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Making Every Contact Count (MECC): evaluation framework

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1. Introduction

This evaluation framework has been developed to support the implementation of Making Every Contact Count (MECC). It is intended for use by local MECC programme managers and operational leads, and those who have an oversight of lifestyle services delivery within their role. It may also be of interest to local health improvement commissioners, and others with an interest in this field. This resource has been developed by the Kent Surrey and Sussex Making Every Contact Count programme, hosted within Medway Council, and draws on learning from the Public Health England Obesity Standard Evaluation Frameworks[1]. It is founded on a model developed by the NHS Leadership Academy and its Leadership Development Partners, and has been piloted with local spearhead MECC projects across the Kent, surrey and Sussex region.

Why evaluate making every contact count

Evaluation is about 'judging the worth of an activity' (Sidell and Douglas, 2012)[2]. It should help establish the extent to which a programme has achieved its objectives, and as part of this, assess how different components have contributed to or influenced the outcome. Evaluation differs from monitoring, which is the routine and systematic collection of information about project activities such as the number of MECC interventions that has taken place during a period, or details on the types of staff who have been trained to deliver MECC. Service monitoring helps indicate the progress of delivery for an initiative and its data is generally drawn from routine programme documents or records. Evaluation differs by involving the collection of specific data to help identify which parts of a programme have worked, and those that may have worked less well. Evaluation cannot usually be undertaken with routine or standard service monitoring data alone,

MECC is an approach that supports public facing workers to 'make every contact count' by using opportunities during routine contacts to support, encourage and enable people to consider healthybehaviour changes such as stopping smoking, to help maintain or improve their mental and physical health and wellbeing. This will involve initiating either a very brief, or a brief healthy conversation with a person as part of a routine appointment or consultation, and where appropriate, signposting them to local services and sources of further information.

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[1] Public Health England Obesity Standard Evaluation Frameworks. Available online at: http://www.noo.org.uk/core/frameworks [accessed 100316]

[2] Nutbeam D, Bauman A. Evaluation in a Nutshell: a Practical Guide to the Evaluation of Health Promotion Programs. Sydney: McGraw Hill Publishers, 2006

Establishing a local MECC programme involves considering:

- Organisational readiness; for example, supporting development of local leadership, governance arrangements and pathways for MECC
- Staff Readiness; supporting managers and service leads to champion and implement MECC, enabling staff to develop an awareness of why MECC is everyone's responsibility
- Training; the delivery of training to frontline staff for them to feel confident and equipped with skills to help individuals to explore issues, to plan for lifestyle change, to set goals, and to engage in healthy conversations and signpost to services where necessary
- Delivery; the delivery of a MECC intervention to patients or clients and colleagues

There are at least six reasons why MECC programmes should be evaluated:

- to establish if local MECC projects are delivering the intended changes aimed for in local project plans. These changes may include cultural or organisational ethos change, workforce development, increasing staff understanding and improving local population health. Evaluation offers the opportunity to measure the impact and benefits of MECC to organisations, to staff and the public
- to support improvement and adjustments to MECC programmes. Evaluation offers a feedback loop to help respond and tailor any programme approaches to meet organisational, staff and local population needs
- to know how things are working. Evaluation will help to show which parts of a MECC approach are working well and which may need to be revised or improved.
- to highlight any unintended outcomes and benefits from local programme delivery.
- to help communicate the value of MECC by quantifying some of the benefits achieved locally
- to help focus on the outcomes and benefits for MECC programmes.Highlighting that the benefits of MECC are broad and reach beyond processes for implementing MECC, such as the delivery of MECC training to professionals. is key.

2. The evaluation model

This document describes the types of information that could be collected to evaluate a MECC programme or activity. It is intended to be an aid for evaluating interventions and programmes that include parts taking place at an individual and an organisational level. This framework provides support in the following areas:

1. How to identify the investment in MECC
2. How to select suitable measures for evaluating outcomes
3. How to approach the challenges of assessing and measuring impact

Logic model and evaluation

A logic model can help to visually map and identify the assumptions that underpin a programme, such as that a certain type of intervention will lead to specific outcomes. It can also help in thinking through project aims and objectives by linking these in a map format to identify whether these are realistic, for example, that MECC activity will lead to an increased uptake of lifestyle services or a reduction in the prevalence of certain health related behaviours. According to NICE* a logic model can help provide:
'narrative or visual depictions of real-life processes leading to a desired result. Using a logic model as a planning tool allows precise communication about the purposes of a project or intervention, its components and the sequence of activities needed to achieve a given goal. It also helps to set out the evaluation priorities right from the beginning of the process.'
A logic model is a key part of an evaluation as it can also help when factoring whether there are specific circumstances or local contextual factors that might favour or hinder the effectiveness of a MECC programme, such as the existence of a single lifestyle hub for local lifestyle services information.

