**Reviewing the Implementation Guide and Toolkit for**

# Making Every Contact Count: Using Every Opportunity to Achieve Health and Wellbeing

**Report of the Review**

## Introduction

In November 2012, the East Midlands Health Trainer Hub commissioned a brief, independent review of the Making Every Contact Count (MECC) Implementation Guide and Toolkit that they had developed and which had been adopted by the Midlands and East SHA Cluster. The purpose of the review was to ensure the toolkit and its resources are left as fit for purpose as possible when the Hub closes in March 2013.

The review took the following form:

1. An invitation to a workshop that was aimed at all staff in commissioning and provider organisations that have being using any element of the implementation guide and toolkit and/or its accompanying resources
2. A pre-workshop survey to find out how people had used the Implementation Guide and Toolkit and to help in the design of the workshop
3. A workshop facilitated by the independent consultant commissioned to undertake the review
4. The production of this short report setting out the information gained from the different sources and to be used as the legacy document to accompany the Implementation Guide and Toolkit once the Hub has closed.

## Aims of the review

The review had the following aims:

1. Is the approach used in the Implementation Guide and Toolkit (ie its core components) helpful and how are organisations ensuring these are implemented with or without the use of the additional resources?
2. What amendments, if any, would individuals like to see made to the actual toolkit?
3. Which of the resources have been used, whether or not they have been helpful and why, how have the resources been used, and how have they been adapted?
4. How are organisations measuring the success of implementation – what does success look like and how will they know when it's been achieved?

## Pre-workshop survey

The pre-workshop survey was issued to 47 individuals who had expressed an interest in attending the workshop. The survey can be found in Appendix 1 to this report. 35 individuals responded to the survey, including two who submitted a joint response. 19 individuals submitted their responses online and the remainder completed a paper form.

Respondents reported using the MECC Implementation Guide and Toolkit across the range of:

- Developing commissioning – 6 responses

- Developing local provision – 19 responses
- Developing &/or delivering training – 21 responses
- Raising awareness of / informing people about MECC – 31 responses
- As a means of evaluating what they were already doing on MECC – 14 responses
- Other (including as an aid to developing an operational strategy, and as part of an induction process for a MECC lead) – 2 responses.

Respondents reported that they were at different stages of implementing MECC with the majority stating they were in the implementation phase (26 responses), while others were still in the process of gaining organisational support (5) or planning how to implement (15), while a few noted that they were in the process of evaluating their effectiveness (8).

Respondents reported that they had been seeking to gain the involvement of a wide range of staff groups in delivering MECC: Professional staff in an NHS organisation – 17 responses; all staff in an NHS organisation – 26 responses; staff within primary care providers such as GPs – 6 responses; staff groups within local authorities – 11 responses; and staff within private and voluntary sector providers – 4 responses. In addition one person reported seeking to gain the involvement of patients in delivering MECC whilst another referred to a range of staff groups within an acute trust.

The vast majority of respondents reported the Implementation Guide and Toolkit to be helpful with 18 respondents stating that it was very helpful and 15 quite helpful. Only two people stated that they did not find the Guide and Toolkit helpful or unhelpful. No respondent stated that the Guide and Toolkit was not much help or no help at all.

Respondents were asked if they had used the Guide and Toolkit and if so, which resources they had used. All of the different resources had been used by someone with the lowest report being two people using the Information on self-care and two using the 'how to access further support' section. The most popular parts of the Guide and Toolkit in terms of use were as follows:

- the Implementation Guide itself (32 responses)
- the Communications toolkit (24)
- the Implementation Checklist (22)
- the Making the Case presentation (18), and
- the Prompt cards and health benefit cards (18).

Interestingly when comparing the answers to the two previous questions, the two respondents who reported the guide and toolkit to be neither helpful nor unhelpful had only used one or two of the resources in total, whereas those who reported the Guide and Toolkit to be very or quite helpful had used an average of eight resources from the toolkit. This suggests that the more resources that are used the more helpful the Guide and Toolkit are perceived to be.

