THE CHESHIRE AND MERSEYSIDE QUICK GUIDE TO MECC EVALUATION

The aim of this document is to provide suggestions and guidance on how Cheshire and Merseyside organisations and systems can evaluate their own MECC programme. It is summarised and adapted from the existing Public Health England MECC Evaluation Framework[1].

Evaluation helps to establish the extent to which a programme has achieved its objectives and involves the collection of specific data to help identify which parts of a programme have worked and those that have worked less well. It should be recognised that there are challenges with attributing health outcome changes to a real-world programme, not least because of other factors influencing behaviour change. Overall, there is a need to be realistic about the aims of evaluation and to not be too ambitious.

Key success factors for MECC programmes include organisational readiness, staff 'buy in' and effective training systems and these should be considered in evaluation.

STEP 1) DEFINE THE AIMS AND OBJECTIVES OF YOUR EVALUATION

MECC programme evaluation is important for establishing that the intended changes are being delivered; supporting improvements to the programme; knowing how things are working; highlighting any unintended outcome or benefits; and communicating the value of MECC.

STEP 2) STRUCTURE YOUR LOGIC MODEL

A logic model can help to visually map and identify assumptions that underpin a programme, such as that a certain intervention will lead to specific outcomes. Inputs (what activity has been undertaken) and outcomes (the expected or intended changes) should be defined. Consideration should be given to what the context, drivers and priorities of the local programme are.

A simple MECC logic model is shown in Appendix 1.

STEP 3) DEFINE ASSUMPTIONS AND EXTERNAL FACTORS

- **Assumptions:** are the underlying beliefs held regarding the programme including beliefs about MECC and how the programme will work
- **External factors**: are those factors which will influence your programme delivery and its success

[1] Public Health England (2016). Making Every Contact Count (MECC): practical resources. https://www.gov.uk/government/publications/making-every-contact-count-mecc-practical-resources

STEP 4) DEFINE INPUTS

Inputs are those resources that are needed to deliver the programme. This will be information that is routinely collected as part of service monitoring.

As a minimum it is suggested that the following are included:

- Financial costs of the programme (including those linked to training packages or MECC communications materials)
- Leadership including:
    - Whether there is a named MECC lead(s) in place; their level of seniority and dedicated time to lead or oversee this programme
    - Whether there is a MECC strategy or plan in place
- Whether MECC is included in contracts and the extent to which this monitored

STEP 5) DEFINE OUTPUTS

Outputs can be defined in terms of:

- **Activities**: what we do (the tasks). As a minimum it is suggested that the following are included:
    - MECC reporting processes
    - Formal inclusion of MECC interventions within pathways
    - Training sessions delivered
- **Participation**: who we reach (likely routinely collected monitoring data)
    - Number of trainers trained
    - Number of staff trained against each type and level of training
    - Number of patients or service users that receive MECC intervention and type of intervention. Organisations will need to consider the best way to capture this activity. This could include electronic patient systems.

STEP 6) DEFINE OUTCOMES

Outcomes refer to the difference or impact that the programme aims to make (i.e. the 'so what'). Outcomes can be short term, medium term or longer term.

- **Short term** – this should include evidence of direct impact of activity.
  As a minimum it is suggested that this should include the short-term outcomes of training. For example:
    - Satisfaction
    - Awareness
    - Knowledge
    - Skills
    - Confidence

  Organisations may wish to consider examples of tools that have been used elsewhere to evaluate the above. One such example is the before-after questionnaire currently being used to evaluate the Cheshire and Merseyside face to face training programme (Chisholm A, Byrne-Davis L, Peters S, Beenstock, J, Gilman S, Hart J (2018). Pre-post

evaluation of online behaviour change technique training to support healthcare staff 'Make Every Contact Count'. I*n submission).*

In addition, for organisations using the Cheshire and Merseyside MECC Communications Toolkit, there will be surveys available to assist with this element of programme evaluation.