A logic model visually shows and maps the components of the MECC programme, enabling the identification of the elements within it for them to be evaluated, such as:

- Inputs; what activity has been undertaken for example, interventions or activities and who did this reach, such as participants
- Outcomes; what are the changes that are expected or intended as a result of the programme

* NICE (2014) Behaviour change individual approaches PH49 https://www.nice.org.uk/guidance/ph49/chapter/7-Glossary

The evaluation should include three components:

1. Process evaluation to show how any MECC outcomes or impact were achieved. Measuring the activities of the programme, the programme quality and who the programme or activity has been reaching.
2. Outcome evaluation to assess the effectiveness of a MECC programme in enabling change. This involves measuring the immediate and medium-term effects of a MECC programme and should be based on the programme's aims and objectives. This may also enable reviewing the effectiveness of different or bespoke elements or activities in the local MECC approach, such as local tailored groups or settings for MECC delivery.
3. Impact evaluation to assess the contribution from the programme to longer-term changes and improvements - as defined within the local programme or project plan – resulting from delivery of a MECC intervention or programmes.

The starting point when developing a programme logic model is identifying the local context or service situation where the MECC activity is taking place, and what the local drivers are for this. This will vary as a MECC programme may take place to meet a local population or service need, or because of an external driver such as a policy change, or sometimes due to a local funding opportunity. Taking the specific context as the starting point for the logic model, consideration should then be made of the MECC priorities that have been decided locally, or those that have arisen For example, will there be a focus for local MECC activity within certain settings such as job centres, or for MECC training to take place with certain professional groups locally, such as primary care practice nurses.

A logic model enables leads to consider both the process or project planning aspects such as the number of people trained; and also the objectives for the programme that are important and are being aimed for locally. The logic model will help map local objectives for the project, and how these are aimed to be delivered and achieved locally; and also how these can also be evaluated to help measure programme impact.

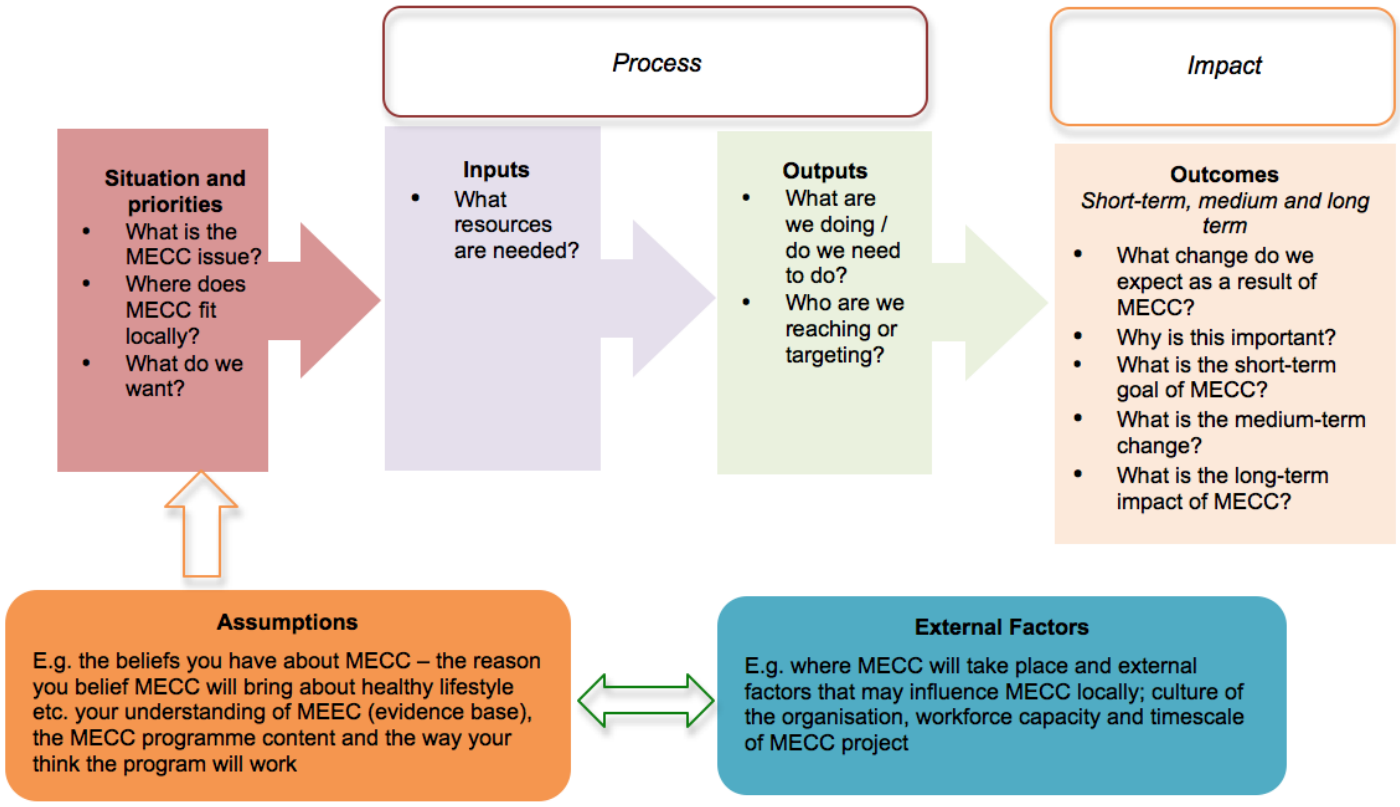
Figure 1: Starting components of logic model

