in their everyday work were more negative and stated that there was little or no evidence of change in practice due to the programme
    - Level 1 FLW showed a greater change due to the MECC process/training than Level 2 FLW.

3. Tools and support

- In order to embed MECC, there is a need to provide guidance, support and examples of tools
- To sustain engagement, support should be resourced with designated staff who already have established relationships with the organisations
- Signposting information and a directory of services /pathways were seen as the tools most likely to help FLW implement MECC, although self-reported knowledge of signposting and referral information was generally high and did appear to benefit from the training

- Communication is key but currently variable – it cannot rely solely on IT or assumptions that cascading will happen.

4. Leadership

- Although some senior leaders are committed and engaged, however, this has not been transmitted through all levels of the organisations
- Managers believe that there may not be the commitment to sustain MECC in the future
- Strong and continuous leadership is required both from a delivery team and from managers within each organisation
- A prescriptive approach to sustainability is unlikely to succeed.

5. Monitoring of MECC

- There is evidence that inclusion of MECC in contracts has not acted as a stimulator and could be counterproductive, due to emphasis on recording data for what should be a relatively routine activity
- Systems for monitoring MECC are not systematic or consistent but they are in practice in some places
- Organisations that were subject to a CQUIN had formal monitoring systems in place but those not subject to CQUIN were doing some form of monitoring, even though not a formal requirement
- Without monitoring data, it is difficult to draw any conclusions in relation to increased number of behaviour change interventions and the majority of staff interviewed or surveyed stated no change in working practice or the interventions they delivered
- FLW were not aware of methods to embed monitoring requirements in their organisation's contracts
- Overall the majority of interviewees felt that collaborative working had stayed the same and it is difficult to develop measures of collaborative working without detailed systems to record referrals
- FLW completing the survey suggested that the referrals pathways and appropriate referral had not altered since MECC .

6. Social Value

- Evaluating social return on investment was not viable within the evaluation budget and timescales
- However, a benefits-realisation model has been used to summarise this evaluation as a whole
- Future Salford Health and Wellbeing Surveys could provide useful measures of the social value of wellbeing and motivations for behaviour change.

Recommendations

The lessons learned from the MECC in Salford evaluation (see Table i.1) can be grouped into four overarching recommendations:

1. **Tailored Delivery**: the continuation of MECC in Salford should build upon the findings that staff currently work at varying levels with regard to behaviour change interventions and that '*one size does not fit all*'. We suggest that the programme:

- Develops a clear definition of a MECC intervention and its benefits based on underlying theory, to help prevent the criticisms by staff taking part in the assessment and training
- Defines what MECC is over and above current job roles ie. understand current behaviours, structures, and theory
- Removes assessment and competencies in terms of 'pass' or 'fail'
- Targets training differently for Level 1 and Level 2 staff; by :
    - focusing training to those who do not necessarily provide interventions at the moment (e.g. opportunistic workers - Level 0/1)
    - consider that Level 0 (Level 1 introductory) showed the greatest benefit from MECC training and targeting these staff may well create the greatest added value (also see 3 below)

- understand that Level 2 staff are *'doing it already'* and link MECC principles into normal training and/or staff development.

2. **Staff Inclusion and Support**: to maintain momentum and enthusiasm for an ambitious city wide project and ensure that MECC is embedded into working practice, staff require buy-in, involvement and support. We recommend that:

- There is regular review, reflection and response to issues identified by stakeholders and that communication / feed-back is geared towards the needs of the individual organisations
- Stakeholders are more involved in the design of the programme now and in the future, especially around the measures needed to enhance collaborative working
- More information is shared about what being *'MECC competent'* means with regard to intervention activity – this is linked to a clear definition of what a MECC intervention is (above)
- Up-to-date and accessible service directory and referral / signposting manuals are developed and maintained.

3. **Added Value / Value Added**: for MECC to achieve its overall aims and objectives, both organisations and staff need to see the added value of continuing to deliver appropriate MECC interventions. The programme as a whole needs to demonstrate what value is achieved through its implementation. Thus:

- The MECC programme may not have been designed to achieve outcomes that were created:
    - Achievable measures (both process and outcome) of success are required at the outset, not aspirational high-level (and un-measurable) outcomes
    - Once developed, specific outcomes relating to the SAT and training should be built into the databases at the development stage
- To better value the programme, staff need to be able to differentiate between a MECC intervention and current practice (relates to 1.)
- Effective and appropriate monitoring system for all participating organisations are required with regular feed-back to the Health and Wellbeing Board
    - Perhaps with a small number of core measures that are sympathetic to each organisation
- There is a need to establish measures by which the value to the Salford population can be assessed
    - A dedicated cost-effectiveness / social return on investment analysis of MECC should be undertaken by an experienced health economist
    - There is some evidence that the MECC programme achieved greatest impact on Level 0 staff, which may be shown to be the most cost-effective way to proceed.

4. **The Future and Sustainability**: the complexity of a city-wide MECC means that considerable resource will be required to sustain its momentum, monitor its implementation and assess the long-term, and specifically the social impact. As well as the above recommendations, MECC in Salford will require:

- Senior leads in each organisation being held to account to the Health and Wellbeing Board for commitments to build MECC targets into health outcome frameworks:
    - Simply signing up to MECC does not necessarily result in actually embedding into practice
    - Realistic expectations for each organisation must be developed and supported
- For more appropriate referrals to be demonstrated, the development of monitoring systems should draw upon the experience of other projects where referrals have been monitored
- Any further re-development of the SAT database should be directly and seamlessly linked into the training databases, so that the process can be streamlined.

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