WESSEX MAKING EVERY CONTACT COUNT (MECC) PILOT

EXECUTIVE SUMMARY

Introduction

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

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

Recruitment

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

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

The Intervention

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

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

- Organisational Readiness: Support senior buy-in and board level sign-up to MECC in order to ensure strong leadership
- Staff Readiness: Support managers and service leads to champion and implement MECC by providing them with a development programme which will enable them to understand MECC, their role in implementation and support their staff to deliver MECC

- Training: The delivery of training to frontline staff who will be equipped to help individuals to explore issues and identify solutions and plan for change, give brief advice and signpost to other services where necessary.

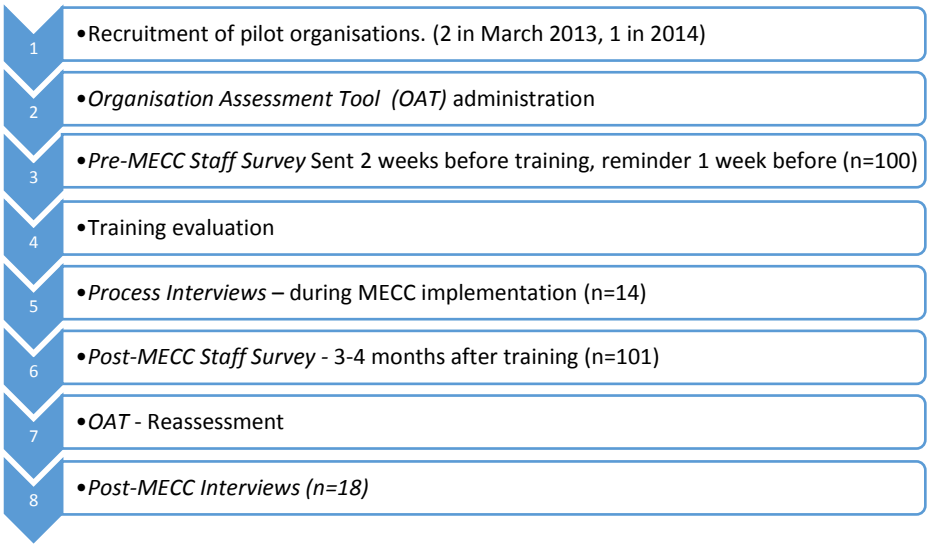
The evaluation was designed to assess a practical approach that was feasible within limited resources, and transferable between different implementation contexts. The aim of the evaluation was to inform the development of local guidance - a toolkit, to learn from a number of different sites how to implement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

Healthy Conversation Skills (HCS) training

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

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

Key evaluation phases



Key Findings

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

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

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

Themes that emerged from the qualitative evaluation interviews included:

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

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

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

Organisational assessment

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

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

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

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

Recording and referral systems

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

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

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

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

Staff views on the introduction and implementing of MECC

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

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

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

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

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

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

Recommendations

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

Organisational readiness

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

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

Management and sustainability

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

Referrals and recording

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

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

Training

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

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

Evaluation and further research

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

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

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