How measurements for a project are selected will be influenced by the local population, service delivery models and priorities. For example:

Local situation: A local delivery model to meet local needs for example, where MECC is being used as a means to increase numbers of the local population who engage in behaviour change opportunities following taking part in a healthy conversation and receiving either a referral to a local lifestyle service, or signposting to sources of further information.
MECC priorities: this will vary depending on local circumstances, but could include engaging non-healthcare and wider workforces in the uptake of lifestyle services through engagement with MECC.

The core components of a logic model and how they relate to the process, outcome and impact elements of an evaluation process

Figure 2: Components of logic model and evaluation



When defining any evaluation measures, thought needs to be given to any assumptions about the programme and its delivery, plus any external influences identified for the MECC initiative. For example:

Assumptions example

MECC will bring about an increase in lifestyle service uptake and reduction in local smoking and obesity prevalence. Some MECC reports show an impact on referrals, although measuring cause and effect is hard. The MECC programme will be offered to social care staff in areas with low uptake of services and will involve half day very brief interventions training and lifestyle services presentations

External factors example

MECC project will focus in adult social care and will be offered to social workers, care managers and assistants. The number trained in each social work team will be influenced by workforce capacity. Team meetings will be attended to explain the project and training will be completed across all participating teams in 3 months.

When choosing MECC measures for an evaluation they need to reflect the boundaries of the local programme and they should also help clarify the important **inputs, outputs** and **outcomes** you need to consider when both designing your MECC project and to also measure its success and impact. It is important to remember that an impact from an intervention or programme could also be negative, undesirable or unexpected. For example, there may be limited workforce capacity to undertake training, or demand for some lifestyle services could increase and outstrip existing capacity following a raft of effective MECC interventions and signposting activity. Evaluation aims to uncover all impacts, including the positive and intended ones, as well as any unplanned or negative impacts.

The next sections of this framework outline what issues need to be considered when setting up the evaluation of a MECC programme and the key steps to take. Vital areas that underpin the successful delivery of any MECC programme are having organisational readiness and ‘buy in’ of staff readiness and effective training systems in place; so these have been included as standard sections within the evaluation outlines included in the following chapters. These are intended as a useful guide for those establishing or refreshing a MECC evaluation process, and local leads may decide in addition, to devise and add their own specific local measures into these tables.

3. MECC Inputs: selecting and measuring

Getting Started

Inputs are any resources that are used to develop or deliver a MECC activity in a local area, setting or organisation. Information on inputs is often collected routinely as part of service monitoring, for example information on human resource funding. Some suggested MECC inputs and how they could be measured for evaluation purposes are outlined below.