- **Medium term** – this should include evidence of change in practice.
  This could include:
  - Number of patients or service users signposted or referred onto relevant services
  - Number of patients or service users accessing further sources of information and/or lifestyle services
  - Reported changes in practice of MECC trained staff (e.g. via a staff survey). Please note that staff undertaking the Cheshire and Merseyside face to face training programme will be followed up via electronic survey with respect to this element.
- **Longer term** – this should include individual or staff behavioural change or organisational change. Note that of all areas this if often the most challenging to evidence and involves some form of follow-up of patients or service users. This could be achieved through routine data recording as part of patient or service user follow up or through bespoke pieces of work (which could involve specifically following up a cohort of staff, patients or services users)
  This could include:
  - Number of people changing their health-related behaviours (staff; patients or service users)
  - Impact upon longer term population health outcomes. This aspect in particular will be very difficult to robustly evidence at scale given that population behaviours are multi-factorial in nature and a mechanism is needed to follow MECC conversation recipients up.

STEP 7) COLLECT AND COLLATE DATA

STEP 8) ANALYSE AND SUMMARISE DATA

STEP 9) DRAW CONCLUSIONS AND MAKE RECOMMENDATIONS

STEP 10) SHARE YOUR EVALUATION

One key consideration in evaluation is the value of sharing the learning that you have gained in implementing MECC. Please do consider sharing with the Cheshire and Merseyside MECC Board as the board is keen to help build the evidence base on MECC implementation and to

identify ways in which organisations across Cheshire and Merseyside can be further supported.

Other top tips

- Remember that potential impacts can also be negative, undesirable or unexpected and it is important that these are also captured and shared
- Consider whether the evaluation will be conducted internally or whether you will commission your evaluation from another organisation
- Consider what types of data may be best to use to evaluate your programme. These can include:
    - Quantitative descriptive data including routinely collected monitoring data
    - Qualitative data including narrative explanation; reflections of leaders and implementers; feedback on training and barriers and enablers to implementation
    - Case studies and best practice examples
- Consider need for formative as well as summative evaluation (i.e. identify how to improve as well as prove that the programme works)
- Consider capturing health economic data as part of your evaluation
- Consider the nature of the evaluation work you are planning and whether a formal ethical opinion or approval is needed

SUMMARY OF MECC EVALUATION STEPS

1) Define the aims and objectives of your evaluation
2) Structure your logic model
3) Define assumptions and external factors
4) Define inputs
5) Define outputs
6) Define outcomes
7) Collect and collate data
8) Analyse and summarise data
9) Draw conclusions and make recommendations
10) Share your evaluation

For further information, detail and advice: please contact Charlotte Simpson at charlotte.simpson@phe.gov.uk

Appendix 1: Example of a simple MECC logic model

MECC Logic Model			
Inputs: What we invest	**Activities: What we do** (what happened during the programme development)	**Activities: Who we reach** (those involved in the training for or the delivery of the MECC activity)	**Outcomes**

• Financial resources:
  ✓ Cost of training
  ✓ Cost of communications resources
• Leadership including:
  ✓ named MECC lead(s): seniority and dedicated time
  ✓ MECC strategy or plan in place
• Inclusion of MECC in contracts and monitoring
	• Training sessions delivered
	• MECC reporting processes
	• Formal inclusion of MECC interventions within pathways
		• Number of trainers trained
		• Number of staff trained against each type and level of training
		• Number of patients or service users that receive MECC intervention and type of intervention.
			• **Short term:** Training participants satisfaction, awareness, knowledge, skills and confidence
			• **Medium term:**
			  ○ Number of patients or service users signposted or referred onto relevant services
			  ○ Number of patients or service users accessing further sources of information and/or lifestyle services
			  ○ Reported changes in practice of MECC trained staff (e.g. via a staff survey)
			• **Longer term:**
			  ○ Number of people changing their health-related behaviours (staff; patients or service users)
			  ○ Impact upon longer term population health outcomes.

making every contact count

Assumptions	External factors
That dedicated resources to support the MECC programme exist That the scope of the MECC intervention is in line with (though not necessarily limited to) PHE Level 1 definition That evidence-based training, messaging and interventions are delivered That staff are released to attend training That MECC is one important component of a broader population behaviour change strategy That achieving individual behaviour change is one important component of a broader population health framework That free online MECC training packages are currently available That a face to face MECC training offer exists That measuring the true impact of a system-wide MECC approach is challenging	• Availability of training • Capacity within lifestyle services