13 respondents reported using other resources to assist with implementation. These were mainly locally produced information, such as local health profiles, local information related to CQUINs and other health performance management targets, local service information and local training packages. The small number of recommendations for improving the Guide and Toolkit that were received in the survey has been included in the outcomes of the workshop session.

**Workshop to review the MECC implementation guide and toolkit**

The workshop to review the MECC implementation guide and toolkit was held in Nottingham on 8 January 2013. 33 people attended from organisations across the length and breadth of the Midlands and East SHA Cluster. The workshop was designed to gain information for the review as well as enable the participants to learn from colleagues in other organisations about implementing MECC – the agenda for the day is given in Appendix 2. The layout of the workshop was cabaret style and participants worked in different sizes and mixes of groups throughout the day. Use was made of post-it notes to record individual and group ideas as well as flip chart sheets to allow detailed recording of groups' and individuals' thoughts.

The outcomes of the workshop below are set out in themes based on the workshop tasks during the day.

**What works well in the MECC implementation guide and toolkit**

Participants were asked to identify the aspects of the MECC implementation guide and toolkit that they would recommend to other people and the reasons for this. A large number of the different resources were identified. The most common are identified in the table below along with some of the reasons that participants identified them as being of use.

| Resource | Why recommended – quotes from participants |
|---|---|
| 1. The Implementation Guide itself | *"Staff focus. Emphasises workplace and staff wellbeing not just patients."*<br>*"Having clarity within the toolkit of what MECC was and was not"*<br>*"Useful signposting to resources / additional info"* |
| 2. Implementation checklist | *"It flowed as a pathway with clear and defined directions of travel."*<br>*"Ensures senior level directors and public health are on board."*<br>*"A useful exemplar that could be adapted / adopted for universities."*<br>*"The implementation approach as it breaks MECC down into components to ensure embedded throughout trust."*<br>*"Implementation plan as a format for the Trust plan – gives a useful structure and reporting framework."*<br>*"The breakdown of the implementation process was very helpful in creating a project plan for delivery."* |
| 3. Communications toolkit | *"It provides a good structure for communications"*<br>*"The press releases, staff announcements, case studies, posters and lanyards etc"* |
| 4. Examples from practice | *"It is always helpful to hear about how people have implemented MECC and also to not reinvent the wheel."* |

| Resource | Why recommended – quotes from participants |
|---|---|
| 5. Links to policy drivers and initiatives | *"Overview of the evidence – helps understand why we are doing it and how we can make a difference."* |
| 6. Making the Case presentation | *"The Powerpoint slides very good for providing an overview."*<br>*"Organisational environment info, gave a basis for the initial engagement at board level."*<br>*"Useful resource to use to sell the message and agenda."* |
| 7. Organisational assessment tool | *"Assessment tool (process). As a starting point to use an assessment of where we are – helps to recognise that some of the work already happening supports the initiative."*<br>*"Focus on strong and weak (points for development)."* |
| 8. Training resources | *"They give structure and guidance."*<br>*"Training – well structured, consistent message."* |
| 9. Prompt cards and health benefit cards | *"Useful when facilitating sessions with staff'*<br>*"Benefits from MECC form a basis for training and to encourage staff to complete."*<br>*"Prompts for staff and patients – keep in everyone's minds."* |

A number of respondents also stated that the whole way in which the implementation guide and toolkit had been put together was of great use (ie the range of resources available that could be drawn from for a range of different purposes), signalling that they found it difficult to separate specific parts from the whole. This was because:

> *"The whole way the implementation guide and toolkit has been put together – means you move forward quickly ie it is there as a guide and able to adapt from it as you will."*
>
> *"Flexibility – the framework allows you / the organisation to choose parts of the toolkit without a rigid step by step approach."*
>
> *"Practically focussed: focussed on service delivery and people"*
>
> *"Additional resources are helpful to save time and clarify what can be done".*

This theme that the implementation guide and toolkit was a resource to be used, parts selected and adaptations made came from a number of participants such as in the statement:

> *"Adapting it as a resource rather than using it as a manual."*

In addition, participants commented on the value of:

1. the MECC e-learning module developed by the West Midlands SHA – as, for example, '*it gives a good overview of what MECC is and so everyone has a similar understanding of MECC*'.