MECC Input	Recommended measure
Organisational readiness	
Financial resources	• Cost of training package or delivery
	• Cost of MECC resources e.g. prompt cards for staff
Human resources	• Size/number of staff group selected for training vs whole population
Organisation leaders buy-in	• Number of key leaders/stakeholders engaged in training
	• Number of presentations/briefings made to leaders
MECC governance and pathways	• MECC strategy in place within organisation
	• MECC lead identified - including how much time/capacity for MECC
	• MECC trainers identified number of trainers secured
	• MECC part of contract delivery or service pathways
Staff readiness	
Managers and service leads involvement	• Number of managers involved in training
	• Number of presentations/briefings made to managers
Awareness of MECC amongst staff groups	• Type of MECC publicity within organisation i.e. staff newsletters and number of publicity activities/or estimated reach e.g.number of readers
	• Number of presentations/briefings made to staff groups

MECC Training	
MECC training delivered to relevant staff group	• Relevant staff groups identified for basic and/or skilled competency training
	• Proportion of the target staff population participating in the training
Delivery	
MECC infrastructure	• Number of topics with a signposting resources in place
	• Local coordinator in place

4. MECC outputs: selecting and measuring

Outputs are about 'what we do and who we reach,' and should include:

- **Activities;** the actual tasks undertaken as part of programme delivery
- **Participation;** who is engaged with the programme, and how those served by the programme engage with its activities. It is useful to consider the local workforce as well as local populations here.

The outputs included in an evaluation could be:

- **Activities;** what happened during the development of MECC i.e. the MECC training delivered, or any organisational preparations for MECC delivery such as local referrals and pathways developments
- **Participants;** those involved in the training for or the delivery of the MECC activity. This data is likely to be routinely collected monitoring data. Some suggested MECC outputs, and how they could then be measured for evaluation purposes are listed below.

MECC Output	Recommended Measure
Organisational Readiness	
MECC governance and pathways	• Number of pathways that now include MECC [compared to the baseline before the MECC programme was first introduced or before it was refreshed/revised]
	• MECC reporting structure in place [e.g. reporting lines in place to Board/senior organisational level for accountability]
Staff Readiness	
Managers and service leads involvement	• Supervision of MECC programme and practice structure/model in place
	• What method of peer observation/ staff supervision or support is used for MECC activity to ensure a good quality of MECC interventions are delivered
MECC Training	
MECC training reached relevant staff group	• Number of staff trained or number of staff who participated in training (level 1 and/or level 2)
	• Number of trainers trained
	• Proportion of staff population participating

	in the training
	• Participant satisfaction, knowledge gain and confidence with training
	• Participants understanding of the different levels of training undertaken
Delivery	
MECC intervention	• Number patients/clients receiving a MECC contact
	• The demographic characteristics of people reached
	• Number of forms of MECC intervention taken place e.g. within routine appointment, opportunistic healthy conversation

5. MECC outcomes: selecting and measuring

An outcome is concerned with the 'so what', the reasons why the programme or activity is being undertaken, and the difference that the programme aims to make.
Outcomes can include:

- **Short term** effect; for example with learning, this could include increasing awareness, knowledge, skills, or individual motivations
- **Medium term** effects; what signs are there that the programme has been able to help deliver or effect change locally, for example, changes in practice, revised or new policies or pathways, which now incorporate MECC or healthy conversations activity, training activity
- **Longer term** impacts; including cultural change, or changes in behaviour.

An outcome indicator needs to be able to link back to, or provide a measure, against the objectives of the MECC programme or MECC activity. For example, by indicating what outcome a healthy conversation intended to achieve or deliver. It is important when devising outcomes in a programme to capture healthy lifestyles behaviour change that they factor for both short-term and longer term activity, along with a wide-ranging measure of impact. Some suggested MECC outcomes, and how they could be measured within an evaluation, are listed below.

Quantitative data collection

MECC Outcome	Recommended Measure
Short term	
Training	• Increase in knowledge eg healthy lifestyle messages
	• Increase in understanding of behaviour change
	• Number obtaining Level 1 competency
	• Number obtaining competency level 2
	• Increase in confidence to undertake a very brief/brief intervention
Interventions	• Number of information-only interventions
	• Number of people signposted to local self-help activities/networks
	• Number of return service users i.e. people seeking further or follow up information or advice
	• Increase in uptake of lifestyle services