2. the 'freebies' (eg pens with scroll out information, key ring cards) were noted as a useful starting point and introduction.

**Overcoming difficulties / issues**

Participants were asked to think about what they had struggled with when they first found out about, or started using, the toolkit and how they overcame the issues. As might be expected from such a question, some of the responses related to the implementation guide and toolkit itself whereas others related to the context in which the work was undertaken. As the purpose of the day was to review the implementation guide and toolkit, more time was spent focusing on any issues experienced in its use although it was acknowledged that the context of implementation was not always as facilitative as it might have been. As one participant noted in their feedback: "*the toolkit is useful but there are issues with the context in which it is being used*".

The ways in which people reported overcoming the difficulties serve as useful pointers for people who are coming to the implementation guide and toolkit for the first time.

| **Struggled with** | **Overcame by:** |
|---|---|
| Found the toolkit itself rather challenging as it seemed very ambitious or designed for perfection. | Basic familiarisation with toolkit<br>Sifting through the resources to identify audience specific information<br>Remembering the toolkit was a framework to be used and adapted not something that had to be used exactly as produced |
| The communications toolkits going directly to communication leads at provider organisations so difficult to organise and coordinate roll out | |
| Communicating the message | Sifting through the messages for the different staff groups, mainly by trial and error but then adapting for audience (ie deciding which staff particular messages were appropriate to)<br>Adapting and rewriting communications for different audiences |
| Getting staff buy in | MECC was a new terminology but nothing new and not a real add-on to jobs. Opportunistic and Quit Chat training has been happening for years<br>We simplified the process so staff could do as simply as possible what was needed eg we developed a one-stop-shop referral card.<br>Acute trusts where staff may see the patient for one specific contact - adapt the resources appropriate for staff so that the staff do not have to look for information. |

| Struggled with | Overcame by: |
| --- | --- |
| | Linking it to Agenda for Change and the appraisal process |
| Organisational readiness tool as difficult to obtain information from our organisations! | Discussing and attending meetings to tackle |
| MECC was sold to the community with a link to CQUIN, which meant that money / providing evidence for targets was then seen as the driver rather than focusing on MECC principles | Developing ownership in the organisation itself rather than seeing it as imposed by embedding into everyday business principles of good practice (eg into induction, mandatory training) so that it becomes an organisational focus.<br>Changing the measures for implementation and making them more realistic.<br>Adapting for local use, using identified teams as a type of pilot. |
| Having MECC as part of an SHA ambition | Fed back to SHA on the metrics and my thoughts about them – went back to local initiatives<br>Setting out a strong message that MECC needs to be delivered over a reasonable timescale and embedded within the organisation as core business rather than being seen as a short term ambition or initiative<br>Developing a real dialogue between commissioners and providers which in turn lead to better, effective measures for evaluating progress |
| Difficulty in making referrals and getting data back | The e-referral tool has been used successfully in some areas.<br>Joining up those to whom the referrals are going.<br>Colour coding business cards to assist with referrals<br>Piloting tools to help people self-refer (eg bar codes on posters that can be scanned by mobiles).<br>Putting pathways in place – simplified referral process |
| e-learning package – some problems using the off-the-shelf package because of the level of detail. | Combining e-learning with face-to-face training (ie blended learning) so that the initial face-to-face supports the later e-learning.<br>Recognise that for some staff it is a very useful resource ie work out who it is helpful for.<br>Maybe develop a condensed version for those staff who do not need the full details eg some staff working in the acute sector |

| Struggled with | Overcame by: |
|---|---|
| Release of staff for training | Provided training during team meetings – go to the staff and adapt training – simplify the training resources |

**Using the MECC implementation guide and toolkit for specific purposes**

During the third session of the workshop, participants looked at the use of the implementation guide and toolkit for different purposes. The session had two broad aims. Firstly for us to understand whether the implementation guide and toolkit served some purposes better than others, and secondly, so that participants could learn from others to inform their own practice.

This was done through participants self-selecting the themes they wished to focus on covering:

- developing commissioning
- developing local provision
- developing and / or delivering training
- raising awareness of / informing people about MECC, and
- evaluating progress and outcomes of MECC.

During this session, participants were asked how they had used the MECC implementation guide and toolkit to help them achieve these different purposes, what else they did to make MECC work and how success was recognised and captured. The learning for the different themes is summarised below.

***Developing commissioning***

The group who focused on developing commissioning summed up the general messages from their discussions as the need to:

1. build relationships between providers and commissioners
2. tailor implementation to meet the particular context or situation.

Participants noted that they had used the action plans within the toolkit as a framework to guide what they did and make appropriate links.

Building relationships included a number of different actions including:

- setting up conversations
- talking & listening
- having conversations as part of the Health and Wellbeing Board and the Joint Strategic Needs Assessment (JSNA).

Tailoring implementation included such activities as:

- keeping a local focus
- focussing on what works in the particular setting
- taking a staged approach to implementation
- freeing providers up to deliver differently

- developing appropriate measures of success for local areas – maybe be linked to CQUINs but not necessarily so.

The group identified the following ways of recognising success in commissioning:

- organisations recognising MECC as real and meeting the organisation's desired outcomes and what it is seeking to achieve (eg with its staff). This might include evidencing:
    - availability of info – posters, leaflets, cards etc
    - workshops, seminars etc with recording the percentage of staff trained
    - having the conversation about lifestyle / brief advice with staff and /or patients
    - recording long term percentage of people smoking and reductions in this, the percentage of people overweight/obese etc
    - prevalence of long-term conditions such as diabetes
    - staff/patient survey outcomes
- developing realistic measures for the local situation that could be developed over time into aspects such as prevalence rates
- developing a real dialogue between commissioners and providers to develop better, more effective measures for evaluating progress.

In the longer term of say 5 years or more, success factors would be having outcomes data showing, for example, reduced prevalence of smoking, reduced obesity.

***Developing local provision***

The group that worked on developing local provision recommended that use was made of the implementation guide and toolkit to get people signed-up and engaged and through this develop ownership of MECC. It was noted that it was difficult to measure success when there is a diversity of service provision and having some form of one-stop shop for lifestyle advice facilitates measurement as does consistency in training. However by using other already available data and including MECC in annual reports , it is possible to show what has been achieved on a local level early on in the process.

The organisations that were represented on the group reported different approaches to developing local provision reflecting the organisation's strengths and areas of development. For example:

- A community trust, having employed a project manager, had used the toolkit to raise awareness of MECC in the Board and for training staff. In order to capture information, they had added new fields to their data system to capture prevention and signposting. They also reported that personal health budgets were a marketable area. For them success was seen as an increase in referrals, mainstreaming prevention and reducing crisis/hospital admissions.
- A PCT reported setting up a MECC Forum and gaining funding for the development from an Education and Training Council. The focus of their MECC provision had been both within and outwith the NHS (including the local authority and fire service) through appropriate targeting of the resources in the implementation guide and toolkit. They reported success as developing a county-wide vision with an agreed plan for moving forward, including involvement of the emerging Local Education and Training Board (LETB).
- Another organisation had focused their development on social marketing, including online and social media resources, using this as a means of enabling patients to make choices

directly rather than only delivering through staff. This enabled the organisation to join up internal messages / services and drive traffic to its own provision keeping referred services within the organisation.

- A fourth organisation acknowledged the support that the toolkit had provided in implementing a MECC training programme and assessing the ability of staff to deliver MECC. This revealed that MECC was not that different from what was already happening and this provided the incentive for empowering staff to deliver appropriate interventions with some additional development. Progress was reported to the Board aligned to CQUINs for midwifery, obesity, smoking and alcohol, and a link was also made to the organisation's salary and development group. Success has been measured to date on the number of frontline staff trained, after which the focus will be the number of members of staff giving advice.
- An acute hospital was using their WHO health promoting champion, who is on a three year funded contract, as the clinical champion for MECC focusing on children and their families. They gained executive support and succeeded in getting MECC as an agenda item on the trust's AGM. As there has been a focus on staff within the implementation plan, this has led to an increase in staff seeking personal support as well as for their family and friends. One measure of success has been an increase in demand, time and spectrum of referrals.