	• Number of people who intend changing their behaviour following a healthy conversation i.e. they set a goal
Longer term	
MECC embedded into policies, procedures & training	• Number of new staff inductions that include mandatory MECC training at a basic competency level
	• Number of job descriptions that include MECC or healthy conversations practice
	• A designated senior MECC or behaviour change lead within the organisation
	• MECC integrated with a referral pathway/signposting into the National Child Measurement Programme (NCMP)
	• MECC integrated with a referral pathway/signposting into the NHS Health Checks Programme
	• Number of trained staff who have not undertaken or engaged in a MECC intervention at 3, 6, 9 and 12 months post training
Training	• Changes in own behaviour/practice of MECC trained staff
	• Progression to other behaviour change training
	• Development of staff well-being and health initiatives
	• Number of staff who uptake lifestyle services
	• Impact on staff sickness either absenteeism and/or presenteeism
Impact*	
Training	• Whole organisation trained at basic MECC or healthy conversations competency, or MECC principles embedded in

* Establishing the impact of MECC is complex . MECC may only be the first step in behaviour change as it is focussed on raising the issue of health and well being and supporting people to consider change, and for some people, it effecting behaviour change may involve multiple healthy converstaions before action is taken. Therefore attributing or linking a specific MECC intervention to a positive change and outcome may be problematic or potentially unatrributable. Additionally confounding influences, such as changes to the local delivery landscape, or impacts from national, regional or local health campaigns, and the wider determinants of health or population changes may influence a change in prevalence rates for local levels of health conditions. Therefore, it is important when approaching an evaluation, that you determine the impact of MECC programmes or activity for your local context and priorities, and that these should be considered in the evaluation work.

	organisational mandatory training
Intervention	• Reduction of behaviours with impact on health amongst staff e.g. fewer smokers
	• Number of people who report a behaviour change or health improvement

6. Types of data to consider using

This framework has outlined the steps and measures that can be used when evaluating a MECC programme or scheme. The types of data that can be used as part of this includes both quantitative i.e. numbers (also known as descriptive) and qualitative data (also know as explanatory data). The quantitative data mentioned in this guide below will fit with both the process and outcome evaluation measures outlined in the previous chapters.

Much of the qualitative evidence available for evaluation may be in the form of narrative explanation and feedback which also provides an opportunity to build a picture of how things were prior to the introduction of the MECC activity (establishing a baseline), and how much these may have changed with the introduction of the MECC activity. It also offers insight into the impact and participant experiences of MECC. The table below outlines the some of the potential narrative feedback that could be used in an evaluation.

Qualitative data collection

MECC Theme	Narrative Content
Organisational Readiness	• Capturing the benefits of MECC to the organisation • Goals for the MECC project, and expectations of the changes which are likely to be made within the organisation as a consequence of the intervention • How the organisation plans to apply learning about MECC • The process changes required internally to support MECC delivery • Reflections about how organisational leaders are thinking, feeling and doing things differently around MECC
Staff Readiness	• How staff feel about MECC • How or whether staff are

	doing things differently around MECC
Training	• Feedback from trainees about the training content and how are they feeling about using their new skills to implement MECC • Reflections from trainees on linking new learning and skills to their own and others' behaviour • Feedback on value of the training
MECC Delivery	• Illustration of MECC pathway and/or client case histories • Examples of expected benefits being delivered • Examples where things went wrong, or unintended outcomes or abandoned interventions (these can also provide useful learning)

Resources

Below are some resources that are available to provide further information on logic models, and help in choosing evaluation methods and measures.

MECC Resources

Public Health England (PHE) and Health Eduction England (HEE),
Practical resources for MECC via https://www.gov.uk/government/publications/making-every-contact-count-mecc-practical-resources

- MECC Implementation guide
- MECC Quality Marker Checklist for Training Resources

Evaluation Tools

The Programme Evaluation toolkit - Canadian templates
Avon Primary Care Research Collaborative website via
http://www.apcrc.nhs.uk/evaluation/toolkit.htm

Logic Models

Evaluation Scotland via
http://evaluationsupportscotland.org.uk/media/uploads/resources/supportguide1.2logicmodelsjul09.pdf

Choosing Outcomes

Evaluating Scotland Clarifying your aims and outcomes
Avon Primary Care Research Collaborative via
http://www.apcrc.nhs.uk/evaluation/documents/general_toolkit.pdf