***Developing and / or delivering training***

The group who were focusing on developing and / or delivering training gave a general message that it was best to modify the toolkit to meet one's own local needs. They noted that developing training and delivering training were quite different things and did not necessarily involve the same people. For example, it was possible to deliver bespoke face-to-face training in bite-size amounts drawing on different parts of the toolkit through having a clear focus on the individuals', who were receiving the training, role in MECC.

Different models of delivering training had been used, such as starting with senior leadership and then cascading down to learning disabilities services, community services, family services and mental health. A stop smoking specialist had used CQUIN money to run MECC training within team meetings. There were also reports about developing and delivering training to new roles and organisations, such as Clinical Commissioning Groups.

It was noted that specific consideration needed to be given to the training needs of different groups, particularly those who struggle with understanding their role in MECC such as healthcare assistants, and that training and development can be supported by other organisational developments, such as linking referral routes to training and having one card with a telephone number that links into a central hub.

Some organisations had started to develop an ongoing programme of training for staff including refresher training a year or more after the initial training on MECC.

There was also a call for training and development across organisations in the broad region, such as developing a network for MECC, so that cross-organisational learning (as was happening during the workshop) could be facilitated.

Training had also been supported by wider workforce solutions, such as working with Human Resource Departments to build MECC into job descriptions and linking to the occupational health service. The sustainability of training had been taken forward through embedding developments on MECC across the organisation, in areas such as induction and mandatory training

There was a range of different measures of success identified for training including:

- changes in staff health and lifestyle
- increased referrals to services within and outwith the organisations (including occupational health)
- staff measures, such as sickness and absence rates
- staff surveys.

***Raising awareness of / informing people about MECC***

The general messages from the group focusing on raising awareness of MECC / informing people about MECC were the need to work in partnership with all other organisations in a combined approach as well as seeking to change the culture through using tools such as social media.

The organisations that were represented on the group reported different approaches to raising awareness as illustrated below.

- An acute hospital trust spread across three sites had a target of increasing MECC in anaesthetics to 95%. Using the implementation toolkit to present MECC, they had a number of 1-1 discussions to tell people about MECC, developed a single point of access for referrals using specially developed referral cards, recorded contacts quarterly and worked closely with mental health teams and public health. Their next stage is to work more widely with health and social care and to continue to develop their MECC champions in the organisation.
- Another acute hospital experienced difficulties in gaining clinical engagement with MECC, due to the acute sector tending to focus on immediate pressures and performance targets rather than longer-term ones. The MECC lead used the toolkit as a means of informing the Board about MECC and built on the good local smoking cessation service. They also developed over time good partnerships with a range of different departments across the hospital, and through this has managed to develop and maintain commitment for both staff' and patients' health. This has included engaging with occupational health initiatives for out of hours staff exercise classes and working with the Human Resource department on their staff health initiatives. In hindsight, the lead thinks that it would have been better to start MECC with staff instead of patients, and to have developed partnerships with service and workforce teams.
- A Community Health Services, which was without a MECC lead initially, now report that they would have focused more on communicating MECC and raising awareness at the start of the process through making more use of the toolkit. However achievements have included training 450 staff on MECC and holding a public launch for the whole health economy. As there was no single point of access for services, they have also developed a single resource for staff.

There was a range of different measures of success suggested for raising awareness, including:

- developing different measures for different areas based on the local population, expectations of achievement and the resources that are available for services
- using tools to facilitate measurement, such as business cards that vary depending on the service (ie colour / symbol coding) and that can be tracked back or used to coordinate across services
- reporting on activity in the early stages, such as reports, consideration by the Board, and number of teams that have received information.

It was suggested that, in the longer term, greater success might be achieved through focusing on children and working upwards rather than focusing efforts only on adults.

The group also agreed that it was useful to work with partners and learn from the experiences of those further ahead in implementing MECC and by being flexible and adaptable in what is done. The feedback from participants at the workshop revealed that awareness of how best to implement MECC develops over time as individuals and organisations try things themselves and use opportunities from others' learning, and the importance of this for maintaining and rejuvenating practice.

***Evaluating progress and outcomes of MECC***

The broad message that emerged from the group who focused on evaluating progress and outcomes of MECC was to focus attention on actions not just numbers, because a focus on the latter misses what is happening on the ground and the developments that are actually taking place in a wide range of diverse areas, such as the fire service.

The organisations represented on the group reported a range of ways that they had been using the implementation guide and toolkit to evaluate progress and outcomes of MECC, or developed other ways of doing so. These included:

- using CQUIN as the starting point and relating evaluation and outcomes to it. This has included rewriting pre-operative assessments to reflect MECC, which in turn means that it becomes part of everyday working life for the practitioners and the patients they see.
- within a healthy lifestyles service, using targets for the number of staff trained, evaluating that training and then focusing on evaluating the referrals into the services.
- another service has tended not to use the term 'MECC' but has focused on the health interventions that need to happen, such as doctors asking questions about smoking and drinking. Using specialist alcohol trainers they have achieved their target on the number of staff trained and now have areas requesting training. They have also started to train security staff in the hospital.
- an A&E service has focused on embedding two CQUINS on smoking and alcohol into the assessment of patients through building this into the assessment records using a tick-box approach so that it becomes embedded into the culture of what the department does.
- another area has used two health promoting champions to record individuals' BMI linked to *Essence of Care* benchmarking and a national audit on health promotion.
- one service that was already working on a health promoting workforce project prior to the publication of the implementation guide and toolkit, has used baseline questionnaires with staff, which they developed with the research and development team. They are planning a second follow-up questionnaire in a longitudinal study to determine the changes that have been made. This has also prompted a number of individuals to offer themselves as champions.
- another organisation noted that its focus was on reporting activities via spreadsheets and the items had included: newsletter communications, use of the e-learning module, MECC being incorporated into job descriptions and the difference that is being made to health and wellbeing.

Building on from the general message that there is a need to focus on undertaking activities prior to being able to report outcomes, and hence having confidence to send back nil returns (with regard to

SHA Metrics) if development is still in progress, the following initial success measures were identified:

- evidence of staff involvement followed by capturing the wider impact on the staff member's family (whilst recognising this is not easy to capture)
- focusing on qualitative evidence rather than numbers and direct benefits to the organisation as well as to the individual
- measuring staff confidence, such as through staff group plans and their plans for patients
- using broader assessment forms to assess lifestyle issues
- linking MECC into other measures such as CQUINs, Essence of Care benchmarks and health promotion benchmarks
- counting the numbers of referrals to services, such as smoking cessation and alcohol services.

In the longer term, the aim would be to embed personalised tailored support to make positive changes for health across the organisation using a 5-10 year plan, such as for individuals who use mental health services.

**The relevance of the MECC implementation guide and toolkit to improve people's health and wellbeing through 'personal tailored support in making positive change' in the future**

Participants were also asked to consider the relevance of the MECC implementation guide in the future given that its principles focused on providing personal tailored support in making positive change. They were asked to think about what the future held for improving people's health and wellbeing and then consider whether the implementation guide and toolkit supported this future, and if not, how it would need to change.

As might be expected there were a range of views on the future from the optimistic to the pessimistic, focusing on MECC specifically or thinking about health and wellbeing more broadly, and from detailed considerations of technological advances (such as IT and social media) to more general approaches (such as moving health services out of NHS buildings and organisations into community organisations and settings, and actions such as peer support and local health champions). Discussions also covered topics such as the benefits and disadvantages of having NHS branding, fragmentation versus coordination of services, and a focus on self-care with reduced resources.

There was concern about widening inequalities, the balance there would be between incentivising people to improve their health or penalising them because of their lifestyle, and the extent to which it would be possible to influence Clinical Commissioning Groups to a health improvement agenda and to commission healthy lifestyle services.