Appendix1: logic model template for MECC

Logic Model Template for MECC

Name of MECC Project: **Local Situation:** **Priorities:**					
INPUTS	**OUTPUTS**		**OUTCOMES**		
What we need to invest	**What will be done (intervention)**	**Who will we reach (participants)**	**What are the results of the programme : short-term outcomes**	**What are the results of the programme: medium term outcomes**	**What are the results of the programme: long term impact**
eg • Staff • Volunteers • Time • Money • Materials • Equipment	eg • Conduct workshops and meetings • Train • Deliver services • Facilitate access to information • Work with media	eg • People • Staff • Organisations • Decision-makers • Customers • Clinical professionals	eg *Learning* • Knowledge • Skills • Opinions • Aspirations • Motivations	eg *Action* • Practice/Delivery • Policies • Social Action	eg *Conditions* • Health • Social • Economic • Organisational

Assumptions	**External Factors**
eg • The beliefs you have about MECC - the reasons you believe MECC will bring about healthy lifestyles etc. • Your understanding of MECC (evidence base) • The MECC programme content • The way you think the program will work	eg • Where MECC will take place • External factors that may influence MECC locally • Culture of organisation and workforce capacity • Timespan of MECC project. • Having a MECC co-ordinator • Having a lifestyle hub • NHS/Local Authority/voluntary sector links

Appendix 2: blank logic model template

Project Name: **Local Setting:** **Priorities:**					
INPUTS	**OUTPUTS**		**OUTCOMES**		
What we need to invest	**What will be done (intervention)**	**Who will we reach (participants)**	**What are the results of the programme : short-term outcomes**	**What are the results of the programme: medium term outcomes**	**What are the results of the programme: longer term impact**

Assumptions	**External Factors**

Appendix 3: sample completed logic model template

Sample completed logic model (based on example within the Evaluation framework document)

Project: MECC within Hollywood Social Services

Local Setting: Local lifestyle services driving the need for MECC as a mechanism for increasing referrals

Priorities: Adult social care workforces to encourage uptake of services, signposting to Stop Smoking, Weight Management and NHS Health Checks

A sample completed logic model template is included on the following page for information.

INPUTS	ACTIVITIES	OUTCOMES

INPUTS	ACTIVITIES		OUTCOMES		
What we invest	**What we do**	**Who we reach**	**What are the results of the programme: short-term outcomes**	**What are the results of the programme: long term outcomes**	**What are the results of the programme: impact**
• Financial resources ie back fill for training • People ie Number of staff group to be trained vs staff population • Organisation leaders buy-in ie Number of presentations/briefings made to leaders • MECC resources ie health message cards	• Supervision of MECC practice structure in place • MECC reporting structure in place • Develop a skills based training program • Develop a Train the Trainer program to sustain project • Review current practice re clients presenting to adult social care ie is health assessed/explored already	• 50 staff trained • 5 trainers trained • Proportion of staff population participating in the training • Trainee satisfaction, knowledge gain and confidence following training • Number of clients receiving a MECC contact • Demographic characteristics of people reached • Number of forms of intervention eg routine appointment, opportunistic	• Increase in lifestyle knowledge amongst staff trained • Increase in understanding of behaviour change amongst staff trained • Number obtaining MECC skill competency(Level 2) • Increase in confidence to have a healthy conversation • Reduction in the number of stopped MECC interventions and reason • Number of service users signposted to local self-help activities/networks • Type of service signposted to • Increase uptake of lifestyle services	• Number of trained staff who never undertaken a MECC intervention at 3, 6, 9 and 12 months post training • Number of new staff receiving MECC training • Number of trainers retained • Change in trained staff's own behaviour • Development of staff well-being and health initiatives • Number of staff who uptake lifestyle services • Impact on staff sickness	• All of social care trained and achieve MECC competency • Social work team training attendance impact on service delivery and capacity • Increase in lifestyle services activity – could be + or -ve • Reduction of risky lifestyles/health behaviour eg fewer smokers • Number of users who report behaviour change or health improvement

Assumptions	External Factors
• MECC will bring about an increase in lifestyle service uptake • MECC will bring a reduction in local smoking and obesity prevalence • Some MECC reports show an impact on referrals, although measuring cause and effect is hard. • The MECC programme will be offered to social care staff in areas with low uptake of services • Training will involve half day VBI training and lifestyle services presentations	• MECC project will focus in adult social care and will be offered to Social Workers, Care Managers and Assistants • The number trained in each social work team will be influenced by workforce capacity • Successful implementation will be enhanced through the MECC lead/project manager attending team meetings to develop MECC approach, work plan and otline philosophy and practical implications • Training will be completed in 3 months

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