Emphasis was placed on the need to:

- take a broad view of health and wellbeing (both mental and physical health as well as happiness)
- educate and develop children and young people in life skills and areas, such as physical activity
- focus on families and make health improvement inter-generational
- involve staff in improving their own health
- mainstream the approach within organisations and workforce development

- embed MECC in pre-registration education of healthcare and other professionals
- continue to work in partnership with a range of other organisations that can influence health
- take a whole system approach as well as national, local and individual action, and
- develop social policy to actively support individuals make healthier choices and to reduce inequalities, as more equal societies have better health and wellbeing outcomes.

The group were positive about the continued use of the MECC implementation guide and toolkit as providing a portfolio of resources for future use. It was felt that any useful resource, which this had proved to be, should not be thrown out but kept, used and embedded. It was noted that if this did not happen then it would be de-motivating for people. However it was noted that there was a risk that with the MECC label, the guide and toolkit would be seen as just another initiative rather than a range of resources that could be used for enabling personal tailored support in making positive change whatever title this is given in the future. The guide and toolkit had particular benefits in embedding health promotion in the culture of an organisation and there would be benefit from some form of central, regular updating of the resources.

The question was raised as to whether the implementation guide and toolkit were sufficiently well publicised and available as an online resource to all other sectors (such as ambulance services, and the voluntary and community sector) and other areas of the country (for example, through a link on NHS Choices). Individuals would also like to see continued regional support through activities such as: case studies so that learning could be shared, train the trainer sessions, peer support for MECC leads and the further development of training materials targeted towards non-healthcare professionals.

**Conclusions and recommendations**

The feedback received during this process of review, both within the pre-survey report and during the workshop, has shown that the MECC implementation guide and toolkit has proved to be a helpful resource for anyone with the responsibility for implementing *Making Every Contact Count.* It is also of use for a range of different purposes, including commissioning, providing services, training, awareness raising and evaluation. There is also an indication that as a resource the guide and toolkit would be of ongoing value in implementing other initiatives or programmes to provide personal tailored support in making positive change that are branded under another name.

It appears that the greater the number of resources within the guide and toolkit that were used, the stronger the positive reception that the implementation guide and toolkit received with all resources having been used by someone. The overall design and development of the whole package was also valued. Users encouraged others to use the guide and toolkit as a resource adapting it to local needs and priorities and the people concerned, as well as developing systems and resources to assist with implementation locally.

Users of the guide and toolkit would ideally like to see it reviewed on a regular basis, and updated if necessary, with support for its ongoing use on some form of regional basis. However, in the potential absence of such support, emphasis was placed on the continued value of the MECC implementation guide and toolkit in taking forward health improvement through personal tailored support in making positive change. As implementation itself is developmental, there is benefit from sharing experiences and learning across organisations.

It is recommended that prior to the disappearance of the SHA, there should be strong consideration to undertaking some rapid work on:

- producing case studies of practice in implementing MECC as this has not been possible within the scope and timescale of this review to enable organisations to continue to learn from one another
- ensuring that the MECC implementation guide and toolkit is readily available for a wide range of organisations to access and use on an ongoing basis
- publicising the MECC implementation guide and toolkit to a range of organisations and potential users and inform them where it can be found
- ensuring that a suitable legacy is left that encourages the sustainability of MECC into the core business of localities and encourages local dialogue between commissioners and providers (whoever or whatever those organisations might be in the future) in order to meaningfully measure and evaluate progress.

**APPENDIX 1: Pre-workshop survey**

## Reviewing the Implementation Guide and Toolkit for Making Every Contact Count

### Pre workshop survey

The purpose of this short survey is to gather more information from individuals who have signed up to the MECC Implementation Guide Review workshop on 8 January 2013. We will use the outcomes to inform the design of the workshop with the aim of making it as effective as possible.

**1. What have you used the MECC guide for?**

*Please indicate all that apply*

a Developing commissioning ☐

b Developing local provision ☐

c Developing &/or delivering training ☐

d Raising awareness of / informing people about MECC ☐

e As a means of evaluating what we were already doing on MECC ☐

f Other, please state:

**2. What stage(s) of implementing MECC are you currently at?**

a Gaining organisational support for implementing MECC ☐

b Planning how to implement MECC ☐

c Implementation ☐

d Evaluating our effectiveness ☐

e Other, please provide further information:

**3. Which staff groups have you been seeking to get involved with MECC?**

*Please indicate all that apply*

a Professional staff in an NHS organisation ☐

b All staff in an NHS organisation ( *including healthcare assistants*) ☐

c Staff within primary care providers (*GP practices*) ☐

d Staff groups within local authorities ☐

e Staff within private and voluntary sector providers ☐

f Other, please state:

**4. How helpful has the implementation guide been?**

a Very helpful ☐

b Quite helpful ☐

| | | |
|---|---|---|
| c | Neither helpful nor unhelpful | |
| d | Not much help | |
| e | Of no help at all | |

**5. The implementation guide consists of the guide itself and a number of resources. Please indicate below which parts of the guide and resources you have used to date.**

| | | |
|---|---|---|
| a | The implementation guide itself | |
| b | Implementation checklist | |
| c | Behaviour change pathway and competence mapping | |
| d | Communications toolkit | |
| e | Example data capture forms | |
| f | Example CQUIN | |
| g | Examples from practice | |
| h | Individual and team assessment tools | |
| i | Information on self-care of how to access further support | |
| j | Links to policy drivers and initiatives | |
| k | Making the case presentation | |
| l | NHS Midlands and East Metrics | |
| m | Organisational assessment tool | |
| n | Orientation workshop slides | |
| o | Prompt card and health benefit cards | |
| p | Training options | |
| q | MECC skills workshop | |
| r | West Midlands MECC E learning | |

**6. Are there any resources from elsewhere that you have used in implementing MECC that are not in the Implementation Guide?**

a Yes

b No

If you stated yes, please indicate what these other resources are

| *Boxes expand with response* |
|---|

**7. Please tell us here about any other information or resources you would have liked to find in the Implementation Guide and resources.**

| |
|---|

***Thank you for completing this survey we look forward to working with you on 8 January 2013 in Nottingham.***

**APPENDIX 2: WORKSHOP AGENDA**

## Reviewing the Implementation Guide and Toolkit for Making Every Contact Count: Using Every Opportunity to Achieve Health and Wellbeing
## Workshop Agenda

09.30 Registration and Refreshments

10.00 Task 1: Using the MECC implementation guide and toolkit – what works

1. If you could only pick a maximum of three aspects of the guide and toolkit to recommend to people, what would they be?
2. Why would you recommend people use these resources?

10.45 Task 2: Using the MECC implementation guide and toolkit – what did you find difficult

1. Thinking about when you first found about / started using the toolkit, what did you struggle with:
2. How did you overcome these issues?

11.15 Task 3: Using the MECC implementation guide and toolkit – for specific purposes

*Sit at the relevant pre-labelled table of:*

*a Developing commissioning*
*b Developing local provision*
*c Developing and/or delivering training*
*d Raising awareness of / informing people about MECC*
*e Evaluating progress and outcomes on MECC*

*Questions for each group*

1. How have you used the MECC implementation and guide to help with … (eg developing commissioning)?
2. What else did you have to do to make MECC work (i.e. beyond the toolkit)?
3. What does success look like and how can you capture it?

*12.45 Lunch and networking*

13.30 Task 4: Into the Future – using the implementation guide and toolkit to improve people's health and wellbeing through 'personal tailored support in making positive change'

*Questions for each the group*

1. What is the future for improving people's health and wellbeing?
2. Does the implementation guide and toolkit support this future?
3. How does the guide and toolkit need to change (be as specific as possible)?

14.35 Task 5: Thinking about improving health and wellbeing generally through 'personal tailored support in making positive change'

1. What has been your biggest achievement to date?
2. What have been the barriers to implementation?
3. What has helped you most with implementation?

15.20 Summary and next steps
15.30 Close